Staffordshire Health and Wellbeing Board

3.00 pm Thursday, 7 September 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 - 6)

2. **Questions from the public**

FOR DECISION

3. **End of Life Care - Public Conversation**

   Verbal update by Allan Reid, Consultant in Public Health

4. **Pharmaceutical Needs Assessment** (Pages 7 - 120)

   Richard Harling, Director for Health and Care

FOR DEBATE

5. **Burton/Derby Hospital Transformation** (Pages 121 - 124)

   Gavin Boyle, Chief Executive, Derby Teaching Hospital NHS Foundation Trust
   Helen Scott-South, Chief Executive, Burton Hospitals NHS Foundation Trust
   Magnus Harrison, Medical Director, Burton Hospitals

NHS Foundation Trust

6. **Families Strategic Partnership Highlight Report** (Pages 125 - 152)

   Helen Riley, Deputy Chief Executive and Director for Families and Communities

7. **Together We're Better: Update on Progress** (Pages 153 - 160)

   Simon Whitehouse, Programme Director

8. **Physical Inactivity Sub-Group** (Pages 161 - 164)

   Ben Hollands, Sports Across Staffordshire & Stoke-on-Trent (SASSOT)

9. **Place Based Approach** (Pages 165 - 184)

   Helen Riley, Deputy Chief Executive and Director for Families and Communities

10. **Prevention Through Wellness - People and Place Based Approach** (Pages 185 - 188)

    Karen Bryson, Assistant Director, Public Health and Prevention

FOR INFORMATION

11. **Better Care Fund Update** (Pages 189 - 190)

    Richard Harling, Director for Health and Care

12. **JSNA Outcomes - August 2017** (Pages 191 - 198)

13. **Forward Plan** (Pages 199 - 204)

14. **Date of next meeting**

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

Membership

Gareth Morgan	Chief Constable Staffordshire Police
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)
Frank Finlay	District Borough Council Representative (North)
Dr John James	South East Staffordshire and Seisdon Peninsula CCG
Roger Lees	District Borough Council Representative (South)
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
Philip White	Staffordshire County Council
Simon Whitehouse	Staffordshire Sustainability and Transformation Pl
Helen Riley	Staffordshire County Council

Contact Officer: Jon Topham, (01785 278422),
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Note for Members of the Press and Public

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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 6 July 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)
Dr. John James	South East Staffordshire and Seisdon Peninsula CCG
Roger Lees	District Borough Council Representative (South)
Mark Sutton	Staffordshire County Council (Cabinet Member for Children and Young People)
Glynn Luznyj	Staffordshire Fire and Rescue Service
Mike Sutherland	Substitute Member
Cheryl Hardisty	Substitute Member

Also in Attendance
Jon Topham (Senior Commissioning Manager, Public Health), Allan Reid (Consultant in Public Health), Karen Bryson (Assistant Director, Public Health and Prevention), Cristian Marcucci (Head of Communications), Vicky Rowley (Commissioning Manager), Martyn Baggaley (Senior Commissioning Manager, All-Age Disability) and Rebecca Wilkinson (BCF Programme Manager).

Apologies: Dr Alison Bradley (North Staffs CCG), Frank Finlay (District Borough Council Representative (North)), Jan Sensier (Executive Director, Engaging Communities Staffordshire) (Healthwatch Staffordshire), Marcus Warnes (North Staffordshire CCG), Dr Paddy Hannigan (Chair, Stafford and Surrounds CCG) (Stafford and Surrounds CCG), Dr Mo Huda (Chair, Cannock Chase CCG) (Cannock Chase CCG), Michael Harrison (Staffordshire County Council), Gareth Morgan (Chief Constable Staffordshire Police), Robin Morrison (Chairman) (Engaging Communities), Helen Riley (Director of Families and Communities and Deputy Chief Executive) (Staffordshire County Council) and Philip White (Cabinet Support Member for Learning and Employability)

39. Declarations of Interest

There were none at this meeting.

a) Minutes of Previous Meeting

RESOLVED – That the minutes of the Health and Wellbeing Board (H&WB) held on 9 March 2017 be confirmed and signed by the Chairman.

40. Questions from the public

There were no questions from the public.

41. Director of Public Health's Annual Report 2017

At their meeting of 9 March the H&WB had received a presentation from the Director of Public Health on his Annual Report. They now received a copy of the final draft report "Time to talk: Getting it right at the end of life". The report highlighted a cultural reluctance to talk about death and dying and addressed end of life issues that encompassed the individual and their families, those working within the health and care sectors and society in general.

The aim was to raise public awareness and promote public discussion. It was intended to follow the report with a media campaign and debate/public conversation entitled "Dying to Talk" which would be in the form of road show events in each of the District and Boroughs.

The H&WB agreed this was an excellent report sensitively written. They highlighted the following:

- the importance of using personal stories to help engage the public and raise awareness;
- the quality of care received at the end of life being paramount;
- early conversations about end of life helping to avoid falling into a spiral of unplanned interventions;
- work already undertaken by Care Home Matrons on end of life care training and the need to consider how to bring all elements together; and,
- the importance of having both a public and a professional conversation as many professionals remained uncomfortable tackling this issue.

Members had reservations about the suggested title of the road show events and were assured that this was a working title and the final language used would be tested by the Communications Team with Hospice Professionals.

RESOLVED- That:

a) the Annual Report of the Director of Public Health be endorsed;
b) the proposed outline for the next H&WB public conversation on end of life be approved;
c) that the outcome of the Communications Team language testing over the proposed conversation title "Dying to Talk" be considered at the 7 September Board meeting; and
d) they actively support the public conversation on end of life and seek support for the campaign across their respective organisations.

42. The Big Fat Chat – Public Engagement Report

The first H&WB public debate was on obesity, entitled “the Big Fat Chat”. A wider engagement campaign had been developed to promote the debate on 1 March and the Board had received initial feedback at their 9 March meeting. They now received further details of the debate outcomes, including that:

- the debate exceeded targets for reach and engagement on social media and also had good press coverage;
- the event was well received and stimulated a varied discussion; and,
- overall there was support for the notion of personal responsibility for health and well-being from the public, partners and stakeholders.

A Stakeholder workshop had taken place last week to reflect on feedback from the Debate and how to take this forward through a system based approach.

Despite being a H&WB event the debate had been perceived as a County Council initiative. It was suggested that the H&WB should consider developing their own website to provide a key point of interaction with the public for future engagement. The merits of a dedicated web page were debated, with Board Members varying as to whether there should be a stand alone H&WB site, a page on the existing SCC site or a Facebook page.

RESOLVED – That: a) the report outcomes and lessons learnt for future debates be noted;
b) the development of a partnership “compact” to address obesity be supported; and
c) further consideration be given to the best way to increase the H&WB visibility and provide a key point of interaction with the public on future engagement around health and well-being.

43. Health in All Policies

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.

At their 9 March meeting the H&WB agreed to act as HiAP champions to advocate this approach within their organisations. They also agreed to host a workshop on the HiAP approach in Staffordshire. Following a meeting of the Chief Executive Group a provisional workshop date of 29 September had been proposed.

RESOLVED – That:

a) the proposal to identify an overall lead for HiAP in each authority be noted;
b) the September workshop be supported; and
c) the proposal to identify leads for HiAP across all organisations who could contribute to the workshop be noted.

44. All-Age Disability Strategy

The current All-Age Disability Strategy was due to expire in March 2018. A new strategy was being developed and Members received an outline of the focus for this new strategy which would be co-produced with disabled people, their families and carers and would set out a life-course vision for all disabled people from birth to old-age. A first draft

of the new Strategy would be circulated for comments in September and the H&WB were asked to send their comments to the report author to help inform the final Strategy.

RESOLVED – That:

a) the approach to development of a new All-Age, lifelong disability strategy, including core principles, scope, timescales and governance for production be endorsed; and
b) the H&WB Members comment on the first strategy draft when it is circulated to them in September.

45. Staffordshire Better Care Fund

The 2016/17 Staffordshire Better Care Fund (BCF) had received official sign off and the Section 75 had been completed. The integrated policy framework for the BCF 2017-19 had been published on 28 March 2017, with the planning template/guidance received this week. Planning for the first 2017-19 submission had begun with a submission deadline of 11 September.

The difficulties in meeting the target around transfer of care were discussed in detail with every effort being made to avoid the escalation process. It was anticipated that the submission would need to identify that the BCF Programme Board was unlikely to meet the target but that a development plan would be included to show how the target would be reached. This was likely to result in an approved BCF with conditions.

RESOLVED: That:

a) the policy framework and progress of the BCF 2017-19 be noted;
b) delegated authority be passed to the co-chairs for signing off the BCF plan on behalf of the H&WB;
c) a workshop for comments on the BCF be arranged prior to its submission.

46. Health & Wellbeing Board Strategy

The current “Living Well” H&WB Strategy runs until 2018 and it was intended to build upon this in developing the new strategy and evolving the approach to have a stronger focus on delivery and action. The new Strategy would focus on the Board’s core role to lead on prevention, early intervention and community activity. Members received an initial draft for comment and discussion.

The Board heard that there was an intention to simplify the Strategy and make it more public facing and succinct. They made the following suggestions:

- the importance of the use of simple language;
- addressing the issue of navigating the system;
- challenge the concept of a service dependent society;
- the need to differentiate between this Strategy and the STP, with a focus on societal determinants rather than services;
- the opportunity to work at a local level, setting challenges to, for example, Parish Councils, to ensure no one in their Parish is lonely, or that everyone can get to a doctors appointment as a way to help address the issues of isolated communities through a bottom up approach;

- the need to include a commitment by this Board that they are willing to learn and evolve, giving examples of development sessions as a commitment to trial and learn; and
- the need to concentrate on a small number of key themes, such as obesity, isolation, end of life, and to consider how to empower the individual to take responsibility for their own health.

Members agreed to a workshop on the developing strategy, to take place one hour before their 7 September Board meeting.

RESOLVED - That:

a) the format and content of the report reflect the H&WB comments listed above;
b) the Board contribute to the development of the Strategy through a workshop session to take place at 2.00pm on 7 September prior to their Board meeting;
c) the broader implications of the Strategy be considered at the 7 September workshop.

47. For Information

The H&WB received the following items for information only:

- JSNA Intelligence

48. Forward Plan

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

Items for decision –

- Children & Families Strategic Partnership (delivery plan for approval)
- SASSOT (local delivery fund update on progress)
- Burton/Derby Hospital transformation
- All-Age Disability

Items for debate –

- STP

Items for information –

- H&WB Strategy

Members also requested the following additions to their Forward Plan:

- the outcome of the Communications Team language testing over the proposed conversation title “Dying to Talk”;

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

Chairman

Staffordshire Health and Wellbeing Board	
Topic:	PNA consultation report
Date:	7 September 2017
Board Member:	Richard Harling
Author:	Ruth Goldstein, Consultant in Public Health Divya Patel, Senior Public Health Epidemiologist
Report Type	For decision

1 Purpose of the report

1.1 The purpose of the report is to brief members of the Health and Wellbeing Board (HWBB) on the Staffordshire Pharmaceutical Needs Assessment (PNA) consultation report.

1.2 The Board is asked to consider this report and approve the recommendations.

2 Background

2.1 A PNA is a statement of the needs of pharmaceutical services for a specified population. The PNA looks at the current provision of pharmaceutical services across a defined area, makes an assessment to see whether this meets population needs and identifies any potential gaps to service delivery.

2.2 There is a statutory requirement for HWBBs to update their PNA every three years. In addition, the HWBB is required to keep up-to-date a map of provision of NHS pharmaceutical services within its area and publish any supplementary statements where there have been changes.

2.3 The primary uses of the PNA are:

- To identify areas where pharmacies can contribute to health and wellbeing priorities to improve population health and reduce health inequalities.
- As an evidence base for local commissioners to identify and commission services from community pharmacies as appropriate.
- To support NHS England's local area team in making decisions on any application for opening new pharmacies and dispensing appliance contractor premises or applications from current providers of pharmaceutical services to change their existing provision.

2.4 The draft consultation report has been overseen by a working group comprising of a range of stakeholders from Staffordshire County Council, NHS England: North Midlands, local Clinical Commissioning Groups, the Local Pharmaceutical Committee (LPC) for North Staffordshire and South Staffordshire and the Local Professional Network (LPN) for pharmacies.

2.5 This consultation report will form the basis of the second comprehensive PNA for Staffordshire.

3 Summary of draft PNA

3.1 Key summary findings include:

- There are sufficient numbers and a good choice of pharmacy contractors to meet Staffordshire's pharmaceutical needs. Access in Staffordshire is also good with pharmacies generally complementing GP surgery opening times.

- There are a number of advanced and locally commissioned services that pharmacies are currently providing to support the health and wellbeing needs of Staffordshire residents, for example medicines use reviews and new medicine services which support the management of long-term conditions, flu vaccination services, the common ailment and emergency supply of medications services which help to alleviate pressures on GPs and the acute sector, emergency hormonal contraception, supervised administration, needle exchange and palliative care with provision generally being matched to meet the varying needs across the County.

- There are opportunities for pharmacies to further complement primary and secondary care services and play a part in improving health and reducing inequalities. There is a good network of Healthy Living Pharmacies and a willingness to extend their roles to further support Staffordshire residents to live healthier, self-care or live independently to meet local need. The HWBB, Sustainable and Transformation Partnership (STP) and local commissioners should consider extending the role of pharmacies in supporting health and wellbeing strategic priorities.

4 Consultation process

4.1 There has already been a range of engagement activities with providers and public to date:

- Pharmacies have been engaged through a survey to confirm which services they are currently providing and which they may be willing to provide

- Healthwatch have led on engaging with Staffordshire residents to have their say on pharmaceutical services

4.2 Following approval of the report by the HWBB key stakeholders as set out in the guidance will be contacted on the content of the draft PNA between September and December 2017.

5 Summary and recommendations

- Pharmacies are at the centre of the community and provide an opportunity to further deliver health and wellbeing services tailored to meet the needs of the people in their locality and grow as community assets. The HWBB should consider how pharmacies can support delivery of health and wellbeing priorities and particularly focus on the contribution pharmacies can make to the STP.

- The Health and Wellbeing Board agree for a consultation period of 60 days between September and December 2017 in order to sign-off the final report at the March meeting for publication by the 1 April 2018.

- Members of the board are encouraged to give feedback either individually or through their respective organisations to the authors/working group to help shape the final PNA as part of the consultation process.

Pharmaceutical Needs Assessment for Staffordshire

A consultation report September 2017

Contents

Document details

Working group	Amanda Alamanos, Primary Care Lead, NHS England North Midlands Susan Bamford, Head of Medicines Optimisation, East Staffordshire Clinical Commissioning Group Matthew Bentley, Public Health Analyst, Staffordshire County Council Ruth Bolderston, Assistant Contracts Manager, NHS England North Midlands Tania Cork, Chief Officer, North Staffordshire Local Pharmaceutical Committee (LPC) Ruth Goldstein, Consultant in Public Health, Staffordshire County Council Dr Gill Hall, Service Development Officer, South Staffordshire LPC Kelly Hyden, Commissioning Officer,, Staffordshire County Council Dr Mani Hussain, Chair, Pharmacy Local Professional Network Divya Patel, Senior Epidemiologist, Staffordshire County Council Andrew Pickard, Pharmacy Advisor, NHS England North Midlands Fiona Porter, PA to the Associate Director- Medicines Optimisation, North Staffordshire Clinical Commissioning Group / Stoke-on-Trent Clinical Commissioning Group Peter Prokopa, Chief Operations Officer, South Staffordshire LPC Sharuna Reddy, Senior Medicines Optimisation Pharmacist, Cannock Chase Clinical Commissioning Group/ South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group / Stafford and Surrounds Clinical Commissioning Group Paul Trinder, Senior Epidemiologist, Stoke-on-Trent City Council
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Executive summary

Introduction

A pharmaceutical needs assessment (PNA) is a statement of the needs of pharmaceutical services for a specified population. The PNA looks at the current provision of pharmaceutical services across a defined area, makes an assessment of whether this meets current and future population needs for Staffordshire residents and identifies any potential gaps in current services or improvements that could be made in future pharmaceutical service provision.

The Health and Social Care Act 2012 transferred responsibility for developing and updating of PNAs to health and wellbeing boards (HWBBs). Every HWBB has a statutory responsibility to publish and keep up to date a PNA for the population in its area through supplementary statements. The PNA will be used:

- To identify areas where pharmacies can contribute to health and wellbeing priorities to improve population health and reduce health inequalities.

- As an evidence base for local commissioners to identify and commission services from community pharmacies as appropriate.

- By NHS England's area team to make decisions on any application for opening new pharmacies and dispensing appliance contractor premises or applications from current providers of pharmaceutical services to change their existing provision.

This consultation document will form the basis of the second comprehensive PNA for Staffordshire.

What is the population of Staffordshire like?

Staffordshire has a resident population of 867,100 and covers a large geographical area of over 1,010 square miles. Similar to many other County areas, a major characteristic of Staffordshire is its ageing population with its population continuing to grow in both size and average age rapidly. Tamworth and East Staffordshire are the only districts in Staffordshire that have a significantly younger population than the national average.

The proportion of people from minority ethnic groups is growing but remains lower than the national average. The single largest minority group is 'white other'. East Staffordshire has the largest proportion of people from a minority ethnic group.

Around a quarter of residents live in rural areas. South Staffordshire (40%), Stafford (32%), Staffordshire Moorlands (30%) and Lichfield (30%) are particularly rural whilst Tamworth's population is classified as entirely urban.

It is a relatively affluent area but has notable pockets of high deprivation in some urban areas. However some of the remote rural areas in Staffordshire do have issues with hidden deprivation, and in particular around access to services. This is coupled with almost one in five households not having access to a car.

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

What is health like in Staffordshire?

Overall people in Staffordshire are healthy, live longer compared with national life expectancy, and have positive experiences of the things that affect their lives and wellbeing. Staffordshire has shown large improvements in life expectancy and made significant progress in reducing overall mortality and preventable mortality over the last decade. However both men and women spend more time in poor health than the average retirement age and there remain large health inequalities across Staffordshire as evidenced by life expectancy and early death rates. 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.

There are a number of factors that can help prevent ill health or diagnose problems early to enable better treatment, especially immunisation and screening. Childhood immunisation rates and coverage of screening programmes in Staffordshire are generally better than average. However fewer Staffordshire adults who are eligible take up their offer of a NHS health check and a lower proportion of people aged 65 and over take up their offer of a flu or pneumococcal vaccination than average.

Around 40% of ill-health is thought to be preventable through healthier lifestyles. 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). Newcastle has a higher rate of children who are obese by the time they are in Year 6. Whilst adult smoking rates overall in Staffordshire have fallen there are large numbers of our population who drink too much over the life course, eat unhealthily and remain inactive

More people in Staffordshire report having a limiting long-term illness. By the time people reach 65 they will have developed at least one chronic condition and large proportions will also have developed two or three conditions. Of particular concern are the growing numbers of people with multiple or complex conditions.

Most care will occur in primary care or community settings. However a higher than average proportion in Staffordshire also occurs in hospital settings particularly young children and older patients. Older people are also higher users of social care. Admission rates in Staffordshire for acute conditions that could be managed effectively in primary care or outpatient settings are increasing more rapidly than average. In addition those that are admitted to hospital are often delayed from being discharged.

What is current pharmaceutical provision like and are there any gaps?

Pharmacy is the third largest healthcare profession, with a universally available and accessible community service. Pharmacies are well used and based on national estimates around seven million visits are made to a community pharmacy for health-related reasons annually in Staffordshire which equates to around 10 visits per person every year. Nationally 79% of people have visited a pharmacy at least once in the last year whilst 37% have visited at least once a month. Local data from a resident survey found around 14% of respondents used their pharmacy weekly and a further 58% monthly.

Staffordshire has 182 community pharmacies, of which seven are distance-selling and in rural areas there are 27 GP practices who can dispense to patients registered with their practice. The rate of community pharmacies and dispensing practices is 24 per 100,000 population which is similar to the national average but ranges between districts from 20 per 100,000 in South Staffordshire to 27 per 100,000 population in East Staffordshire although districts with low rates do also have nearby access to pharmacies in neighbouring areas such as Wolverhampton and Stoke-on-Trent.

There is a gap as to the clarity of controlled localities and reserved locations. It is therefore proposed that NHS England North Midlands undertake further mapping of controlled localities, dispensing practice areas and reserved locations to provide assurance on the patients who fall into dispensing and prescribing groups for these practices, and clarity on the status of these areas, to support applications for new pharmacies or those considering relocations.

A national patient survey indicated that the public value a variety of types of pharmacy. In terms of ownership around two-fifths of pharmacies in Staffordshire are owned by independent contractors whilst the remaining three-fifths are owned by multiple contractors.

Based on data from the latest *Feeling the Difference* survey, the majority of Staffordshire residents are satisfied with current pharmacy provision. The engagement survey also found that local pharmacy services met the needs of respondents. National research also indicates that 86% would trust advice from pharmacies on how to stay healthy.

Overall there are sufficient numbers and a good choice of pharmacy contractors to meet Staffordshire's pharmaceutical needs.

There is good geographical coverage across the County for pharmaceutical services and the majority of Staffordshire residents (98%) live within a 10 minute drive of their local pharmacy. Around 86% of residents can also access their local pharmacy within a 20 minute walk and almost two-thirds within 10 minutes using public transport.

In terms of opening hours, there are 18 '100 hour' pharmacies across Staffordshire equating to around one in ten pharmacies, with all residents in the County with the exception of South Staffordshire, having access to a community pharmacy for at least 100 hours during the week. Most residents have good access to a pharmacy during weekdays and Saturdays.

However there appears to be less provision and choice on Sundays and in particular on Sunday evenings. Around one in six pharmacies are open on Sunday from around 10am but tend to close by around 4pm; three pharmacies across the County are open after 5pm.

Some of the restricted provision is due to trading regulations which restricts opening hours for pharmacies located in supermarkets and shopping centres to six hours. However Staffordshire residents do have access to dispensing services on Sundays from alternative provision, for example walk-in-centres, minor injury units or from pharmacies in neighbouring areas such as Stoke-on-Trent or Wolverhampton.

A number of pharmacies also now open on Bank Holidays. NHS England North Midlands also commission community pharmacies to ensure there are adequate pharmaceutical services available on Christmas Day and Easter Sunday as these are the two days where pharmacies are still traditionally closed and those located in supermarkets and shopping centres unable to open due to current trading laws.

There appears to be a gap in service provision on Sunday evenings. However the demand for dispensing services is likely to be much lower at weekends compared to weekdays as GP surgeries are usually closed.

The STP may also want to consider commissioning extended pharmaceutical services on Sundays as one of the potential solutions to reducing A&E attendances.

In terms of the protected characteristics, pharmacies have a positive impact in meeting the needs of all people. Examples of this include:

- Antenatal and postnatal support to pregnant women and mothers
- At least two-fifths of pharmacies have staff members who speak a number of languages that are amongst the frequent main languages across the County
- Adjustments to medicines for disabled people as appropriate, for example large print labels. Most pharmacies also have a separate consultation room with wheelchair access
- Delivery of dispensed medicines to an individual's home

Findings from the engagement survey found that most people used pharmacies for collecting their prescriptions. Almost half of respondents also used their pharmacy for health advice or disposal of unwanted medicines. However very few respondents used their pharmacy for lifestyle advice (10%). Around a fifth of respondents would like pharmacies to maintain their current level of services with small proportions wanting to see the introduction of basic testing such as blood pressure measurements, blood tests and holiday vaccinations (10%), information and advice on the availability of other services (7%) and/or basic health appointments or clinics for certain conditions or lifestyle (5%).

National evidence suggests that between 5-8% of unplanned emergency admissions in adults are due to avoidable issues related to medicines. Overall there is good provision of advanced pharmacy services such as the Medicines Use Review (MUR) and New Medicine Service (NMS) across Staffordshire that help to deal with adherence to medicines and the management of people with long-term conditions.

However in terms of MURs, there is variation between pharmacies and some fall considerably below both the Staffordshire and national average. Provision of NMS also varies by district and pharmacy although this is dependent on the number of patients that start new medicines during the year.

Coverage of appliance use reviews and stoma appliance customisation services are low which is similar to the trend seen across England due to these services being a specialist area with many patients receiving the support they require either from a clinic or hospital or from a dispensing appliance contractor located in another area, for example Stoke-on-Trent.

An adult flu vaccination service was introduced as the fifth advanced service in September 2015. The number of pharmacies signed up to provide flu vaccination is high and there has been an increase in the number of flu vaccinations within community pharmacies with overall uptake per pharmacy higher than the national average. However provision across the County is variable.

Pharmacies falling considerably below the average number of MURs should be supported to increase the numbers of MURs, particularly in areas where there is an identified need, to help with the management of long-term conditions and reducing emergency admissions. This may be done by promoting the concept of MURs to the public so that they understand the differences between reviews done by GP and pharmacies. GP practices are also ideally placed to work with their local pharmacies to identify and refer on patients who require a MUR or NMS. Overall uptake of flu vaccination through community pharmacy across the County is better than the national average; however provision varies across the County and further work should support and market community pharmacies to increase the provision of flu vaccination in these areas. Commissioners should also consider the provision of pneumococcal vaccination within community pharmacy settings given the current low rates of coverage across the County.

There are also opportunities for pharmacies to support the health, wellbeing and care needs of Staffordshire residents through locally commissioned services. In Staffordshire there are a number of services that are currently provided by pharmacies alongside other providers helping to meet the health needs of local residents. These include provision of: common ailment service, emergency supply of medication, treatment of urinary tract infections and impetigo, emergency hormonal contraception, supervised administration, needle exchange and palliative care. Provision across the County is generally matched to needs.

NHS England North Midlands, Staffordshire County Council, and other local commissioners need to ensure there is equitable provision of locally commissioned services across Staffordshire. This could be coordinated through the STP.

Local commissioners, providers and key stakeholders such as LPCs and Local Medical Committees should continue to explore new ways in which community pharmacies could complement other primary and secondary care services and play a part in improving health and reducing inequalities, particularly around health and wellbeing strategic priorities. There is also a willingness from most community pharmacies to extend their roles to further support Staffordshire people to live healthier, self-care or live independently to meet local need. There is also ample national evidence to suggest that this could help alleviate current financial pressures on the NHS.

The STP should consider the wider role of pharmacies in commissioning strategies (e.g. primary care) so that opportunities to provide effective services are maximised locally.

The HWBB will continue to monitor any major developments (e.g. planned housing developments) and in line with regulations produce supplementary statements to the PNA where deemed necessary. They will also monitor any proposed changes to Government policy that could have an effect on the provision of pharmaceutical provision, for example extended opening of GP services.

The HWBB will continue to monitor any local or national policy development that impact on the provision of pharmaceutical services in the County and continue to publish supplementary statements where needed.

1 Introduction

1.1 What is a pharmaceutical needs assessment?

A pharmaceutical needs assessment (PNA) is a statement of pharmaceutical service needs for a specified population. The PNA looks at the current provision of pharmaceutical services across a defined area, makes an assessment of whether this meets current and future population needs and identifies any potential gaps to service delivery.

The Health and Social Care Act 2012 transferred responsibility for developing and updating PNAs to Health and Wellbeing Boards (HWBBs). Every HWBB has a statutory responsibility to publish and keep up to date a PNA for the population in its area through supplementary statements.

The NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations (2013 Regulations) stated that HWBBs must have published their first PNA by 1st April 2015 which should be updated at least once every three years or before if there has been a significant change in service need or provision. In addition, the HWBB is required to keep up-to-date a map of provision of NHS pharmaceutical services within its area and publish any supplementary statements which Staffordshire last did in September 2016.

This consultation document will form the basis of the second comprehensive PNA for Staffordshire.

1.2 How will the PNA be used?

Uses of the PNA include:

- Identifying areas where pharmacies can contribute to health and wellbeing priorities to improve population health and reduce health inequalities. It will help the HWBB to work with providers to target services to the areas where they are needed and limit duplication of services in areas where provision is adequate.

- Providing an evidence base to NHS England area teams to identify and commission advanced and enhanced services. It should also be used to inform local authority and clinical commissioning groups (CCGs) when commissioning local services from community pharmacies.

- Market entry – the PNA will be used by NHS England's area team to make decisions on any application for opening new pharmacies and dispensing appliance contractor premises or applications from current providers of pharmaceutical services to change their existing provision. Under legal regulations potential contractors of NHS pharmaceutical services must submit a formal application to NHS England to be included on a relevant list by proving they are able to meet a current or future pharmaceutical need that has been identified in the relevant PNA. NHS England's area team will then review the application in light of any gaps identified in local PNAs. The NHS Litigation Authority will also refer to the PNA when hearing appeals on NHS England's decisions.

1.3 What are NHS pharmaceutical services?

NHS pharmaceutical services as set out in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 are commissioned solely by NHS England.

For the purposes of the PNA, pharmaceutical services included within the scope are:

- **Community pharmacies** are registered premises where pharmacists work as healthcare professionals either as sole traders, partnerships or limited companies

- **Dispensing appliance contractors (DACs)** who are appliance suppliers for a specific subset of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings and bandages but cannot supply medicines.

- **Distance selling contractors** are internet and mail order based contractors who provide their services across England to anyone who requests it. They may be pharmacy or dispensing appliance contractors. Under the 2013 Regulations only pharmacy contractors may now apply to be distance selling premises.

- **Local pharmaceutical services (LPS) contractors** provide a level of pharmaceutical services in some HWBB areas. A LPS contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements.

- **Dispensing doctors** are medical practitioners authorised to provide pharmaceutical services from medical practice premises in designated rural areas known as "controlled localities". They can dispense NHS prescriptions to their own patients who live more than one mile (1.6 km as the crow flies) from a pharmacy. Controlled localities are rural areas which have been determined by NHS England, a predecessor organisation (primary care trust), or on appeal by the NHS Litigation Authority. The one mile rule does not apply to practices in **reserved locations** and patients in these localities both within one mile of the pharmacy and beyond have the right to choose whether to have their medicines dispensed at a pharmacy or at their GP surgery. A reserved location is an area within a controlled locality where the total of all patient lists for the area within a radius of one mile of the proposed premises or location is fewer than 2,750.

Under the NHS Community Pharmacy Contractual Framework (CPCF) there are three different levels of services that pharmacies can provide. These are:

- **Essential services** - these are those services which every community pharmacy who provides NHS pharmaceutical services must provide as set out in their terms of service and includes the dispensing of medicines, promotion of healthy lifestyles and support for self-care

- **Advanced services** - these are services that community pharmacies and dispensing appliance contractors (DACs) can provide subject to accreditation as necessary. These include Medicines Use Reviews and the New Medicines Service for community pharmacists and Appliance Use Reviews and the Stoma Customisation Service for dispensing appliance contractors.

- **Enhanced services** - additional locally commissioned services that are commissioned by NHS England such as services to care homes, language access and patient group directions.

Other organisations, for example CCGs and local authorities can commission services from community pharmacies. However these services are not part of NHS Pharmaceutical Services as defined by the Regulations and described above and therefore cannot be described as enhanced services and should be described as ***locally commissioned services***.

1.4 What has been the process for developing the Staffordshire PNA?

A PNA working group was set up in Staffordshire to shape the production of the Staffordshire PNA. This includes a range of stakeholders from Staffordshire County Council, NHS England North Midlands, the Local Pharmaceutical Committees (LPC) for North Staffordshire and South Staffordshire, the Local Professional Network (LPN) for pharmacies and members from local Clinical Commissioning Groups.

The PNA process includes:

- **Engagement** with the public, through a survey run by Healthwatch and pharmacies, through an online survey using PharmOutcomes, about current and future pharmaceutical needs and services to feed into the PNA

- **Identifying local needs** through use of the Joint Strategic Needs Assessment (JSNA) process (see Figure 1 which illustrates the JSNA process in commissioning cycle)

- Collecting information on **service provision** from NHS England, Staffordshire County Council, the LPC and other commissioners

- **Consultation on the draft PNA (current stage)** with residents and professionals

- Production of the PNA for Staffordshire and **sign-off by the HWBB (next stage)** for publication by 1 April 2018

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

1.5 Definition of localities for the PNA

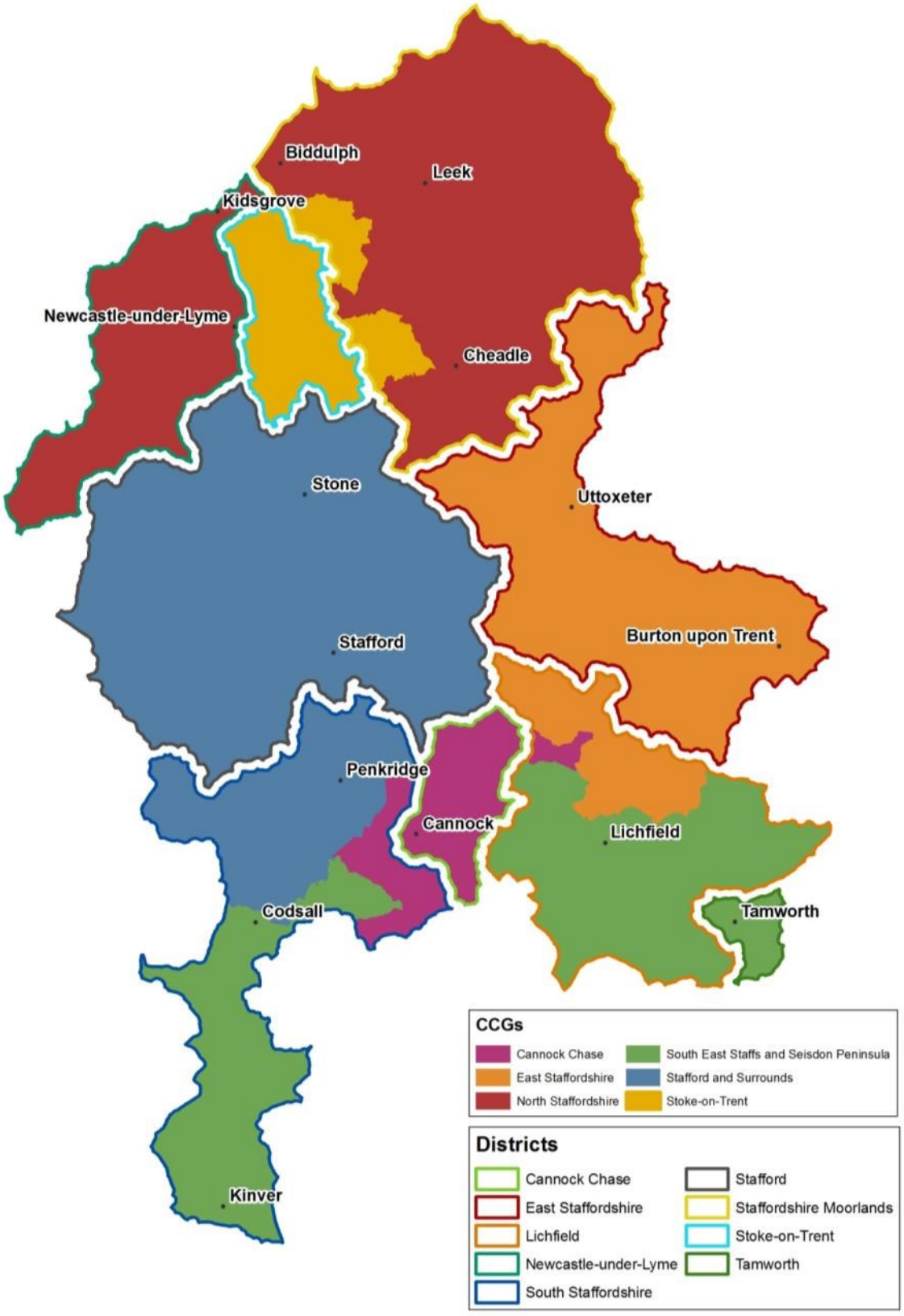
Staffordshire has a resident population of 867,100 and covers a large area of 1,010 square miles. The area is composed from a mixture of cities, towns and villages and is governed locally by an upper-tier authority: Staffordshire County Council and eight district councils (Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands and Tamworth).

In Staffordshire, health, social and wellbeing services or programmes are commissioned by five Clinical Commissioning Groups (CCGs), NHS England, Public Health England, Staffordshire County Council and eight Borough/District Councils.

The PNA for Staffordshire will use its eight district areas in the main to assess needs; this is in line with the disaggregation of intelligence within the Joint Strategic Needs Assessment (JSNA) and endorsement of recommendations by the HWBB in July 2014 of '*Achieving strategic outcomes through locality-based delivery*'.

District and CCG boundaries in Staffordshire are illustrated in Map 1.

Map 1: District and CCG boundaries in Staffordshire



1.6 Pharmacy services aligned to Sustainability and Transformation Partnerships

The NHS planning guidance published in December 2015 asked every local health and care system in England to come together to create their own ambitious local plan for accelerating the implementation of the Five Year Forward View. These local plans, called Sustainability and Transformation Partnerships (STPs), are place-based, multi-year plans built around the needs of local populations. STPs must cover all areas of CCG and NHS England commissioned activity including: specialised services; primary care; local authority services, including prevention and social care, and reflect local health and wellbeing strategies. Nationally 44 STP footprint areas have been agreed that will bring local health and care leaders, organisations and communities together.

The local STP covers Staffordshire and Stoke-on-Trent and details how current demographic changes, increasing health needs and financial constraint challenges will be tackled, including:

- An increase in services delivered in the community through 23 specialised multi-disciplinary teams (also known as localities) which will be based on local populations in Staffordshire and Stoke-on-Trent of between 30,000 and 70,000 residents. 18 of these multi-disciplinary teams are within Staffordshire's HWBB catchment area.

- Encouraging more people to live healthily and avoid illness, and when they are ill to provide them with the tools and technology to help manage their own conditions.

Pharmacies are at the centre of the community and provide an opportunity to further deliver health and wellbeing services tailored to meet the needs of the people in their locality and grow as community assets. Each of the 23 localities know their local population and will have the opportunity to enhance the future services they offer as a community asset to support the needs of their population.

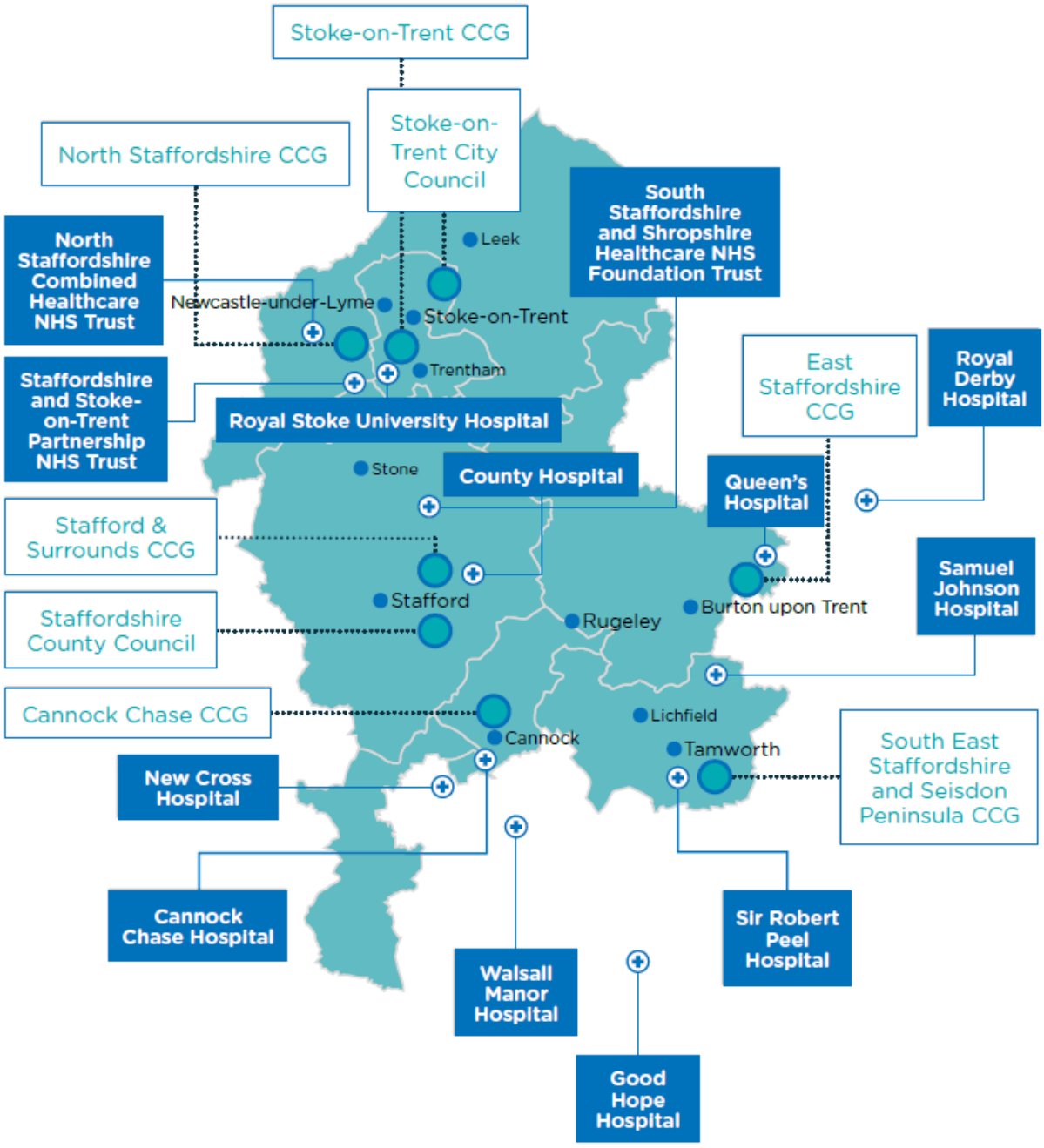
The STP's programme for pharmacies can be found in Appendix 1.

1.7 The Murray Report

An independent *Community Pharmacy Clinical Services Review* (also known as the Murray report) was commissioned by the Chief Pharmaceutical Officer and published by the Kings Fund in December 2016. The Murray report proposes that pharmacy needs to "work in partnership with other parts of the health and care system whether this means other professions or, critically, patients themselves" and be a "core part of the integrated, convenient services that people need".

The report provides a summary of national policy reports, presents barriers, opportunities and recommendations for expanding the role of community pharmacy and pharmacists. The full recommendations from the report can be found in Appendix 2.

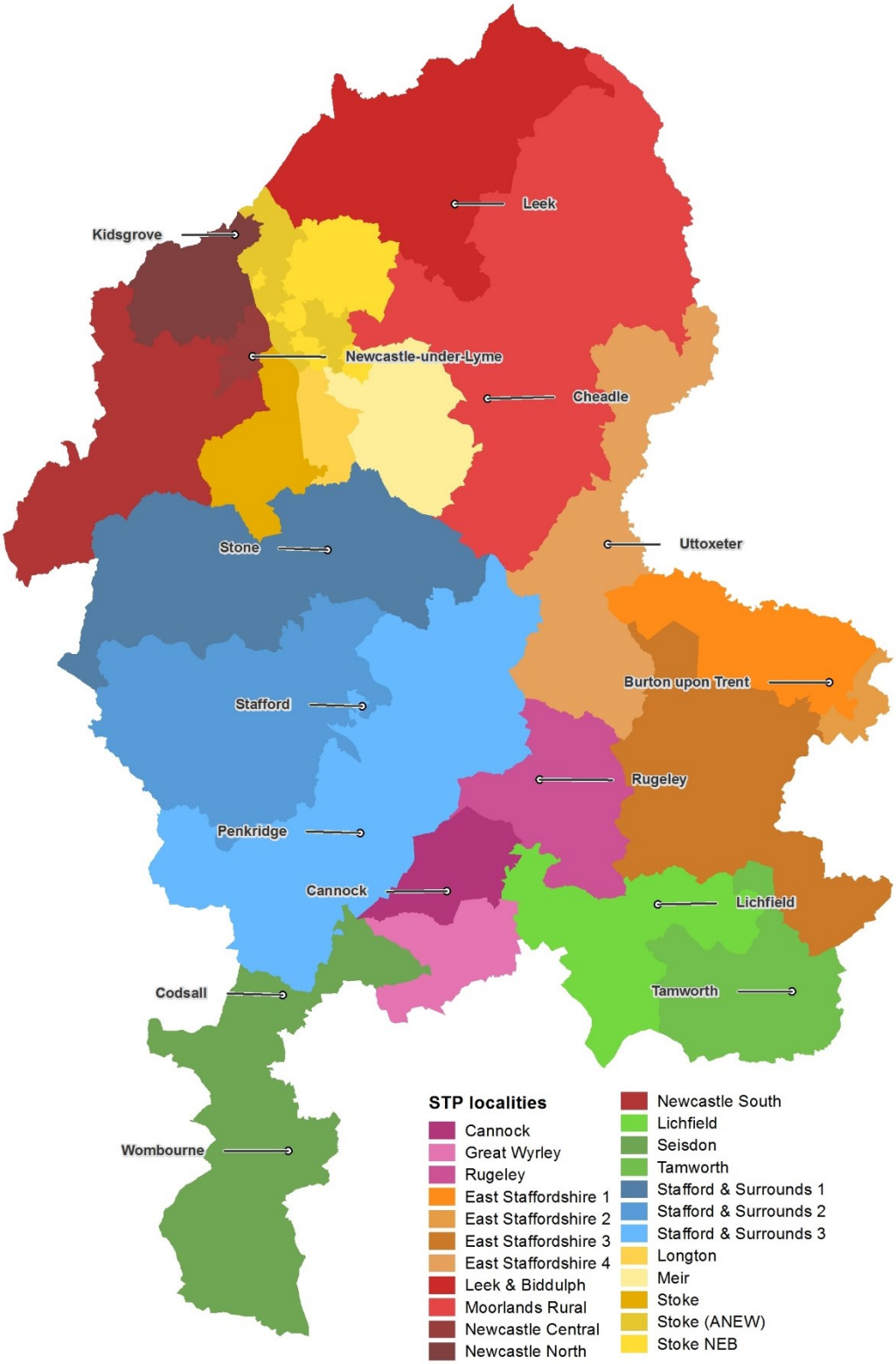
Map 2: Staffordshire and Stoke-on-Trent's STP area



Note: Not a geographical representation

Source: Together We're Better, An Introduction to the Staffordshire and Stoke-on-Trent Sustainability and Transformation Plan

Map 3: Staffordshire and Stoke-on-Trent's STP localities



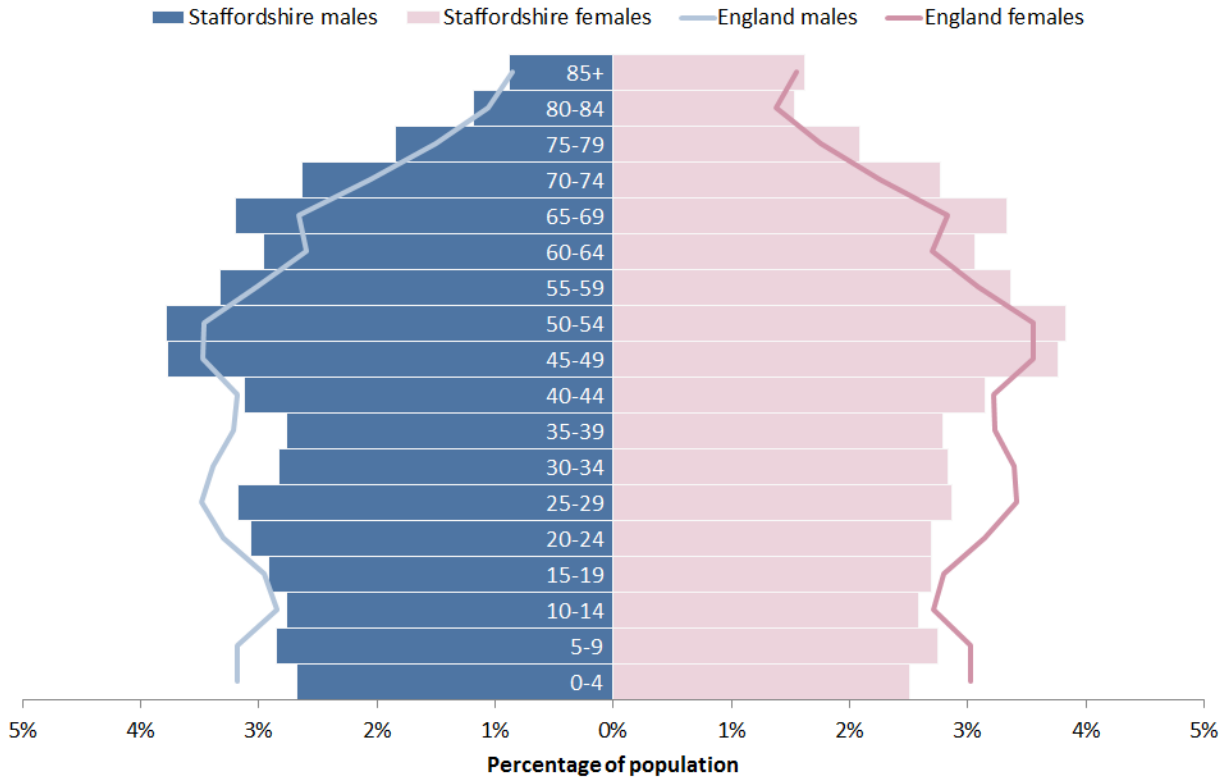
2 What is the population of Staffordshire like?

2.1 Population structure

Staffordshire has a resident population of 867,100 and covers a large geographical area of over 1,010 square miles. The age structure of a population gives an indication of potential utilisation of health services, for example people aged over 50 are more likely to have long-term conditions and are consequently greater users of health and social care services including pharmaceutical services.

The overall population pyramid shows that Staffordshire has a relatively older population compared to the England average (Figure 2). Around 21% residents are aged 65 and over compared to the national average of 18%. This ranges from 18% in Tamworth to almost 24% in Staffordshire Moorlands (Table 1 and Figure 3). East Staffordshire and Tamworth both have a significantly younger population than the national average.

Figure 2: Population structure of Staffordshire compared with England, 2016



Source: 2016 mid-year population estimates, Office for National Statistics, Crown copyright

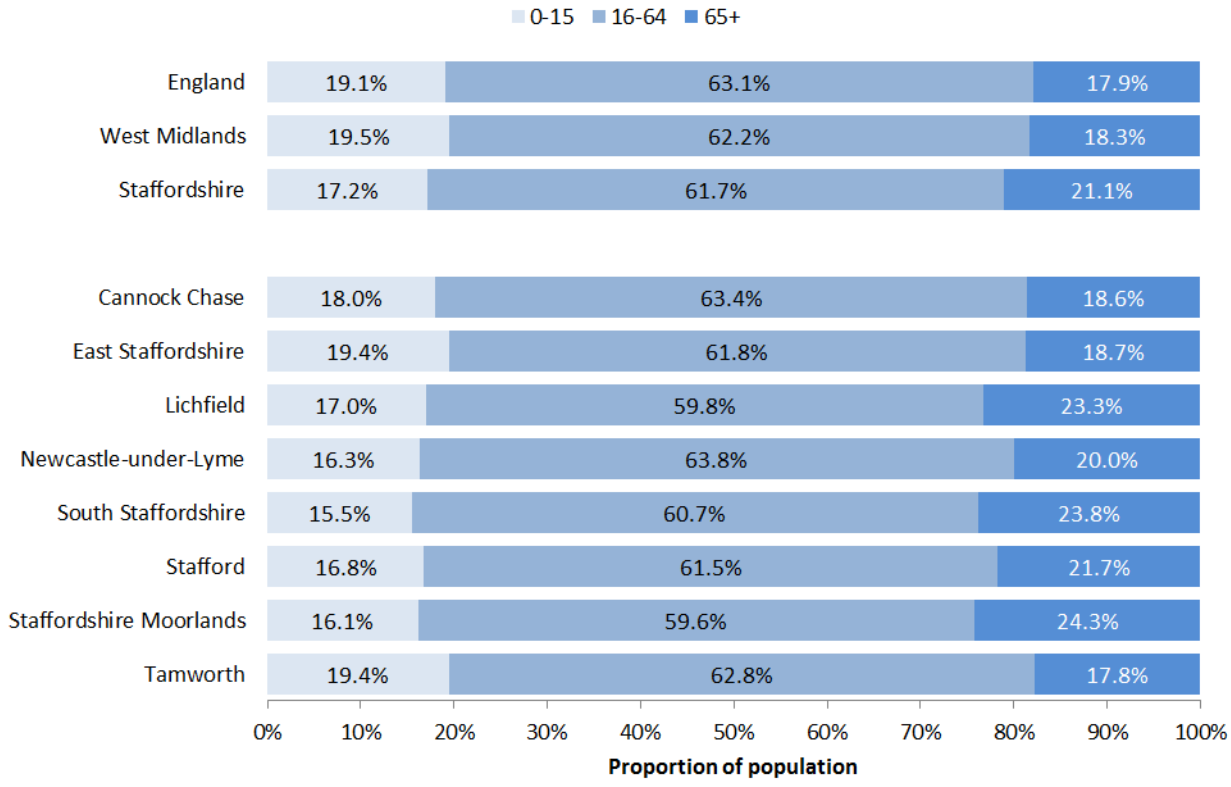
Table 1: Population structure by age group and district, 2016

	0-4	5-15	16-24	25-49	50-64	65-74	75+	All ages
Cannock Chase	5,500 (5.5%)	12,200 (12.4%)	10,200 (10.3%)	32,700 (33.2%)	19,700 (20.0%)	10,500 (10.6%)	7,800 (7.9%)	98,500 (100.0%)
East Staffordshire	7,400 (6.3%)	15,300 (13.1%)	11,500 (9.8%)	37,700 (32.3%)	23,000 (19.7%)	12,200 (10.4%)	9,700 (8.3%)	116,700 (100.0%)
Lichfield	5,100 (4.9%)	12,400 (12.0%)	9,600 (9.3%)	30,800 (29.9%)	21,200 (20.5%)	13,800 (13.4%)	10,200 (9.9%)	103,100 (100.0%)
Newcastle-under-Lyme	6,300 (4.9%)	14,600 (11.4%)	17,100 (13.3%)	40,200 (31.3%)	24,700 (19.2%)	14,200 (11.1%)	11,400 (8.9%)	128,500 (100.0%)
South Staffordshire	5,000 (4.5%)	12,200 (11.0%)	10,800 (9.7%)	32,300 (29.1%)	24,300 (21.9%)	14,700 (13.2%)	11,800 (10.6%)	111,200 (100.0%)
Stafford	6,700 (5.0%)	15,800 (11.8%)	13,500 (10.0%)	41,700 (31.1%)	27,300 (20.4%)	16,300 (12.2%)	12,800 (9.6%)	134,200 (100.0%)
Staffordshire Moorlands	4,300 (4.4%)	11,500 (11.7%)	8,900 (9.0%)	28,200 (28.8%)	21,300 (21.8%)	13,600 (13.9%)	10,200 (10.4%)	98,100 (100.0%)
Tamworth	4,700 (6.1%)	10,300 (13.4%)	7,800 (10.1%)	25,700 (33.4%)	14,800 (19.2%)	8,200 (10.6%)	5,500 (7.2%)	77,000 (100.0%)
Staffordshire	**45,000 (5.2%)**	**104,300 (12.0%)**	**89,200 (10.3%)**	**269,400 (31.1%)**	**176,300 (20.3%)**	**103,500 (11.9%)**	**79,400 (9.2%)**	**867,100 (100.0%)**
West Midlands	**365,300 (6.3%)**	**768,700 (13.3%)**	**673,800 (11.6%)**	**1,873,700 (32.3%)**	**1,058,100 (18.2%)**	**579,100 (10.0%)**	**482,100 (8.3%)**	**5,800,700 (100.0%)**
England	**3,429,000 (6.2%)**	**7,100,100 (12.8%)**	**6,137,800 (11.1%)**	**18,536,600 (33.5%)**	**10,181,700 (18.4%)**	**5,413,300 (9.8%)**	**4,469,500 (8.1%)**	**55,268,100 (100.0%)**

Note: Numbers may not add up due to rounding

Source: 2016 mid-year population estimates, Office for National Statistics, Crown copyright

Figure 3: Population structure by age group and district, 2016



Source: 2016 mid-year population estimates, Office for National Statistics, Crown copyright

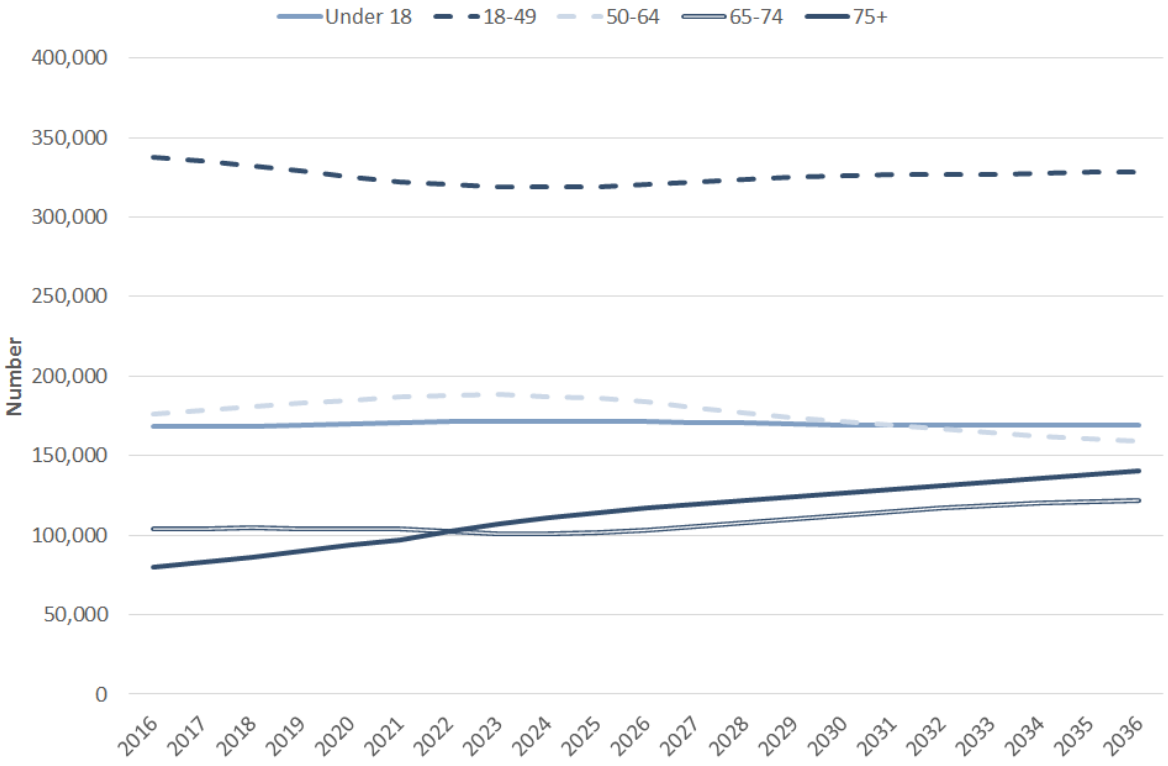
2.2 Population projections

A major characteristic of Staffordshire like many other County areas is its ageing population with its population continuing to grow in both size and average age. There are now 64,700 more people aged 65 and over than there were 20 years ago. This trend is predicted to continue.

The overall population for Staffordshire is projected to increase by 3% between 2016 and 2026 to 895,800. Staffordshire's older population is predicted to grow faster than average: by 2026 the number of residents aged 75 and over, traditionally people who need the most support will rise more dramatically from 78,000 in 2016 to 117,200 in 2026, an increase of 47% or around 37,200 people (Figure 4). Whilst the number of children under 16 will remain fairly stable, the number of working age people (16-64) is projected to decline. The impact of these demographic changes means there will be a significant fall in old age dependency support ratios with the ratio falling from three people of working age for every person aged 65 and over in 2016 to two people by 2036.

The changing population of Staffordshire will continue to have an impact on the provision and use of a range of health, social care and pharmaceutical services with the ageing population bringing greater challenges to already scarce resources within the area. It also is likely to put strains on the formal care workforce and may mean a necessary increase in informal, unpaid care from family, friends and communities in the future.

Figure 4: Population projection trends in Staffordshire



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

In line with projected population growth, Table 2 shows the planned housing requirements by district. However, across Staffordshire there are a number of housing developments in various stages of planning and not all plans have been adopted yet and are subject to change. The largest developments with planning permission granted that are projected to make an impact on the time period of this needs assessment are in East Staffordshire, Lichfield, South Staffordshire and Cannock Chase.

The Health and Wellbeing Board will therefore continue to monitor whether future housing developments require additional pharmaceutical provision. As well as schools and other community facilities such as local shops and newsagents, districts need to ensure they include pharmaceutical provision as part of their planning process under the consideration of provision of health care facilities.

Table 2: Planned housing requirements for the next 20 years

	Average planned houses per year	Planned location over next five years for large builds
Cannock Chase	295	Hednesford and Norton Canes
East Staffordshire	582	Branson, Beamhill, Outwoods and Derby Road areas of Burton and Pinfold Road area of Uttoxeter
Lichfield	478	Streethay area, East of Rugeley, Burntwood and Fradley
Newcastle-under-Lyme	285	Cross Heath, Knutton, Silverdale and Kidsgrove
South Staffordshire	193	Gospel End and Penkridge
Stafford	500	Yarnfield and Corporation Street, Stafford
Staffordshire Moorlands	276	Leek and Biddulph
Tamworth	275	Small sites across the Borough
Staffordshire	**2,884**	

Source: Strategic Housing Land Availability Assessments 2012-2014, District and Borough Councils in Staffordshire and Staffordshire County Council

2.3 Ethnicity

People from some ethnic minority groups often experience poorer health outcomes. This may be as a result of multiple factors including genetic predisposition to certain diseases (e.g. diabetes, coronary heart disease and mental health), poor access to services, language barriers and cultural differences.

According to the 2011 Census there were 54,700 people from a minority ethnic group in Staffordshire, which is 6.4% of the population, with the single largest minority group being 'white other'. Whilst this is a significant increase from the 2001 Census (3.8%), it remains lower than the England average of 20%

At a district level East Staffordshire has the highest proportion of residents from minority ethnic groups, mainly concentrated in Burton-on-Trent.

Table 3: Ethnic populations in Staffordshire, 2011

	Staffordshire	West Midlands	England
White: British	93.6%	79.2%	79.8%
White: Irish	0.5%	1.0%	1.0%
White: Gypsy or Irish Traveller	0.1%	0.1%	0.1%
White: Other White	1.6%	2.5%	4.6%
Mixed/multiple ethnic group: White and Black Caribbean	0.5%	1.2%	0.8%
Mixed/multiple ethnic group: White and Black African	0.1%	0.2%	0.3%
Mixed/multiple ethnic group: White and Asian	0.3%	0.6%	0.6%
Mixed/multiple ethnic group: Other Mixed	0.2%	0.4%	0.5%
Asian/Asian British: Indian	0.8%	3.9%	2.6%
Asian/Asian British: Pakistani	0.8%	4.1%	2.1%
Asian/Asian British: Bangladeshi	0.1%	0.9%	0.8%
Asian/Asian British: Chinese	0.3%	0.6%	0.7%
Asian/Asian British: Other Asian	0.4%	1.3%	1.5%
Black/African/Caribbean/Black British: African	0.2%	1.1%	1.8%
Black/African/Caribbean/Black British: Caribbean	0.3%	1.5%	1.1%
Black/African/Caribbean/Black British: Other Black	0.1%	0.6%	0.5%
Other ethnic group: Arab	0.1%	0.3%	0.4%
Other ethnic group: Any other	0.1%	0.6%	0.6%
Non-White British	**6.4%**	**20.8%**	**20.2%**
Total population	**848,489**	**5,601,847**	**53,012,456**

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

Table 4: Ethnic populations by local authority, 2011

	Number from non-White British group	Percentage	Statistical difference to England
Cannock Chase	3,420	3.5%	Lower
East Staffordshire	15,729	13.8%	Lower
Lichfield	5,391	5.4%	Lower
Newcastle-under-Lyme	8,361	6.7%	Lower
South Staffordshire	5,792	5.4%	Lower
Stafford	9,709	7.4%	Lower
Staffordshire Moorlands	2,449	2.5%	Lower
Tamworth	3,829	5.0%	Lower
Staffordshire	**54,680**	**6.4%**	**Lower**
West Midlands	**1,167,514**	**20.8%**	**Higher**
England	**10,733,220**	**20.2%**	

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

2.4 Rurality

Living in a rural area has a positive association with people's overall life satisfaction. However it can also present difficulties in accessing services with evidence suggesting that poor access and availability of good transport, both private and public, can mean that some people living in rural areas may not make use of health and care services that they need. This is sometimes known as "distance decay" where uptake of services decreases with increasing geographical remoteness from the service. The increase in older populations is thought to be the single most significant factor in the increasing prevalence of rural isolation.

Based on the 2011 Rural and Urban Classification 24% of Staffordshire residents live in rural areas, which is higher than the national average of 17%. South Staffordshire (40%), Stafford (32%), Staffordshire Moorlands (30%) and Lichfield (30%) are particularly rural whilst Tamworth's population is classified as entirely urban.

2.5 Deprivation

Poverty, poor education and inappropriate housing can all have an adverse effect on an individual's health with people living in deprived communities often experiencing poorer health outcomes compared with those living in more affluent communities. Other groups of people who have poorer health outcomes compared to the average include prisoners, people with disabilities and people with severe mental illness.

The Index of Multiple Deprivation 2015 (IMD 2015) measures deprivation in its broadest sense by including indicators which assess deprivation by combining seven areas (called domains): income, employment, health and disability, education, skills and training, barriers to housing and services, crime and disorder and living environment at a lower super output area (LSOA) level. LSOAs are geographical areas which have a population of around 1,500 people.

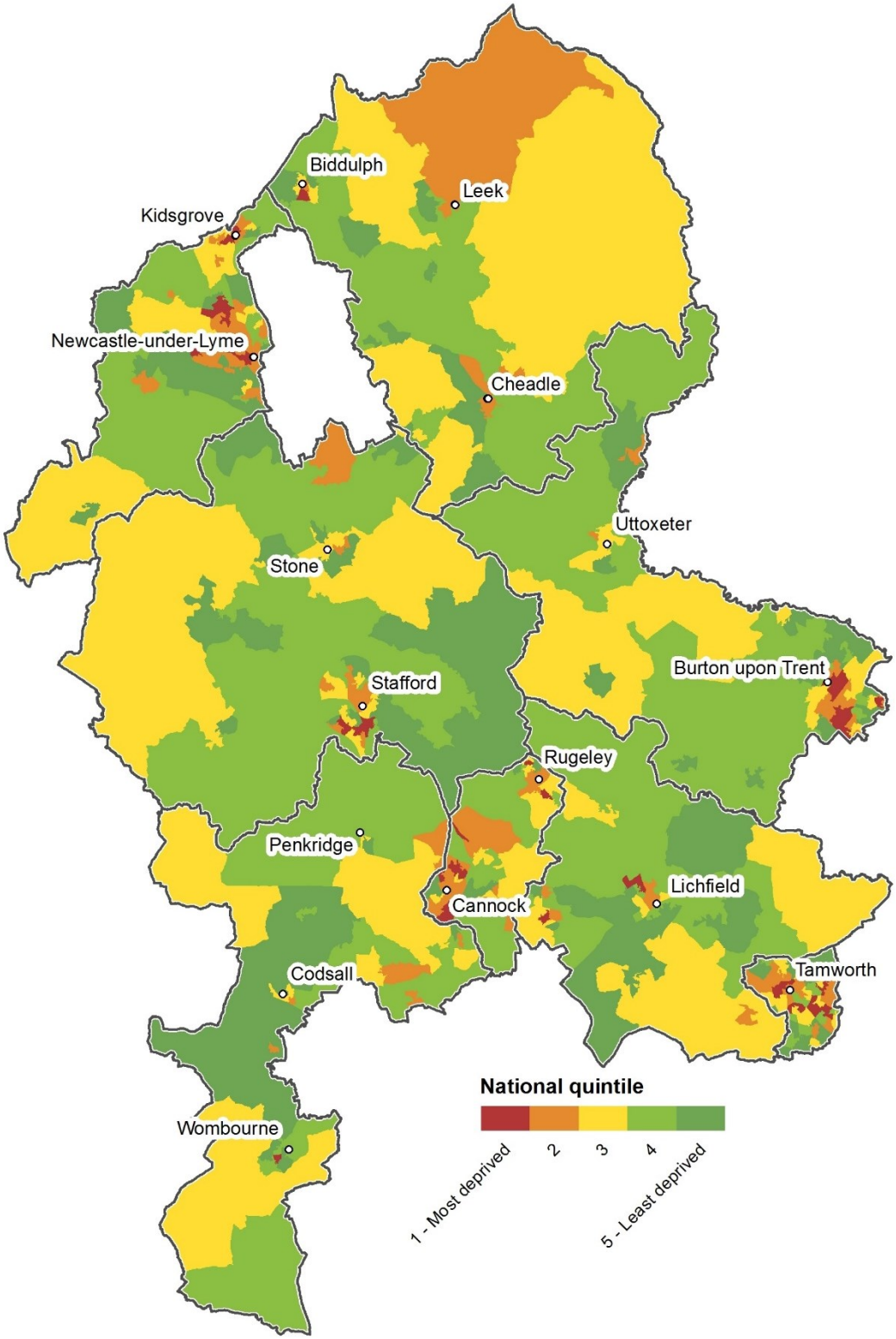
Based on the IMD 2015, Staffordshire is a relatively affluent area but has notable pockets of high deprivation in some urban areas with 9% of its population living in the most deprived fifth of areas nationally. As Map 4 shows these fall in:

- Cannock North, Etching Hill and The Heath, Cannock South, Cannock East, Hednesford North and Brereton and Ravenhill wards in Cannock Chase
- Eton Park, Stapenhill, Burton, Shobnall, Winshill, Horninglow and Anglesey in East Staffordshire
- Chadsmead and Chasetown in Lichfield
- Cross Heath, Knutton and Silverdale, Chesterton, Holditch, Town, Silverdale and Parksite, Butt Lane and Kidsgrove in Newcastle
- Wombourne South West in South Staffordshire
- Highfields and Western Downs, Penkside and Manor in Stafford
- Leek North and Biddulph East in Staffordshire Moorlands
- Glascote, Belgrave, Castle, Amington and Stonydelph in Tamworth

High levels of limiting long-term illness, shorter life expectancy and high teenage pregnancy rates have been noted in some of these areas.

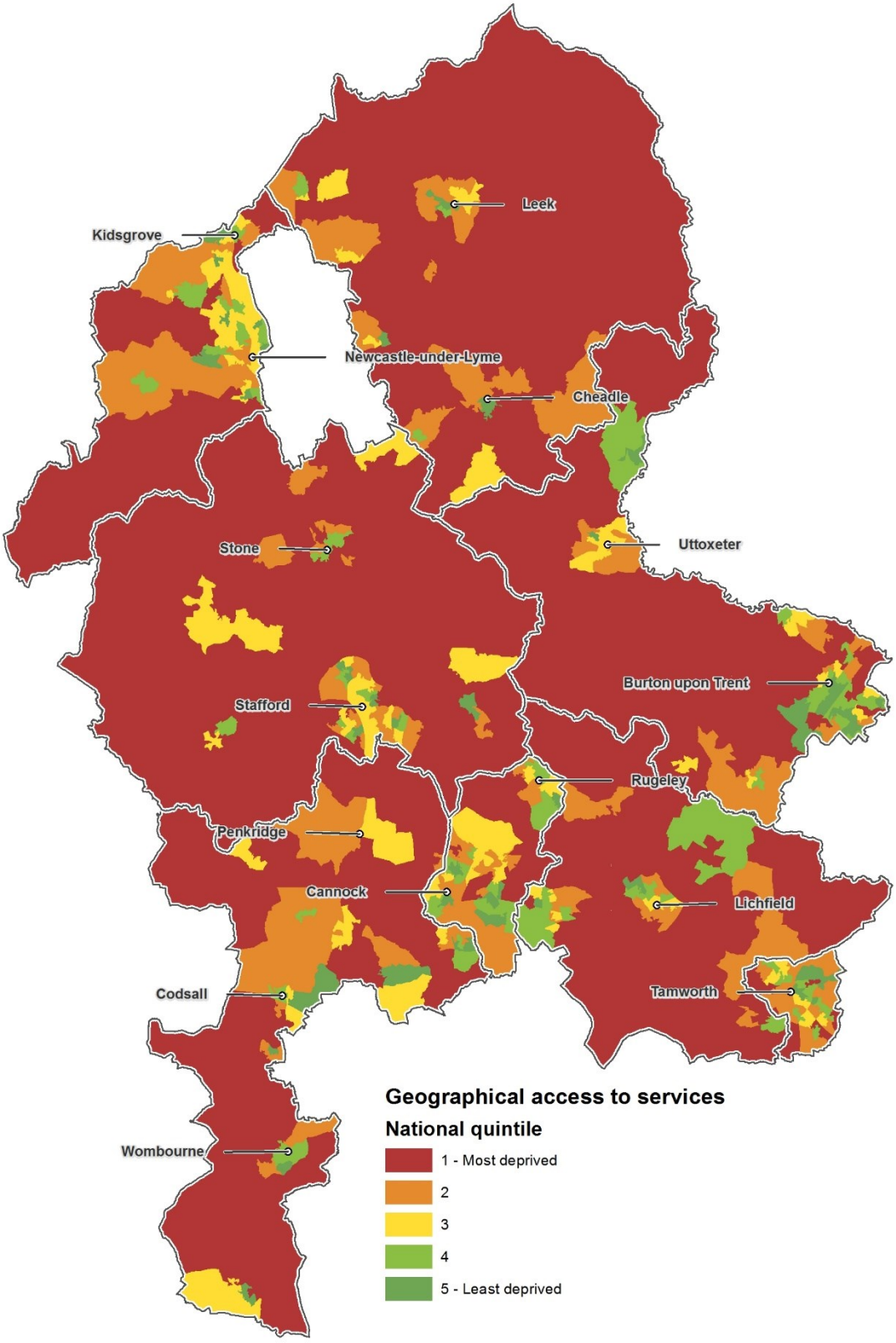
Traditionally deprivation scores have tended to use indicators that are biased towards urban areas. The 'geographical barriers' sub-domain measures geographical access to local services that are important for people's day-to-day life such as supermarkets, post offices, GP surgeries and primary schools. This measure is therefore particularly relevant for some of the more rural areas of Staffordshire where individuals have to travel long distances to key services and are therefore disadvantaged. This shows that some of the remote rural areas in Staffordshire have issues around access to services (Map 5).

Map 4: Index of Multiple Deprivation 2015



Source: Indices of Deprivation 2015, Communities and Local Government, Crown Copyright 2016

Map 5: Geographical barriers (access to services) sub-domain, 2015



Source: Indices of Deprivation 2015, Communities and Local Government, Crown Copyright 2016

3 What is health like in Staffordshire?

The population's health and wellbeing is described in detail in various key documents which together form Staffordshire's JSNA evidence base which is available on the Staffordshire Observatory website. An overview of the latest position of a range of health and wellbeing indicators by districts is also provided on the Staffordshire Observatory website which will allow pharmacies to identify more localised needs:

- http://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx
- https://www.staffordshireobservatory.org.uk/publications/thestaffordshirestory/LocalityProfiles.aspx

This section provides a summary of the key health challenges from these reports and particularly focuses on those where pharmacies could potentially contribute to improving.

The priorities that have been identified in Staffordshire's Health and Wellbeing Strategy are across the life course as shown in Table 5.

Table 5: Health and wellbeing priorities across the life course

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 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 latest strategy can be found at: http://www.staffordshirepartnership.org.uk/Health-and-Wellbeing-Board/Health--Wellbeing-Board.aspx

Pharmacies are ideally located and a local community asset. They are frequently visited by our residents and therefore ideally placed to provide information, advice and guidance about healthy living, self-care and the management of long-term conditions and support the priorities of both the Health and Wellbeing Board and the STP.

3.1 Life expectancy and healthy life expectancy

Overall health across Staffordshire is improving with life expectancy at birth continuing to increase. Men and women in Staffordshire live on average for 80 years and 83 years respectively. Men in Newcastle have shorter life expectancy at birth by 12 months whilst women in East Staffordshire can also expect to live 10 months less than the national average (Table 6).

Overall there is a six year difference between the average life expectancy of a man in Newcastle, compared to a woman in South Staffordshire. Furthermore, men and women living in the most deprived areas of Staffordshire live seven years less than those living in less deprived areas. 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.

Table 6: Life expectancy at birth, 2013-2015

	Men		Women	
	Life expectancy at birth (years)	Difference to England (months)	Life expectancy at birth (years)	Difference to England (months)
Cannock Chase	78.9	-7	82.5	-7
East Staffordshire	79.2	-3	**82.3**	-10
Lichfield	**80.2**	9	83.2	1
Newcastle-under-Lyme	**78.4**	-12	82.7	-5
South Staffordshire	**80.3**	10	**84.0**	11
Stafford	**80.4**	11	83.4	4
Staffordshire Moorlands	80.1	8	82.8	-4
Tamworth	79.0	-5	82.6	-6
Staffordshire	**79.6**	**2**	**83.0**	**-1**
West Midlands	**78.7**	**-9**	**82.7**	**-5**
England	**79.5**		**83.1**	

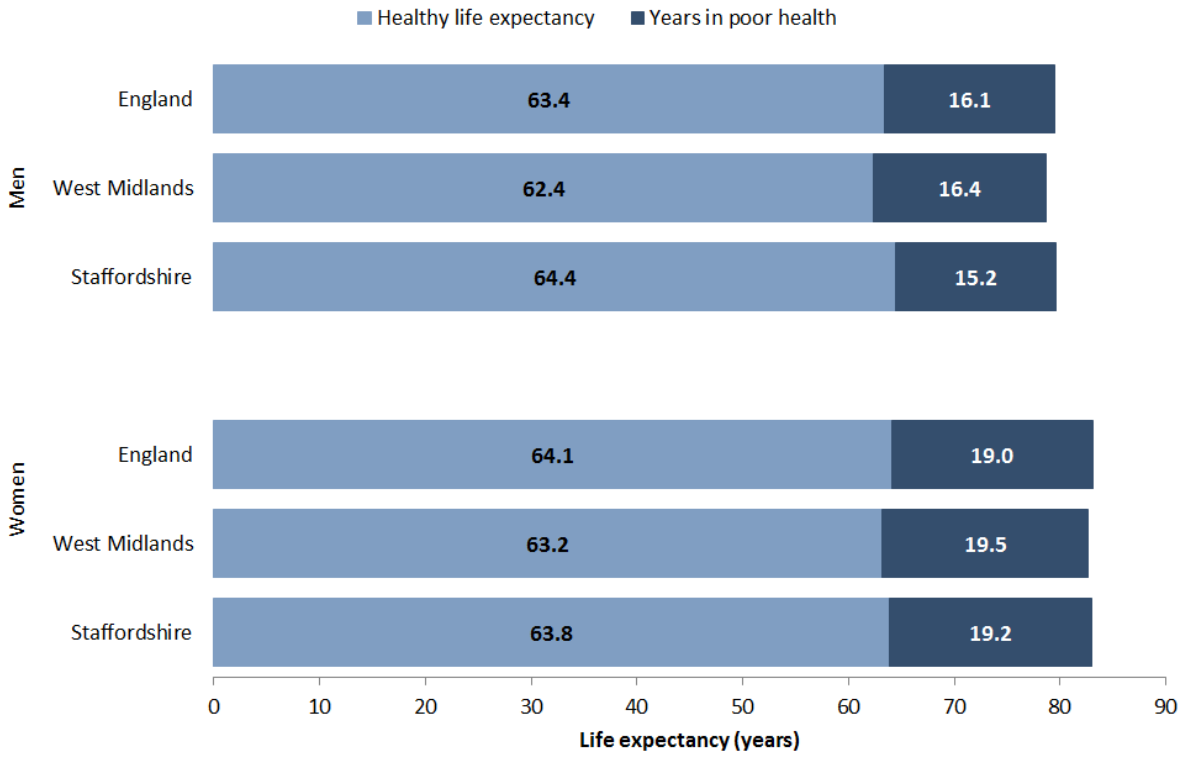
Key: Statistically better than England; statistically worse than England

Source: Office for National Statistics, Crown copyright

Advances in care also mean that people are living longer with diseases. A key measure of the quality of life years is healthy life expectancy (HLE). HLE 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. 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 5).

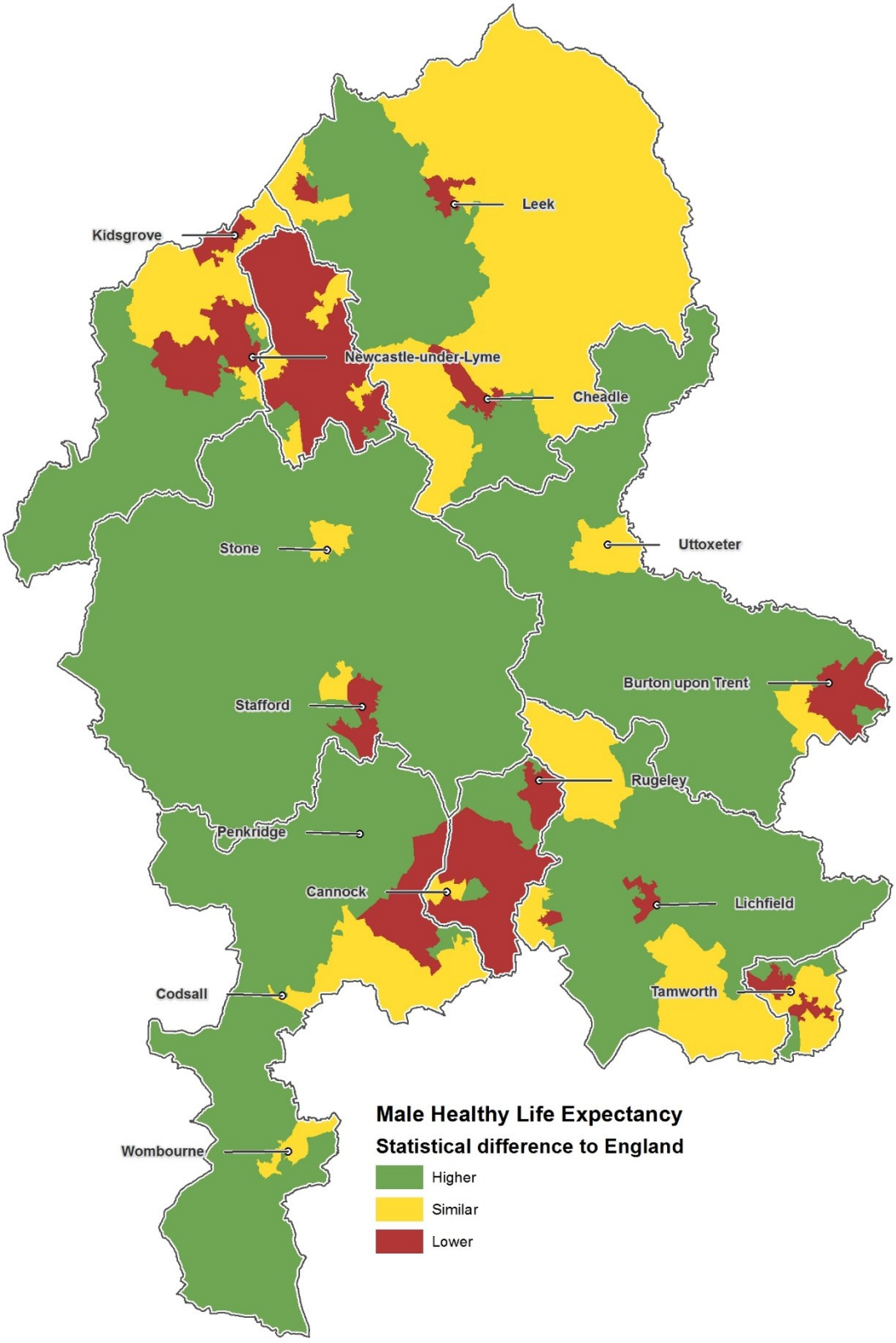
There is also a marked gap in HLE with men and women living in the most deprived areas of Staffordshire having a HLE which is 12 years shorter than those living in the most affluent areas of Staffordshire (Map 6 and Map 7).

Figure 5: Healthy life expectancy at birth, 2013-2015



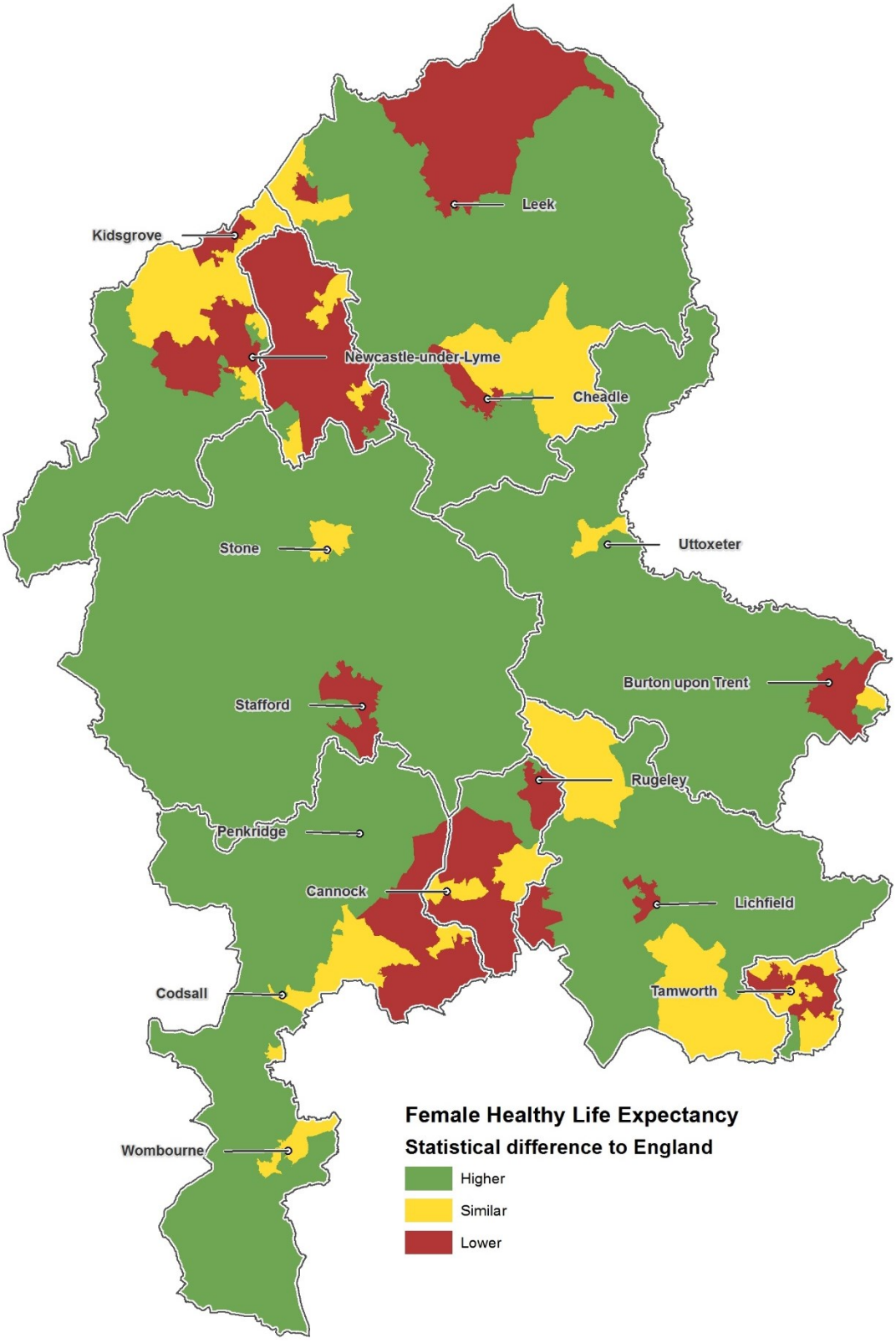
Source: Office for National Statistics

Map 6: Healthy life expectancy for males – comparison to England, 2009-2013



Source: Office for National Statistics

Map 7: Healthy life expectancy for females – comparison to England, 2009-2013



Source: Office for National Statistics

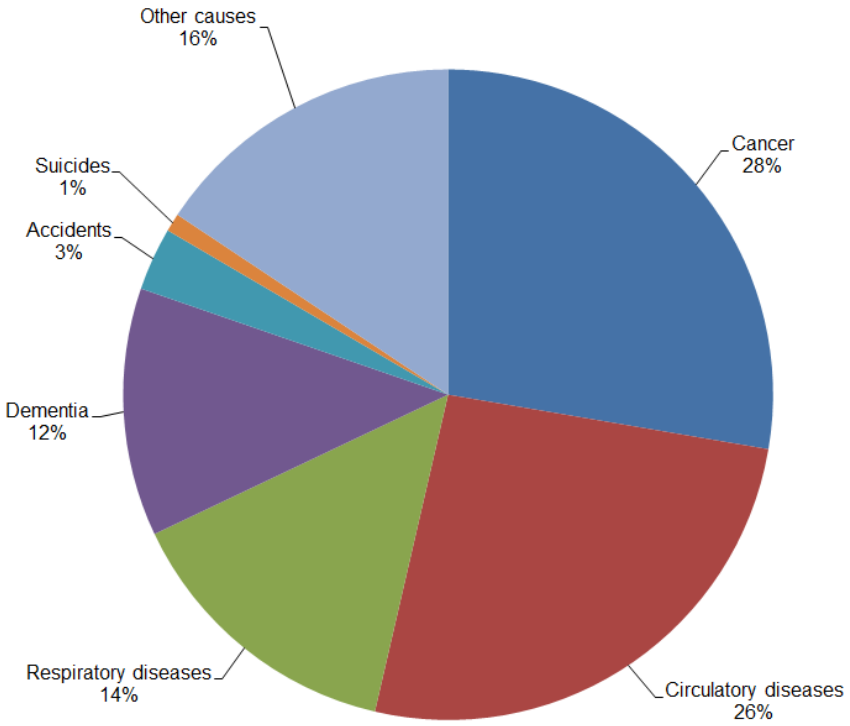
3.2 Common causes of death

Around 8,600 people died in Staffordshire during 2015, with almost seven in every ten deaths occurring in those aged 75 and over. Similar to England the common broad causes of deaths in Staffordshire during 2015 were cancer (2,400 deaths, 28%), circulatory disease (2,200 deaths, 26%) and respiratory disease (1,200 deaths, 14%) (Figure 6).

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 (1,100 deaths, 12%). This is largely due to people living longer, improved detection and diagnosis of dementia which has been accompanied with reductions in other causes such as heart disease and stroke (Figure 7).

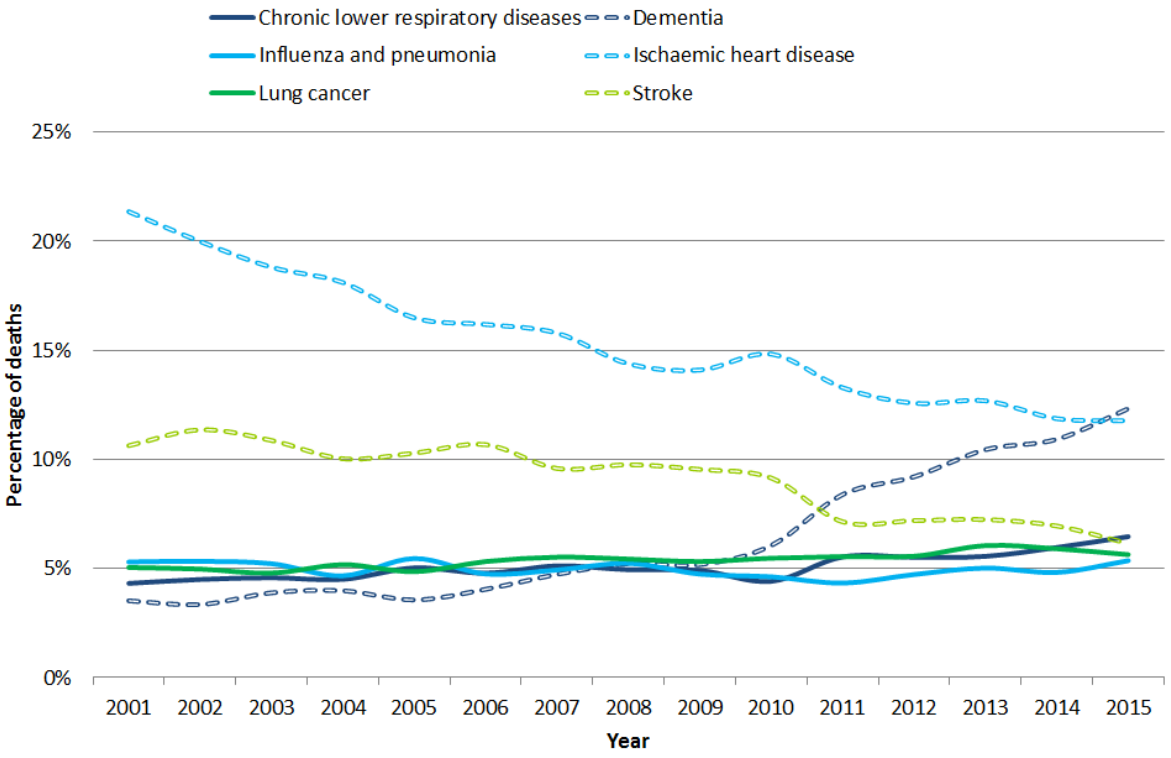
Community pharmacies can support the reduction of preventable mortality through supporting healthy lifestyles as well as provision of advice on management of long-term conditions. They also provide support through public health campaigns such as early detection of cancer and dementia.

Figure 6: Common causes of deaths in Staffordshire, 2015



Source: Primary Care Mortality Database, Office for National Statistics

Figure 7: Trends in leading causes of death in Staffordshire



Source: Primary Care Mortality Database, Office for National Statistics

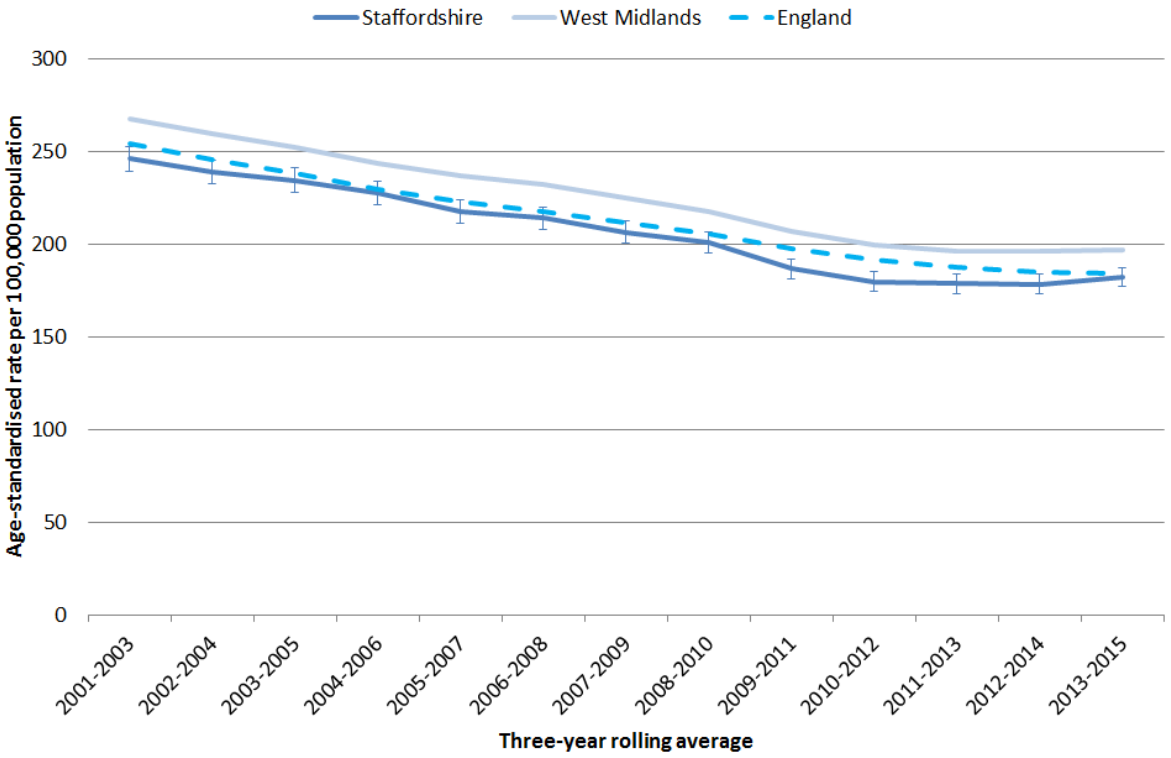
3.3 Preventable mortality

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

In Staffordshire almost one in five people die from causes that are largely thought to be preventable, equating to around 1,600 deaths every year.

Preventable mortality rates in Staffordshire fell by 26% between 2001-2003 and 2013-2015 compared with 28% for England with overall rates being similar to the England average (Figure 8). During 2013-2015 preventable mortality rates in Newcastle and East Staffordshire were however higher than the England average.

Figure 8: Trends in preventable mortality



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

- **Cancer** - Since 2011 cancer overtook cardiovascular disease as the largest killer. It also remains the biggest cause of premature death (those under 75). More than one in three people will develop cancer at some stage in their lives and around 2,400 Staffordshire residents died from cancer during 2015 (equating to 28% of all deaths). During 2015 around 1,100 Staffordshire residents died prematurely from cancer, accounting for 42% of all premature deaths. In recent years rates in Staffordshire have fallen at a faster rate than England and in 2013-2015 were significantly below the England average.

- **Circulatory disease** - Up until 2011, circulatory disease was the largest killer both nationally and locally. Around 2,200 Staffordshire residents died from circulatory disease in 2015 making up around 26% of all deaths. Of these around 560 are premature making up 21% of all premature deaths. Premature mortality due to circulatory diseases have fallen by 48% between 2001-2003 and 2013-2015 with Staffordshire rates remaining lower than England.

- **Respiratory disease** - In 2015 1,200 people died from respiratory disease in Staffordshire making it the third biggest killer. It is also the third biggest cause of premature death with almost 270 people dying prematurely in Staffordshire making up around 10% of all premature deaths. During 2013-2015 respiratory deaths in Staffordshire were lower than the England average; however Newcastle rates during this period were higher than average.

- **Liver disease** - Around 220 Staffordshire residents died from liver disease during 2015, accounting for about 3% of all deaths. Over 70% of these deaths occur to people who are under 75 with around half of these due to alcoholic liver disease. Unlike the reductions seen in under 75 mortality from cancer and cardiovascular disease, rates of people dying early as a result of liver disease increased by 37% between 2001-2003 (280 deaths) and 2013-2015 (430 deaths). This may be a result of increased alcohol consumption over the life course and consequently increased alcohol-related harm within Staffordshire.

- **Deaths from communicable diseases** - around 80 Staffordshire residents die from communicable diseases every year with rates being similar to average.

3.4 Health protection

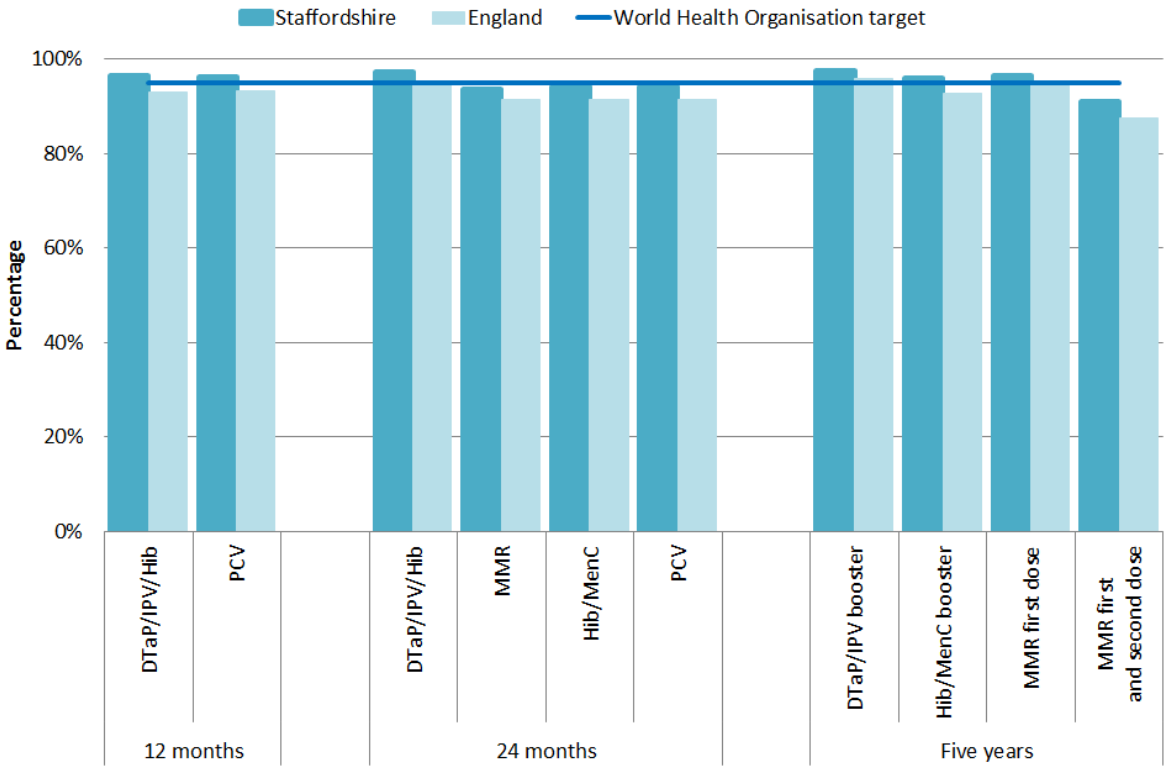
There are a number of factors that can help prevent ill health or diagnose problems early to enable better treatment, especially immunisation and screening. This section reports on some interventions designed to keep Staffordshire's population healthy by preventing ill health or detecting disease early to improve treatment outcomes.

- **Immunisation** - uptake rates for childhood immunisation are higher than the England average (Figure 9). However, for some diseases, for example diphtheria, tetanus, polio, and pertussis booster at five years, immunisation rates do not reach the 95% optimum protective target set by the World Health Organisation (WHO). Fewer Staffordshire residents aged 65 and over take up their flu vaccination or their offer of a pneumococcal vaccine than average (Table 7). Large numbers of people in this age group are admitted to hospital for vaccine preventable conditions such as influenza and pneumonia. Adult vaccination for seasonal flu is already available within community pharmacy settings. Having developed this skill set there is also the potential for pharmacies to support delivery of pneumococcal vaccination to increase uptake rates across the County.

- **Cancer screening** – coverage of screening programmes in Staffordshire are generally better than the England average although trends for breast cancer and cervical screening have in recent years fallen and therefore should be monitored (Figure 10). Factors which affect screening uptake include age, ethnicity and deprivation.

- **NHS health checks** – this programme aims to help prevent cardiovascular conditions by offering everyone between the ages of 40 and 74 a health check that assesses their risk of heart disease, stroke, kidney disease, diabetes and some forms of dementia and gives them support and advice to reduce that risk. Fewer adults in Staffordshire have attended to receive their health check to assess their cardiovascular risk than the average. The variation of uptake also varies between districts from only 21% in Stafford to 39% in East Staffordshire.

Figure 9: Childhood immunisation rates, 2016/17



Source: COVER statistics, Public Health England

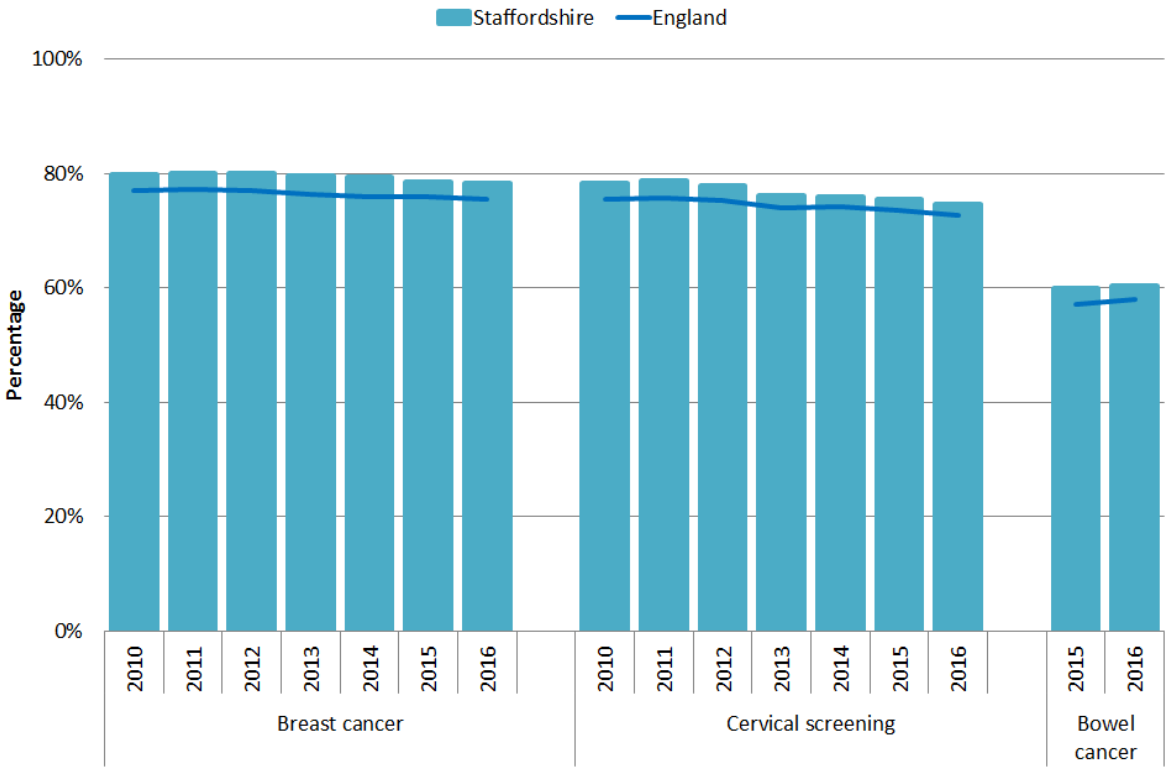
Table 7: Summary of adult immunisation uptake rates, 2016/17

	Seasonal flu vaccination		People aged 65 and over immunised with pneumococcal vaccine (at end of March 2017)
	People aged 65 and over	People aged under 65 at risk	
Cannock Chase	68.0%	49.7%	62.5%
East Staffordshire	68.4%	48.0%	64.4%
North Staffordshire	69.1%	50.0%	67.7%
South East Staffordshire and Seisdon Peninsula	70.4%	48.6%	68.6%
Stafford and Surrounds	69.5%	49.4%	62.4%
Staffordshire	69.3%	52.6%	65.6%
West Midlands	70.0%	49.6%	68.5%
England	**70.4%**	**48.7%**	**69.8%**

Key: Statistically better than England; statistically worse than England

Source: Public Health England

Figure 10: Coverage of cancer screening programmes



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

3.5 Lifestyle risk factors

Around 40% of ill-health is thought to be preventable through healthier lifestyles. The focus of lifestyle strategies and interventions tend to be on single risk factors and addressed independently of other risk factors. However those people with one lifestyle risk factor are likely also to have others as well. National research also indicates that highest concentrations of people with multiple lifestyle risk factors are in more deprived communities leading to inequalities in health outcomes.

Poorer lifestyles, combined with an ageing population will mean that not only are there more older people in the population, but they will be suffering from more of the conditions related to poor lifestyles than in previous generations.

People are more likely to make healthier lifestyle choices when they are fully informed about the risks to ill health. Community pharmacies are ideally placed to provide information, advice and guidance to residents about healthy lifestyles.

Smoking

In Staffordshire, 12.6% of mothers continued to smoke throughout their pregnancy during 2016/17 which was higher than the England average of 10.5%. Rates in Cannock Chase and in the North of the County are particularly high.

Based on data from the 'What About YOUth' (WAY) survey, 8% of Staffordshire children smoke which is similar to the England average. However around 21% of children aged 15 in Staffordshire are likely to have tried an e-cigarette compared with 18% nationally.

Based on data from the latest Annual Population Survey (2016) smoking prevalence for adults aged 18 and over in Staffordshire was 15%, which is similar to the England average. Data from the same survey found that the prevalence of smoking in routine and manual groups was significantly higher (30%) contributing to increases in health inequalities.

Around one in six Staffordshire residents die every year as result of smoking with overall smoking-attributable death rates for Staffordshire being lower than the England average. However smoking-related deaths in Cannock Chase are higher than average.

Alcohol and substance misuse

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

More people in Newcastle die as a result of alcohol than the England average. There were 6,500 alcohol-related admissions during 2016 in Staffordshire with overall rates continuing to be higher than the England. The majority of alcohol admissions are due to complications of drinking too much alcohol over the life course (e.g. high blood pressure, heart disease, stroke and a variety of cancers). At a district level Cannock Chase, Newcastle, Stafford, South Staffordshire and East Staffordshire, have rates higher than the England average.

Staffordshire is about average for successful completion of alcohol and drug treatment.

Obesity, healthy eating and physical activity

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 11). Newcastle has a higher rate of children who are obese by the time they are in Year 6.

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

Around two in three adults in Staffordshire are overweight or obese which is higher than average. This is coupled with high numbers of people who eat unhealthily and are inactive.

A large proportion of older people are also at risk of malnutrition (especially in people aged 85 and over) with numbers projected to increase sharply in Staffordshire in line with demographic changes.

Figure 11: Children who are obese, 2015/16

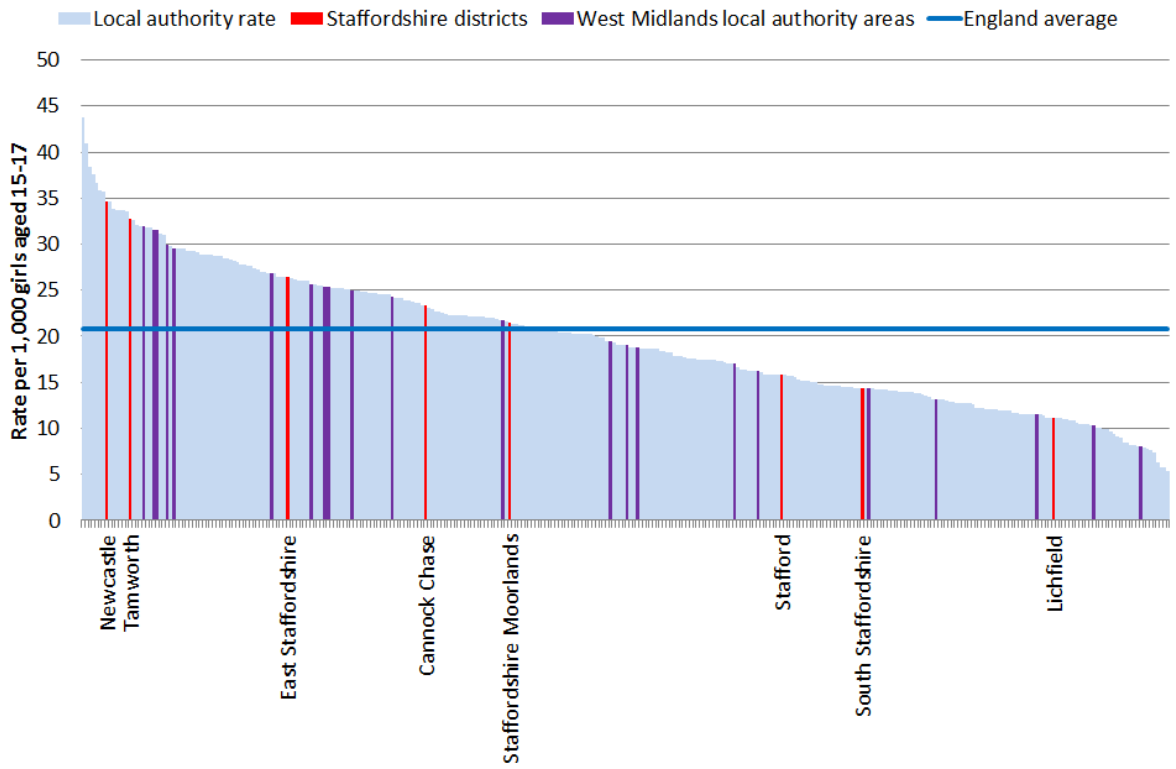
Source: National Child Measurement Programme: results from the school year 2015/16, headline results, Copyright, The Information Centre for Health and Social Care. All Rights Reserved

Sexual health

There are around 320 under-18 teenage conceptions in Staffordshire, with overall rates being similar to the national level although rates are not reducing as fast as the England average. In addition rates in Newcastle and Tamworth continue to be amongst the worst in the Country (Figure 12).

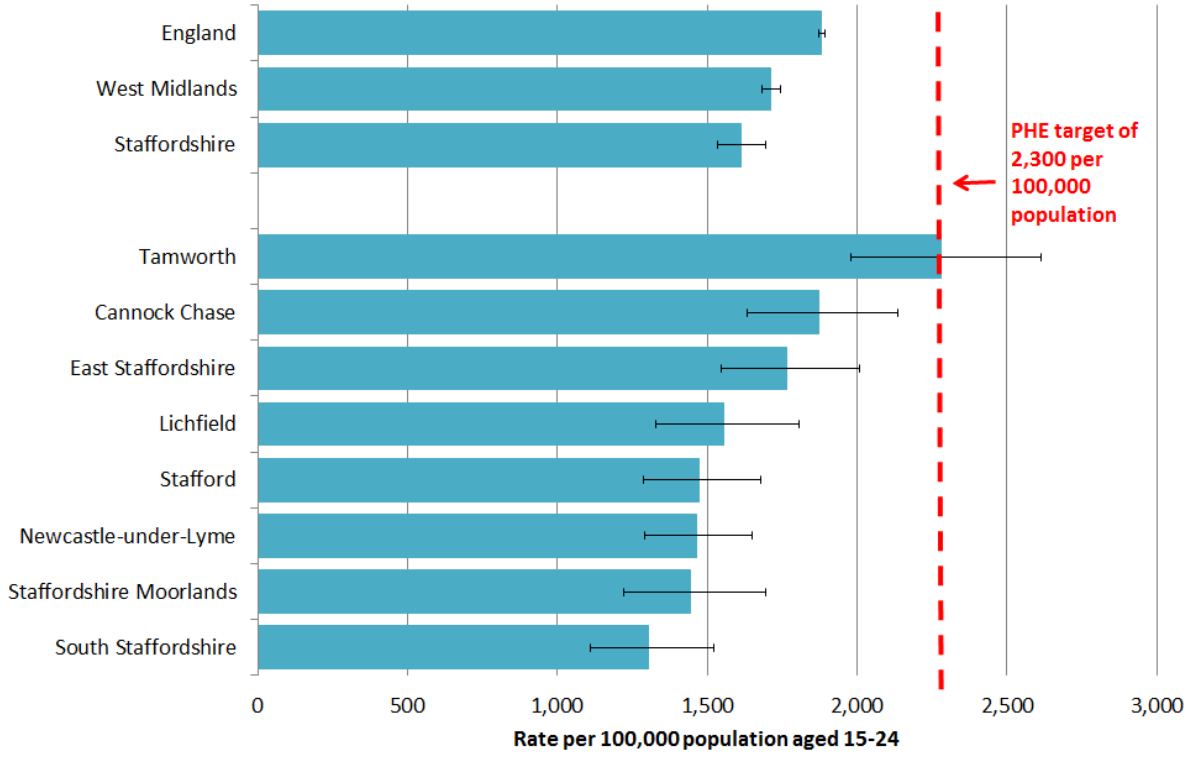
Chlamydia is often asymptomatic so a large proportion of cases remain undiagnosed. The National Chlamydia Screening Programme (NCSP) was set up to control and prevent the spread of chlamydia, targeting the high risk group, i.e. young people aged under 25 who are sexually active. Around 19% of young people aged 15-24 in Staffordshire were tested for chlamydia during 2016 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 (Figure 13). We do not currently know if this 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.

Figure 12: Under-18 conception rates in England, 2015



Source: Office for National Statistics

Figure 13: Chlamydia diagnosis rates in 15-25 year olds, 2016



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

3.6 Long-term conditions

Long-term conditions (LTCs) are those that cannot currently be cured but can be controlled with the use of medication or other therapies. People with LTCs are more likely to see their GP, be admitted to hospital and stay in hospital longer than people without LTCs. People with LTCs account for a significant and growing proportion of health and social care resources.

National estimates also suggest that there is a rising demand for the prevention and management of people with multiple conditions rather than single conditions. By the time people reach 65 most will have developed at least one chronic condition and large proportions will also have developed two or three conditions. The proportion of multiple conditions is also more prevalent in deprived communities.

More people in Staffordshire report having a limiting long-term illness than average. The recorded number and prevalence of selected LTCs according to disease registers within general practice are: hypertension (15.7%, 133,400 patients), depression (8.5% people aged 18 and over, 58,300 patients), diabetes (7% people aged 17 and over, 49,100 patients), asthma (6.0%, 51,200 patients) and chronic kidney disease (4.1% people aged 18 and over, 28,300 patients). Many of these conditions can also be supported by pharmacies, for example through the collection and delivery service, through medical user reviews or new medicine services.

- **Dementia** –Assuming that the prevalence of dementia remains the same, the ageing population means that the total number of people aged 65 and over with dementia in Staffordshire is projected to rise from around 11,100 in 2016 to 20,300 in 2036, an increase of 83%. Diagnosis rates of dementia have improved and as at March 2017 around two-thirds of patients (7,200 people) were known to have a dementia diagnosis.

- **Frail elderly** - research suggests that between a quarter and half of people aged 85 and over are estimated to be frail and that the overall prevalence in people aged 75 and over is around 9% which equates to around 7,100 Staffordshire residents.

- **Carers** - around 12% of Staffordshire's population provide unpaid care to family and friends which is higher than the England average. Carers are often older and in poor health themselves. Pharmacies can act as resource for carers to help meet the needs of both carers and the people they care for. This could be through dispensing medicines, provision of advice on management of conditions as well as signposting to local community support groups.

3.7 Growing demand on health and social care

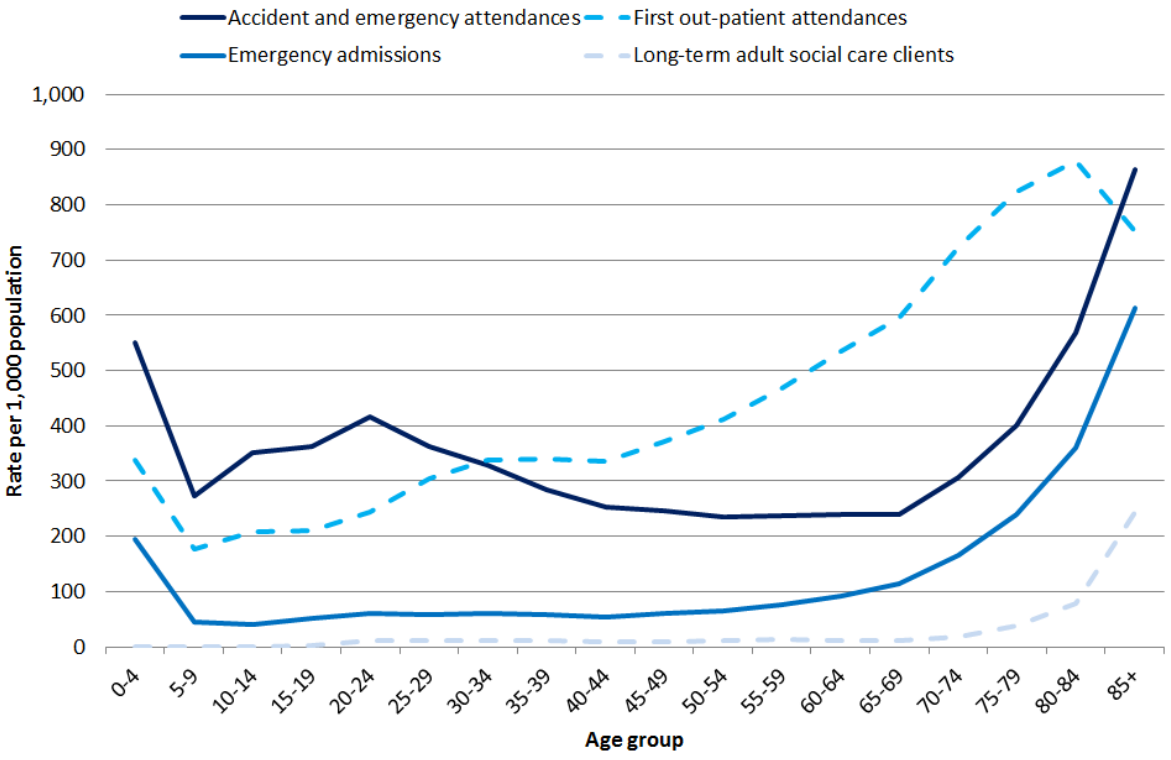
Most care will occur in primary care or community settings. However a higher than average proportion in Staffordshire also occurs in hospital settings. Based on 2016/17 activity every day in Staffordshire:

- Almost 800 patients attend an accident and emergency department
- Over 3,100 patients attend an out-patient clinic of which 1,000 are new patient whilst the remaining 2,100 are follow-up attendances
- Over 600 patients are admitted to hospital, 250 of these are unplanned admissions and 45 are those who are readmitted within 30 days of discharge

In addition, the demand on health and care has been rising. These increases are more than is explained by demographic change (e.g. increase in older people) alone and are likely to continue with increased complexity of needs. Young children and older patients tend to be greater users of hospital services; as expected older people are also higher users of social care (Figure 14). In addition those that are admitted to hospital are often delayed from being discharged.

Recent analysis of local accident and emergency and minor injury units data found that a large proportion of patients require information and advice for minor illnesses; pharmacies are ideally placed to help reduce some of this demand through the common ailments services which support patients for many common minor illnesses, such as diarrhoea, minor infections, headache and sore throats.

Figure 14: Health and care utilisation by age group in Staffordshire, 2016/17



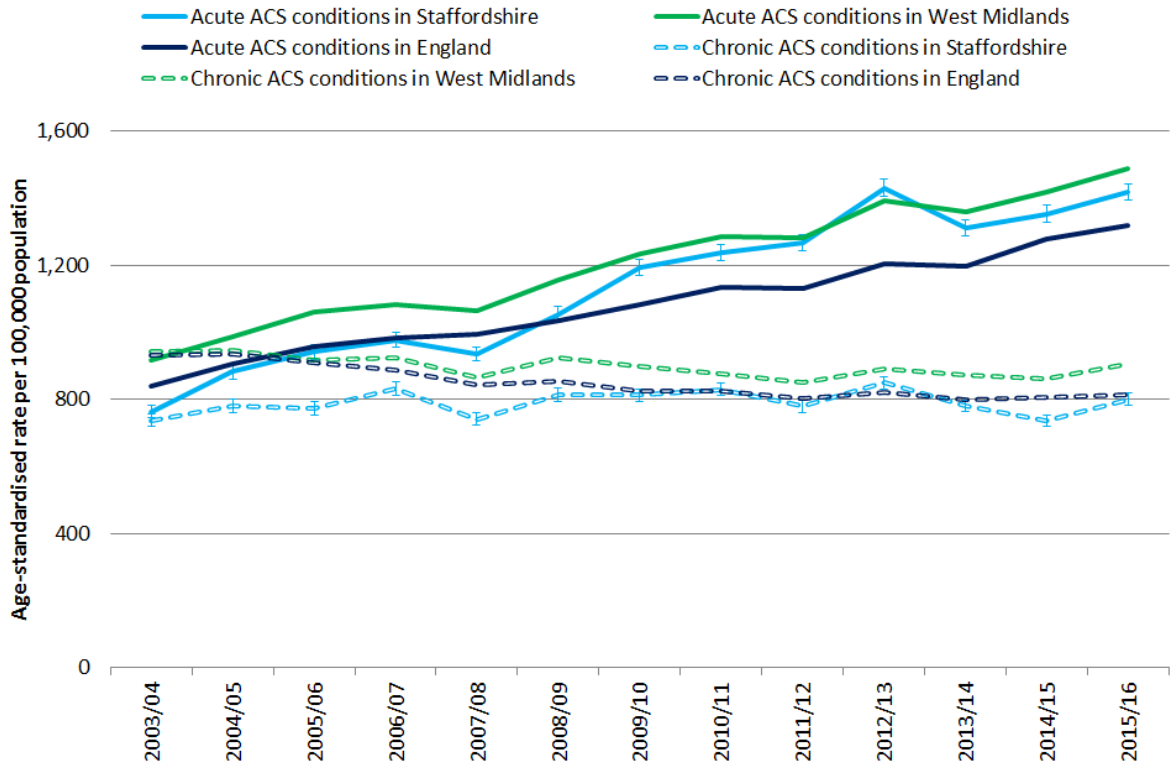
Source: Hospital Activity Data Extract, Midlands and Lancashire Commissioning Support Unit, Staffordshire County Council and 2016 mid-year population estimates, Office for National Statistics, Crown copyright

Older people also spend longer in hospital because their needs are often more complex, for example people aged 65 and over spend on average 7.6 days in hospital for unplanned admissions compared to 2.4 days for those under 65. National research suggests that longer hospital stays themselves can lead to harm.

Many people in Staffordshire are admitted to hospital for acute and chronic conditions that can be managed effectively in primary care including community pharmacy or outpatient settings (known as ambulatory care sensitive (ACS) conditions).[1]

Trends in Staffordshire for patients being admitted to hospital for acute conditions are increasing more rapidly than average (Figure 15).

Figure 15: Unplanned admissions from ambulatory care sensitive (ACS) conditions



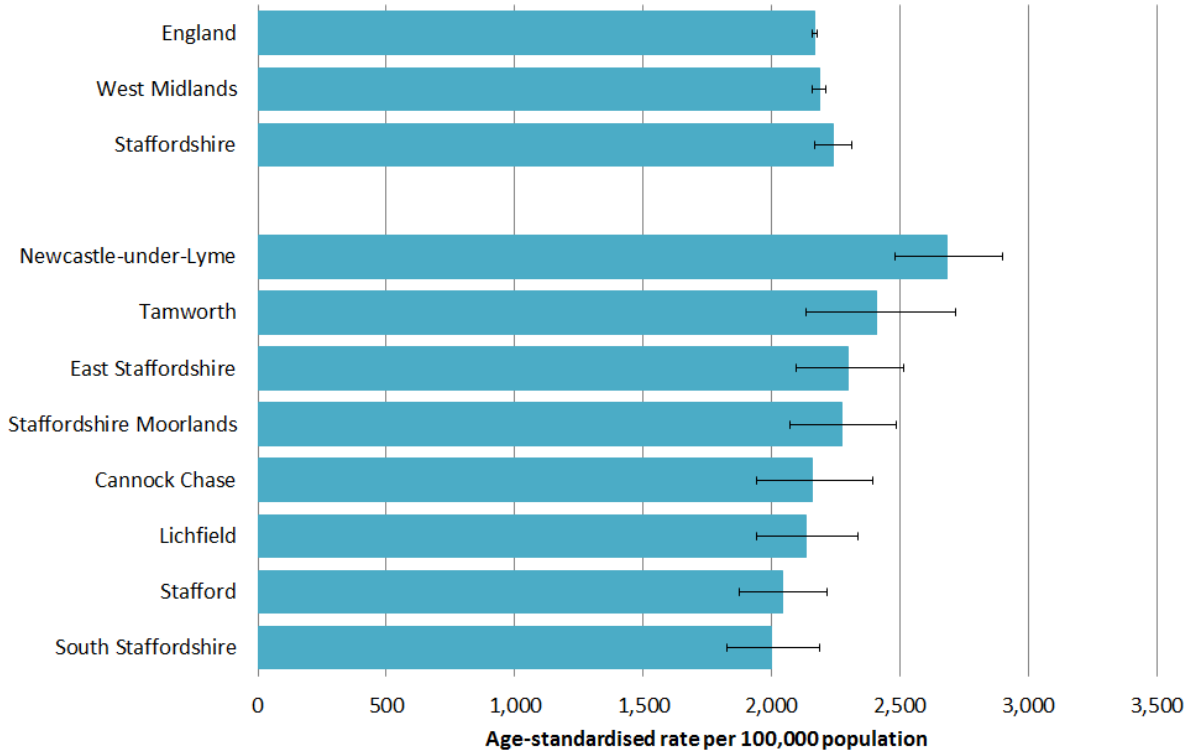
Source: NHS Digital Indicator Portal (https://indicators.hscic.gov.uk/webview)

During 2015/16 around 3,800 Staffordshire residents aged 65 and over were admitted to hospital as a result of a fall-related injury with rates being similar to the England average. Rates in Newcastle-under-Lyme however were higher than the England average (Figure 16). Rates for falls in people aged over 80 were higher than the England average and make up two-thirds of all falls in older people.

[1] Common acute ACS conditions include urinary tract infections, influenza and pneumonia, dehydration and gastroenteritis; common chronic ACS conditions include management of chronic obstructive pulmonary disease, heart failure and atrial fibrillation

The risk of adverse effects and interactions with other drugs increases with the number of medicines an individual takes and may contribute to the increased risk of falls, particularly amongst older people. The risk of falls can also increase when starting a new medicine or changing a dose and community pharmacists are well placed to advise patients on this during medicine reviews.

Figure 16: Admissions due to falls in people aged 65 and over, 2015/16



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

In 2015/16 more older people (aged 65 and over) who were discharged from hospital into reablement services were still at home after 91 days than the national average (88% compared with 83% across England). However the number of people who were offered reablement services remains lower than the national average. A post-discharge MUR (one of the four nationally agreed target groups) can support those patients who have been recently discharged from hospital, and who has had changes to their medicines whilst they were in hospital.

During 2015/16 there were around 1,100 permanent admissions to people aged 65 and over to residential and nursing care homes with the rate being similar to the national average. South Staffordshire however has a statistically higher rate of admissions to care homes than the national average.

3.8 End of life care

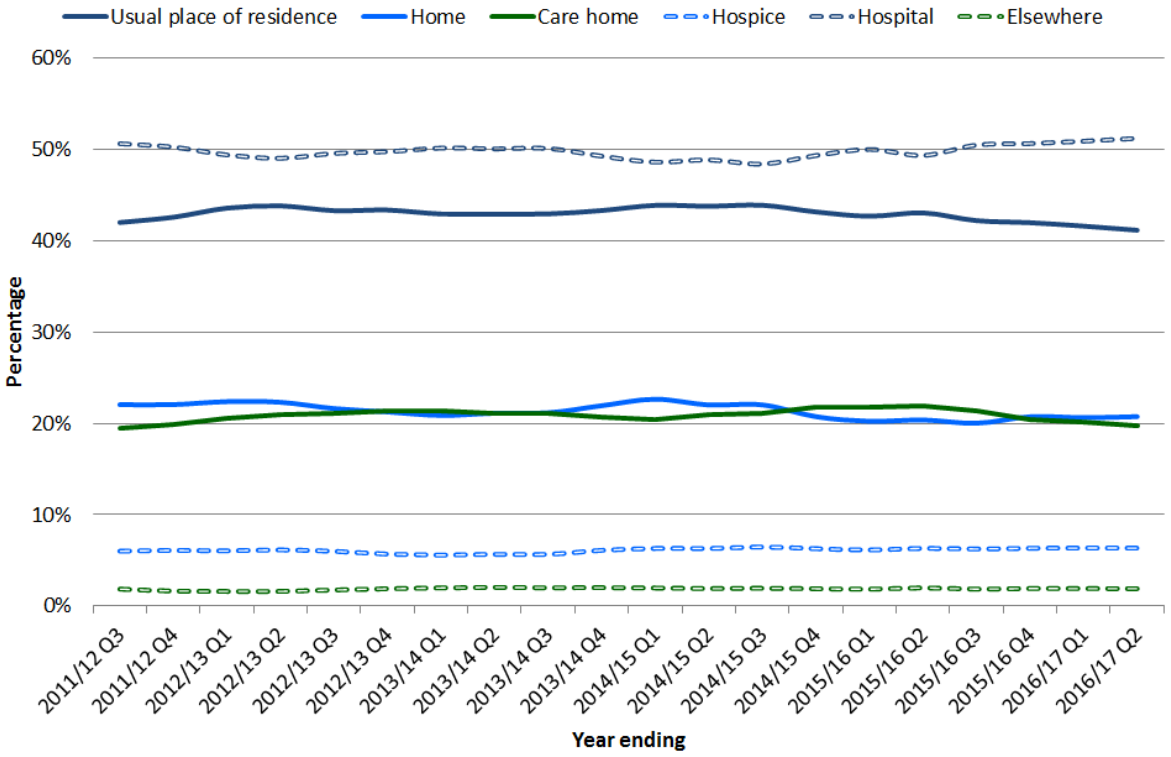
Research by Public Health England suggests that on average around 25% of deaths are unexpected. This means that around 75% of people who have died should be on palliative care GP registers which record the number of patients who are expected to die within the next six to 12 months. This equates to around 6,500 deaths in Staffordshire. However during 2015/16 only around 2,500 Staffordshire residents were on such registers indicating that many people's end of life care needs are not being identified prior to their death.

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.

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 17).

The pharmacy palliative care service supports end of life care within community settings by providing timely medicines that are commonly prescribed in palliative care. Pharmacists should also be considered as being part of the community multidisciplinary palliative care team.

Figure 17: Trends in proportion of Staffordshire residents dying by location



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

4 Current provision of pharmaceutical services

The NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations (*2013 Regulations*) also provides the legal framework that govern the services that pharmaceutical services providers can provide. Although dispensing practices provide a wide range of services for their patients, for the purpose of the PNA, only the prescription dispensing services are considered within the regulation and PNA.

As described in Section 1.3 there are three levels of pharmaceutical services that community pharmacies can provide:

- Essential services – services all pharmacies are required to provide
- Advanced services – services to support patients with safe use of medicines
- Enhanced services – services that can be commissioned locally by NHS England

Pharmacies can also provide locally commissioned services which are commissioned by local commissioners such as Staffordshire County Council.

This chapter describes the current provision of these services in Staffordshire.

4.1 Pharmaceutical provision in Staffordshire

Pharmacy is the third largest healthcare profession, with a universally available and accessible community service. Pharmacies are well used and based on national estimates around seven million visits are made to a community pharmacy for health-related reasons annually in Staffordshire which equates to around 10 visits per person every year. Nationally 79% of people have visited a pharmacy at least once in the last year whilst 37% have visited at least once a month. Local data from a resident survey found around 14% of respondents used their pharmacy weekly and a further 58% monthly.

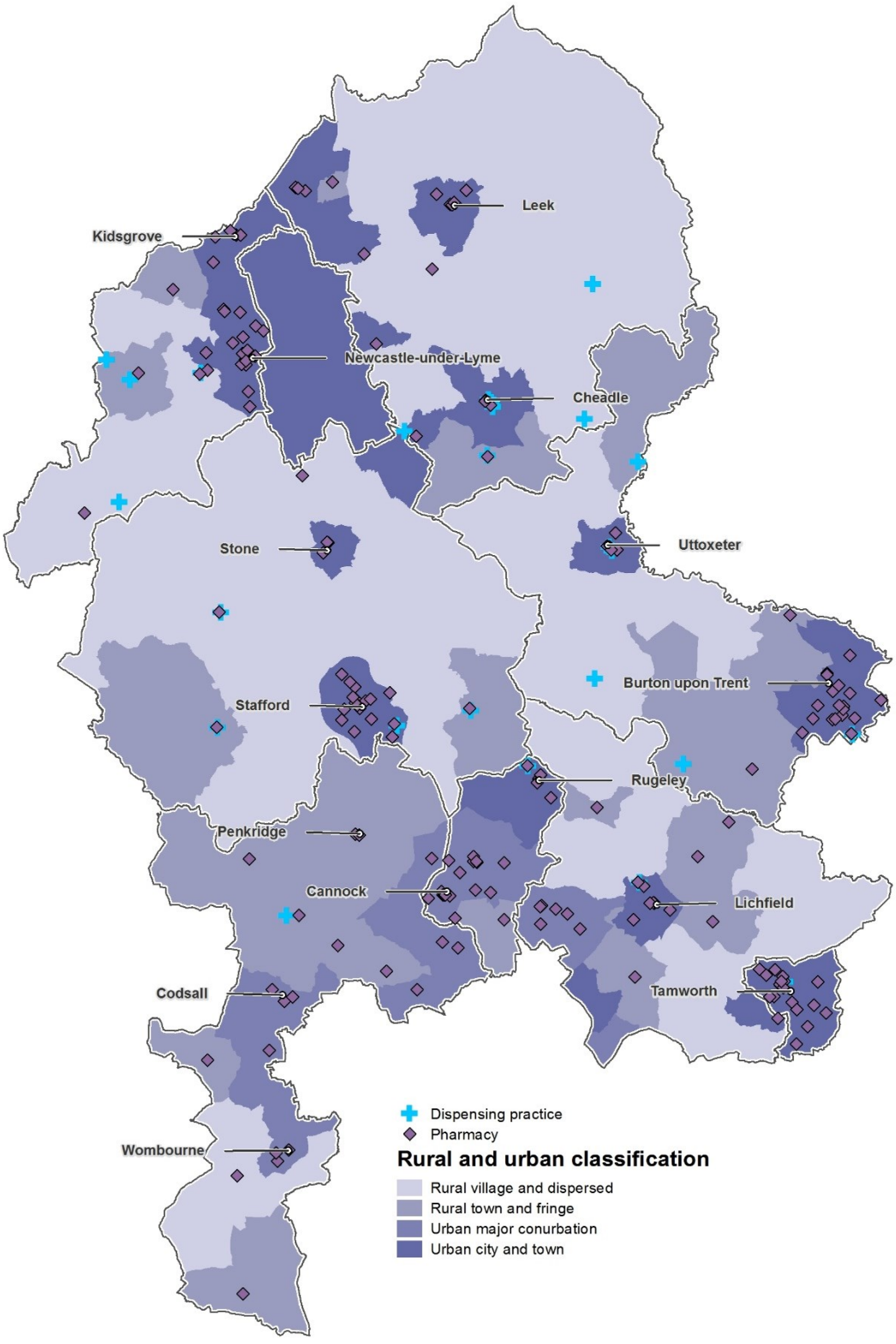
There are 182 pharmaceutical service providers of which seven are distance-selling pharmacies. There are also 27 dispensing GP practices in Staffordshire (Table 8 and Map 8). A Walsall practice also dispenses from its branch practice, Stonnall Surgery, in Lichfield district. Map 9 shows the location of pharmaceutical providers alongside GP practices within Staffordshire.

Table 8: Pharmaceutical providers in Staffordshire as at July 2017

	Community pharmacies s	Distance selling pharmacies	Dispensing practices
Cannock Chase	25	0	0
East Staffordshire	24	1	7
Lichfield	19	0	2
Newcastle-under-Lyme	29	2	4
South Staffordshire	20	1	2
Stafford	27	0	4
Staffordshire Moorlands	19	0	7
Tamworth	19	3	1
Staffordshire	**182**	**7**	**27**

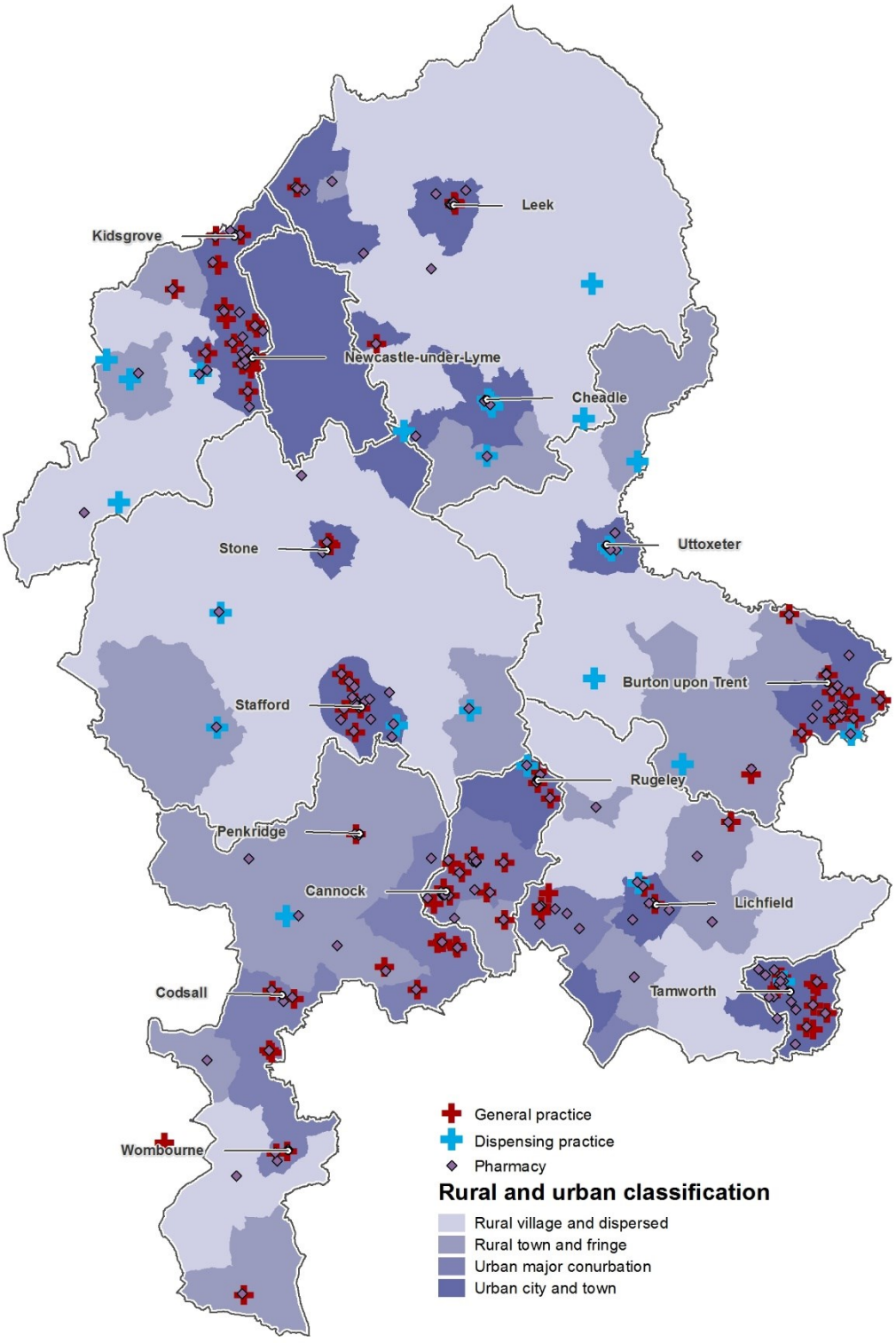
Source: NHS England North Midlands and NHS Business Services Authority

Map 8: Pharmaceutical providers in Staffordshire, July 2017



Source: NHS England North Midlands, NHS Business Services Authority and The Rural and Urban Classification 2011, Office for National Statistics

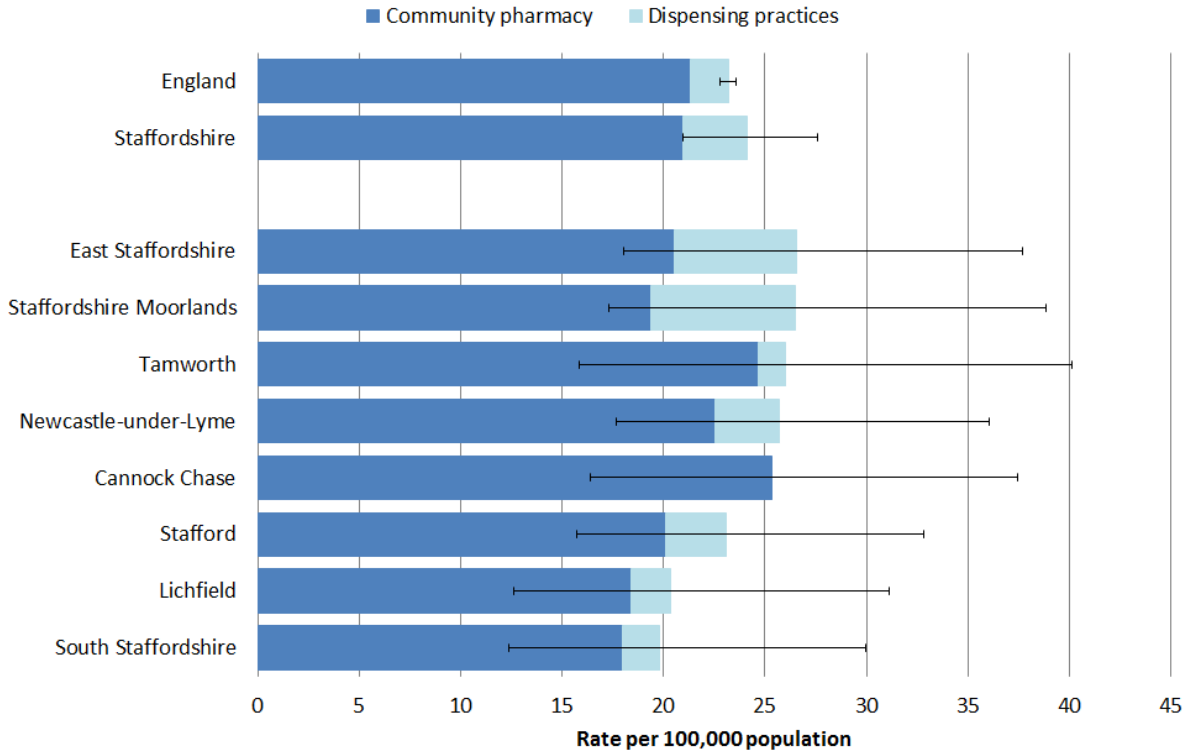
Map 9: Pharmaceutical providers and GP practices in Staffordshire, July 2017



Source: NHS England North Midlands, NHS Business Services Authority and The Rural and Urban Classification 2011, Office for National Statistics

The rate of community pharmacies and dispensing practices is 24 per 100,000 population which is similar to the national average (23 per 100,000) but ranges between districts from 20 per 100,000 in South Staffordshire to 27 per 100,000 population in East Staffordshire although districts with low rates do also have nearby access to pharmacies in neighbouring areas such as Wolverhampton and Stoke-on-Trent. Rates across all Staffordshire districts are similar to the national average rate (Figure 18).

Figure 18: Pharmaceutical providers per 100,000 population, July 2017



Source: NHS England North Midlands, NHS Business Services Authority and General Pharmaceutical Services in England 2006/07 to 2015/16, Copyright 2016, Health and Social Care Information Centre. All Rights Reserved

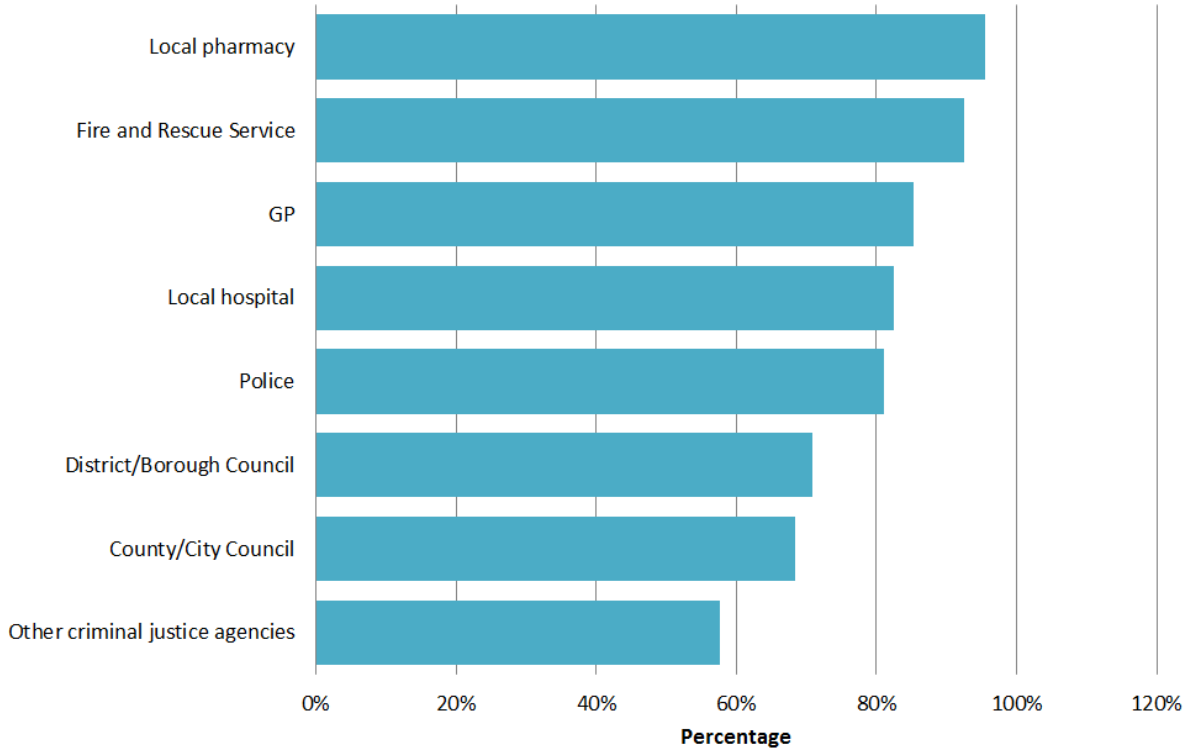
There is a gap as to the clarity of controlled localities and reserved locations. It is therefore proposed that NHS England North Midlands undertake further mapping of controlled localities, dispensing practice areas and reserved locations to provide assurance on the patients who fall into dispensing and prescribing groups for these practices, and clarity on the status of these areas, to support applications for new pharmacies or those considering relocations.

A national patient survey indicated that the public value a variety of types of pharmacy. In terms of ownership around two-fifths of pharmacies in Staffordshire are owned by independent contractors whilst the remaining three-fifths are owned by multiple contractors. (Note: for the purposes of this assessment the national definition of multiple contractors is used which are those community pharmacies who own six or more pharmacies).

Staffordshire residents are generally satisfied with pharmacy provision. Data from the latest *Feeling the Difference* survey found that 95% of residents were satisfied with their local pharmacy which is the highest amongst other public serving organisations (Figure 19). The engagement survey also found that local pharmacy services met the needs of respondents.

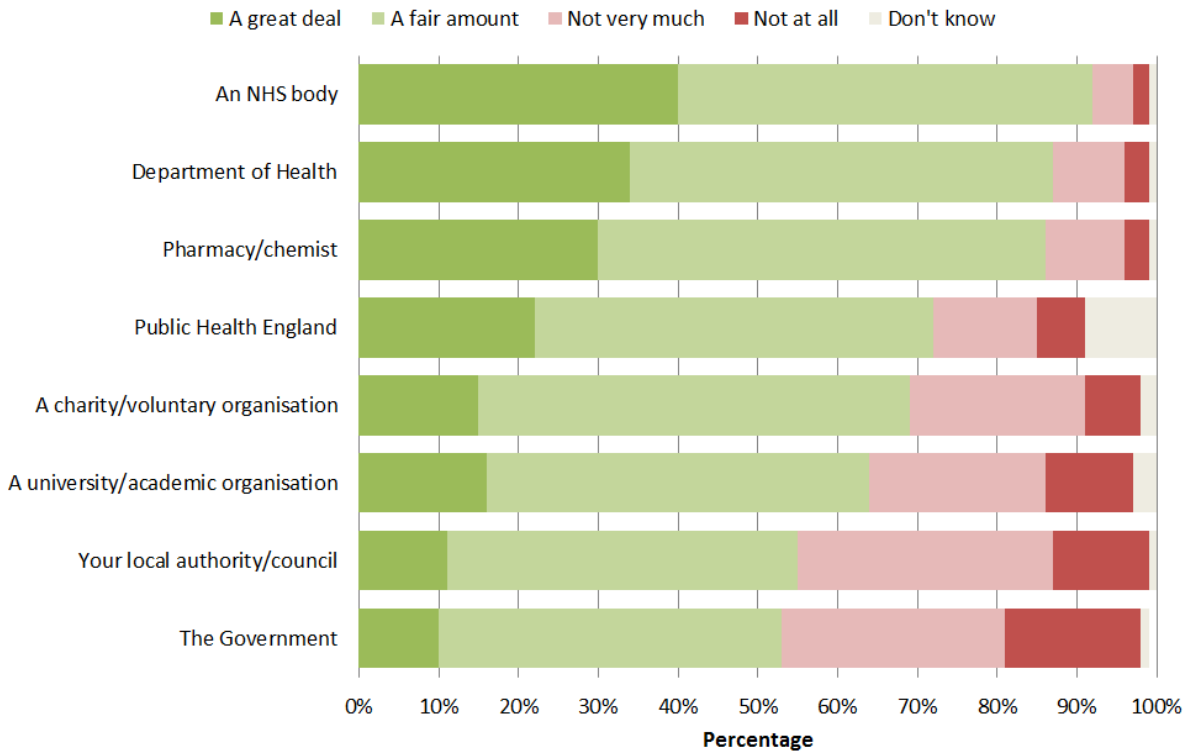
In addition a recent MORI survey for Public Health England published in August 2016 suggests that nationally almost 86% say they would trust advice from pharmacies on how to stay healthy (Figure 20). The same survey found that around 14% of respondents would contact their pharmacy for info on how to stay healthy.

Figure 19: Proportion who are 'very' or 'fairly satisfied' by service, March 2017 (n= 1,207)



Source: Feeling the Difference Survey Wave 22, Staffordshire Observatory, March 2017

Figure 20: Respondents "to what extent would you trust advice on how to stay healthy from the following organisations/bodies?" 2016 (n = 1,640)



Source: 2016 Public awareness and opinion survey for Public Health England, Ipsos MORI, October/November 2016, Copyright Ipsos 2016

4.2 Essential pharmacy services

These are services which pharmacies providing NHS pharmaceutical services must provide as part of the NHS Community Pharmacy Contractual Framework. Whilst distance-selling pharmacy contractors provide essential services they must not provide these services face-to-face at their premises. Essential services include:

- Dispensing medicines
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted medicines
- Public Health - promotion of healthy lifestyles
- Signposting
- Support for self-care
- Clinical governance

Dispensing medicines and/or appliances - the safe supply of medicines or appliances. Advice is given to the patient about the medicines being dispensed and how to use them. Records are kept of all medicines dispensed and significant advice provided, referrals and interventions made. An Electronic Prescription Service (EPS) has also being implemented as part of the dispensing service and all pharmacies are now "Release 2 enabled". In terms of GP practices around 87% of Staffordshire practices were also EPS2 enabled with around 57% of all prescriptions being issued electronically (54% across England between January and March 2017).

Electronic Prescription Service (EPS) allows prescriptions to be sent direct to pharmacies and appliance contractors through IT systems used in GP surgeries. This means that patients do not have to collect a paper repeat prescription from the GP practice, but can go straight to the nominated pharmacy or dispensing appliance contractor to pick up their medicines or medical appliances. Prescriptions for acute items such as antibiotics can also be sent electronically if it is practical to do so. Eventually EPS will remove the need for most paper prescriptions, but the expectation currently is that up to 75% of all prescriptions should be issued electronically where the GP practice is EPS enabled. Patients have to nominate a particular community pharmacy or appliance contractor that the electronic prescription can be sent to them securely, but this nomination can be changed at any time if a patient consents to do so.

Nationally there has been a growth in the number of monthly items dispensed from 5,658 per month in 2006/07 to 7,096 in 2015/16. Some of the reasons which help to explain why rates have been increasing are shown in Table 9.

Table 9: Factors which influence the number of prescriptions dispensed

- the size of the population
- the age structure of the population, notably the proportion of the those aged 60 and over, who generally receive more prescriptions than the young
- improvements in diagnosis, leading to earlier recognition of conditions and earlier treatment with medicines
- development of new medicines for conditions with limited treatment options
- development of more medicines to treat common conditions
- increased prevalence of some long term conditions, for example, diabetes
- shifts in prescribing practice in response to national policy, and new guidance and evidence
- increased prescribing for prevention or reducing risk of serious events, e.g. use of lipid-lowering drugs to reduce risk of stroke or heart attack

Source: Prescriptions dispensed in the community in England, 2003-2013, Copyright 2014, Health and Social Care Information Centre. All rights reserved

Repeat dispensing - the management of repeat medication for up to one year, in partnership with the patient and prescriber. It is a great way for the GP practice to stay in control of prescription items and the service specification states that pharmacies must ask if anything has changed since the previous items were issued and do they need everything on the script today. The patient will return to the pharmacy for repeat supplies, without first having to visit the GP surgery. Before each supply the pharmacy will ascertain the patient's need for a repeat supply of a particular medicine. It is suitable for stable patients on regular medication and pharmacies can help identify suitable patients.

Disposal of unwanted medicines - pharmacies accept unwanted medicines from individuals. The medicines are then safely disposed of.

Promotion of healthy lifestyles (public health) - opportunistic one to one advice is given on healthy lifestyle topics, such as stopping smoking, to certain patient groups who present prescriptions for dispensing. Pharmacies will also get involved in upto six local campaigns every year as directed by NHS England. Campaign examples may include promotion of flu vaccination uptake or advice on increasing physical activity.

In Staffordshire campaigns are coordinated by NHS England across the West Midlands Region with every pharmacy normally provided with posters and/or leaflets or links on where to access them. During 2016/17 the public health campaigns were: dementia awareness and sun awareness / skin cancer. The following campaigns are planned for this financial year (2017/18):

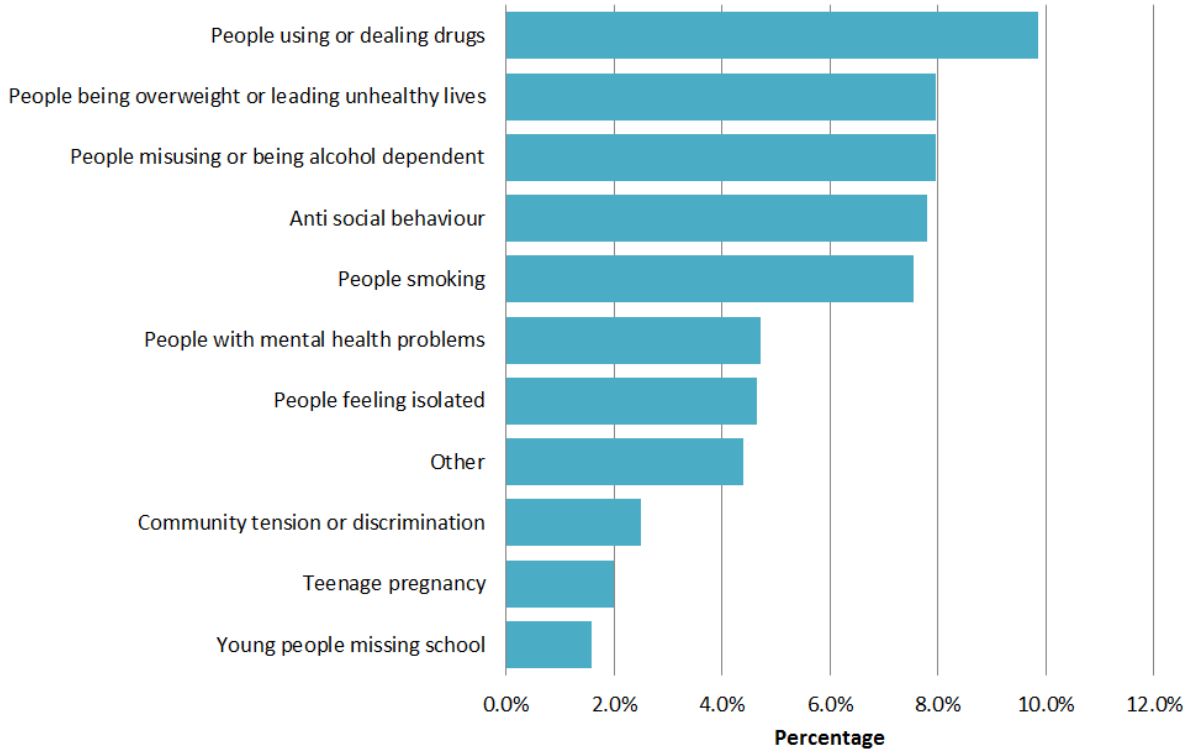
- Be Clear on Cancer (respiratory symptoms)
- Stay Well (Flu campaign)
- Antimicrobial resistance awareness
- Know your numbers (blood pressure awareness)

Feedback from pharmacies has generally been good; going forward it will be collected electronically by NHS England so further work can be done to evaluate the campaigns. Future campaigns should continue to be planned to complement identified local needs (as described in Chapter 3) and concerns raised by local residents as shown below.

In terms of public opinion data from the Winter 2014 wave *of the Public Perceptions of the NHS and Social Care Tracker Survey,* when asked "what are the biggest health problems facing people today?" the top issues mentioned are: cancer (35%), obesity (33%), age-related illnesses (22%), diabetes (18%), alcohol abuse (16%) and mental health (15%).

The latest *Feeling the Difference* survey published in March 2017 identify substance misuse, being overweight, alcohol misuse, anti-social behaviour and smoking as the biggest problems raised by Staffordshire respondents locally (Figure 21).

Figure 21: What are the biggest problems in Staffordshire? March 2017



Source: Feeling the Difference Survey Wave 22, Staffordshire Observatory, March 2017

Signposting patients to other healthcare providers - pharmacists and staff will refer patients to other healthcare professionals or care providers when appropriate. The service also includes referral on to other sources of help such as local or national patient support groups.

Support for self-care - the provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families. The main focus is on self-limiting illness, but support for people with long-term conditions is also a feature of the service.

Clinical governance - pharmacies must have a system of clinical governance to support the provision of excellent care; requirements include:

- provision of a practice leaflet for patients
- use of standard operating procedures
- patient safety incident reporting to the National Reporting and Learning Service
- conducting clinical audits and patient satisfaction surveys
- having complaints and whistle-blowing policies
- acting upon drug alerts and product recalls to minimise patient harm
- having cleanliness and infection control measures in place

Findings from the engagement survey found that most people used pharmacies for collecting their prescriptions. Almost half of respondents also used their pharmacy for health advice or disposal of unwanted medicines. However very few respondents used their pharmacy for lifestyle advice (10%).

4.3 Advanced pharmacy services

There are six advanced services that are available within the community pharmacy contract. Community pharmacies can choose to provide any of these services commissioned by NHS England as long as they meet the requirements set out in the Secretary of State Directions.

The number of pharmacies who provide these in Staffordshire is shown in Table 10. There is overall good coverage of Medicines Use Review (MUR) and New Medicine Service (NMS) across Staffordshire although coverage of NMS does vary by district.

Coverage of appliance use reviews and stoma appliance customisation services in Staffordshire are low which is similar to the trend seen across England due to these services being a specialist area with many patients receiving the support they require either from a clinic or hospital or from a dispensing appliance contractor located in another area, for example Stoke-on-Trent.

The number of pharmacies providing influenza vaccination services is better than the national average but again is variable at district level.

The sixth advanced service, NHS Urgent Medicine Supply Advanced Service, is currently running as a national pilot until 31 March 2018. Whilst this service is currently not active as an advanced service in Staffordshire there is good coverage of the locally enhanced service Emergency Supply.

Table 10: Number of pharmacies providing advanced services in Staffordshire, July 2017

	Medicines Use Review Service	New Medicine Service	Appliance Use Review Service	Stoma Appliance Customisation Service	National Influenza Adult Vaccination Services
Cannock Chase	24 (96%)	23 (92%)	0 (0%)	4 (16%)	18 (72%)
East Staffordshire	23 (96%)	18 (75%)	0 (0%)	0 (0%)	18 (75%)
Lichfield	19 (100%)	17 (89%)	0 (0%)	2 (11%)	11 (58%)
Newcastle-under-Lyme	29 (100%)	23 (79%)	1 (3%)	4 (14%)	19 (66%)
South Staffordshire	18 (90%)	12 (60%)	1 (5%)	4 (20%)	12 (60%)
Stafford	25 (93%)	24 (89%)	0 (0%)	3 (11%)	20 (74%)
Staffordshire Moorlands	19 (100%)	14 (74%)	0 (0%)	2 (11%)	15 (79%)
Tamworth	17 (89%)	13 (68%)	0 (0%)	1 (5%)	9 (47%)
Staffordshire	**174 (96%)**	**144 (79%)**	**2 (1%)**	**20 (11%)**	**122 (67%)**
England 2015/16	**11,029 (94%)**	**9,439 (81%)**	**140 (1%)**	**1,732 (15%)**	**7,195 (62%)**

Source: NHS England North Midlands and General Pharmaceutical Services in England 2006/07 to 2015/16, Copyright 2016, Health and Social Care Information Centre. All Rights Reserved

Medicines Use Review (MUR) - The pharmacist conducts an adherence medicines review with the patient. The review assesses the patient's use of their medicines and identifies any problems they may be experiencing. The service aims to increase the patient's knowledge of their medication and improve their adherence to the regimen. At least 70% of the MURs provided each year must be for patients who fall within one of the national target groups:

- patients taking high risk medicines
- patients recently discharged from hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge
- patients with respiratory disease
- patients at risk of or diagnosed with cardiovascular disease and regularly being prescribed at least four medicines.

National evidence suggests that between 5-8% of unplanned emergency admissions in adults are due to avoidable issues related to medicines.

The average number of MURs during 2016/17 for Staffordshire per participating pharmacy was 297. This is similar to the national average (300) but below the maximum number of MURs (400) that pharmacies can claim for which indicates there may be some potential for increasing the numbers of MURs undertaken by pharmacies every year. In addition the annual average number of MURs varies significantly between districts and between pharmacies across Staffordshire (Table 11 and Map 10).

Some pharmacies fall considerably below the maximum number of MURs they can claim for and both Staffordshire and national averages.

Table 11: Medicines Use Reviews activity, 2016/17

	Number of pharmacies	Number of MURs	Average number per pharmacy
Cannock Chase	24	8,991	375
East Staffordshire	23	6,682	291
Lichfield	19	6,356	335
Newcastle-under-Lyme	29	7,610	262
South Staffordshire	18	5,073	282
Stafford	25	8,094	324
Staffordshire Moorlands	19	4,794	252
Tamworth	17	4,184	246
Staffordshire	**174**	**51,784**	**298**
England 2015/16	**11,029**	**3,313,309**	**300**

Source: NHS England North Midlands and General Pharmaceutical Services in England 2006/07 to 2015/16, Copyright 2016, Health and Social Care Information Centre. All Rights Reserved

New Medicine Service (NMS) - This service is designed to improve patients' understanding of a newly prescribed medicine for a long-term condition, and help them get the most from the medicine. Research has shown that after 10 days, two thirds of patients prescribed a new medicine reported problems including side effects, difficulties taking the medicine and a need for further information. The successful implementation of NMS is designed to:

- improve patient adherence which will generally lead to better health outcomes
- increase patient engagement with their condition and medicines, supporting patients in making decisions about their treatment and self-management
- reduce medicines wastage
- reduce hospital admissions due to adverse events from medicines

The Department of Health commissioned researchers at the University of Nottingham to lead an academic evaluation of the service, investigating both the clinical and economic benefits of it. The findings from the evaluation were published in August 2014 and were overwhelmingly positive; with the researchers concluding that as the NMS delivered better patient outcomes for a reduced cost to the NHS it should be continued. This was the basis for NHS England's firm decision to continue commissioning this advanced service.

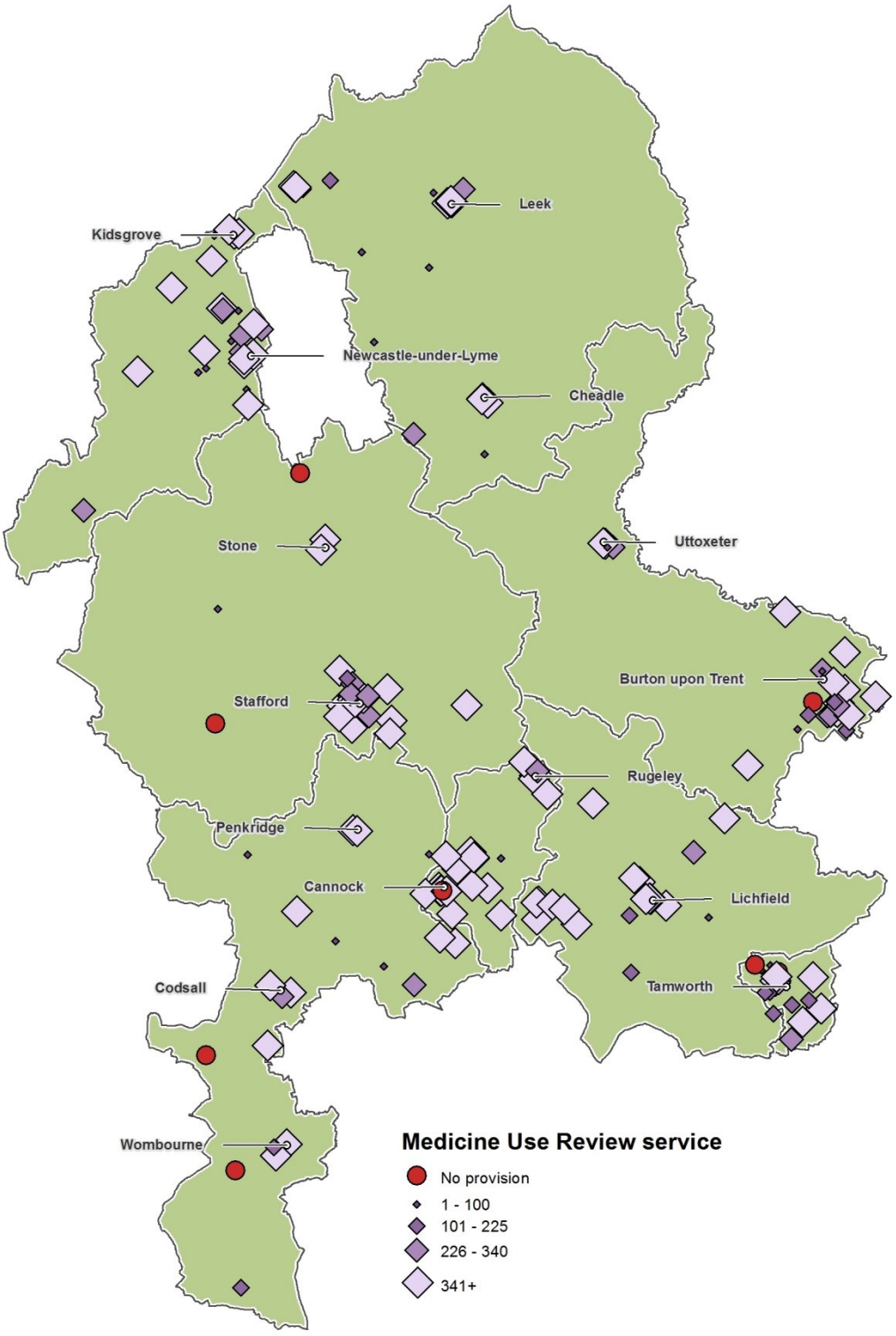
The pharmacist will provide the patient with information on their new medicine and how to use it when it is first dispensed. The pharmacist and patient will then agree to meet or speak by telephone in around a fortnight and a final consultation around 21-28 days after starting the medicine. Any issues or concerns identified can therefore be resolved. On average every participating pharmacy saw 95 patients annually which is higher than the national average of 87. However there is significant variation between districts (Table 12).

Table 12: New Medicine Service activity, 2016/17

	Number of pharmacies	Number of NMS	Average number per pharmacy
Cannock Chase	23	2,554	111
East Staffordshire	18	2,354	131
Lichfield	17	1,462	86
Newcastle-under-Lyme	23	1,351	59
South Staffordshire	12	1,608	134
Stafford	24	1,840	77
Staffordshire Moorlands	14	1,101	79
Tamworth	13	1,503	116
Staffordshire	**144**	**13,773**	**96**
England 2015/16	**9,439**	**821,893**	**87**

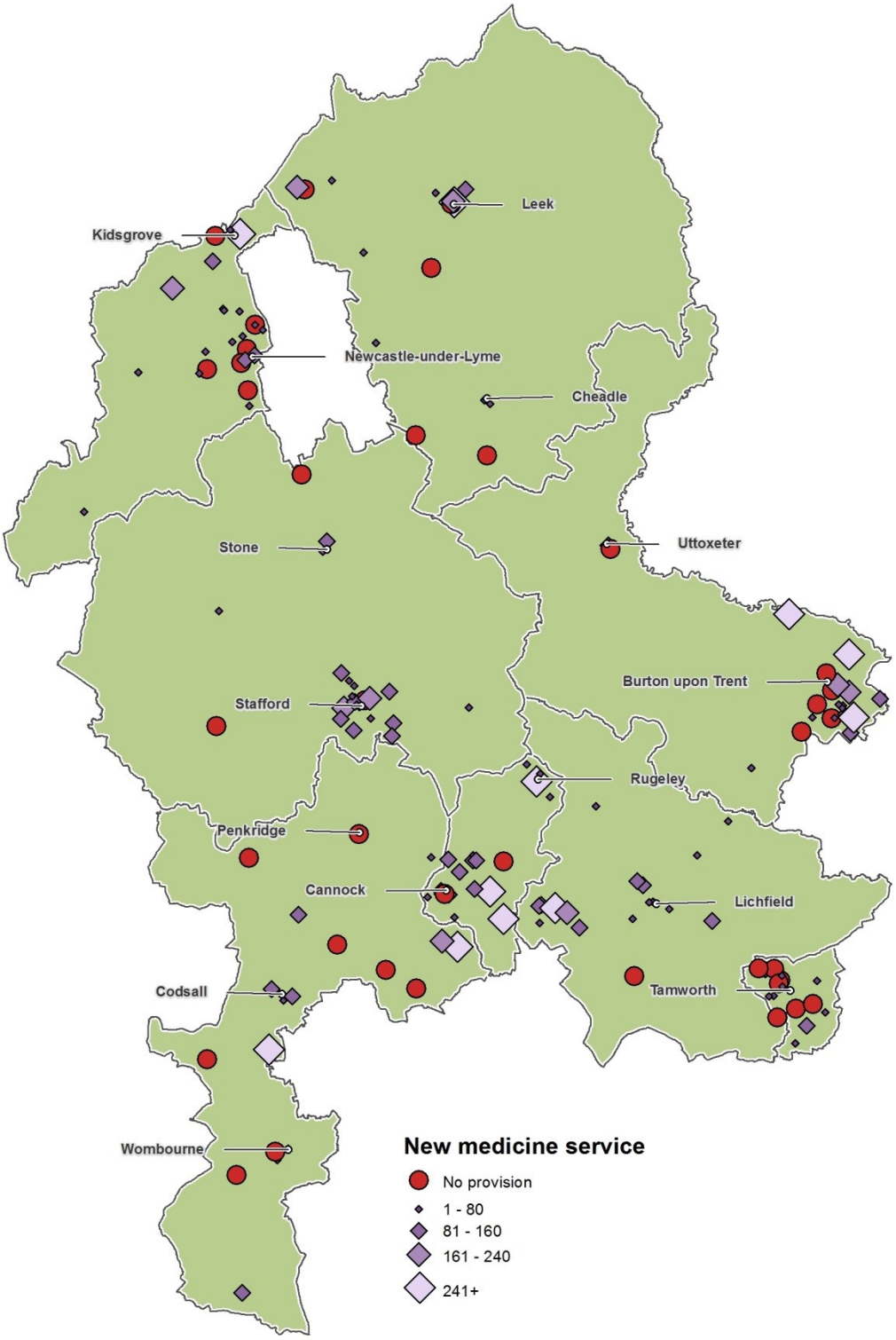
Source: NHS England North Midlands and General Pharmaceutical Services in England 2006/07 to 2015/16, Copyright 2016, Health and Social Care Information Centre. All Rights Reserved

Map 10: Provision of Medicines Use Reviews in Staffordshire, 2016/17



Source: NHS England North Midlands

Map 11: Provision of New Medicine Service in Staffordshire, 2016/17



Source: NHS England North Midlands

Appliance Use Review (AUR) Service - This service is similar to the MUR service, but it aims to help patients better understand and use their prescribed appliances (e.g. stoma appliances) rather than their medicines by establishing the way the patient uses the appliance and the patient's experience of such use and identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient, advising the patient on the safe and appropriate storage of the appliance and proper disposal of the appliances that are used or unwanted. The service is conducted in a private consultation area or in the patient's home.

Stoma Appliance Customisation (SAC) Service - This service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.

The provision of AUR and SACs during 2016/17 in Staffordshire is shown in Table 13.

Table 13: Appliance Use Review and Stoma Appliance Customisation (SAC) Service activity in Staffordshire, 2016/17

	Number of pharmacies	Number	Average per pharmacy
Appliance Use Review (AURs)	2	53	27
Stoma Appliance Customisation (SAC)	20	492	25

Source: NHS England North Midlands

Influenza Adult Vaccination Service - this service supports the provision of the national flu vaccination programme between September and January every year and provides an alternative option to general practice. For most healthy people, influenza is usually a self-limiting disease. However, children, older people, pregnant women and those with certain long-term conditions are at increased risk of severe illness if they catch it. The vaccination provides protection against the most prevalent strains of the virus. This service commenced in September 2015.

There has been a significant increase in the number of vaccinations provided by pharmacies between 2015/16 and 2016/17 and both the proportion of pharmacies signed up to provide flu vaccination services and average provision per pharmacy being better than the national average (Table 14). Provision however across the County is variable and community pharmacies should be encouraged to continue to increase the provision, particularly given that there is generally a lower uptake of seasonal flu vaccination across Staffordshire.

Table 14: Influenza Adult Vaccination Service activity, 2016/17

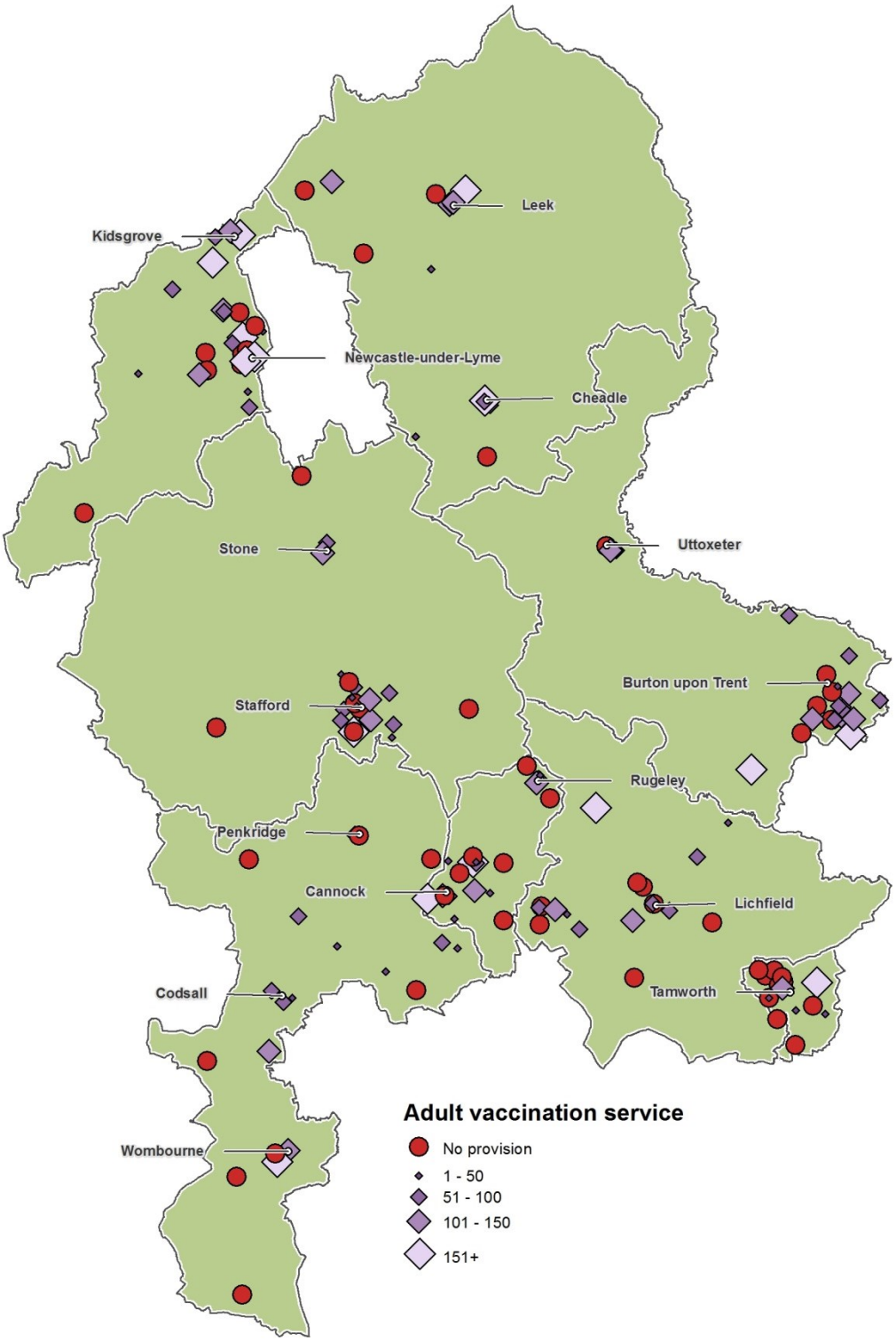
	Number of pharmacies	Number of vaccinations	Average number per pharmacy
Cannock Chase	18	1,338	74
East Staffordshire	18	1,561	87
Lichfield	11	1,188	108
Newcastle-under-Lyme	19	2,005	106
South Staffordshire	12	899	75
Stafford	20	1,645	82
Staffordshire Moorlands	15	2,871	191
Tamworth	9	1,563	174
Staffordshire	**122**	**13,070**	**107**
England 2015/16	**7,195**	**595,467**	**83**

Source: NHS England North Midlands and General Pharmaceutical Services in England 2006/07 to 2015/16, Copyright 2016, Health and Social Care Information Centre. All Rights Reserved

NHS Urgent Medicine Supply Advanced Service (NUMSAS) – this service is currently a pilot service commissioned by NHS England that manages a referral from NHS 111 to a community pharmacy where a patient has contacted NHS 111 because they need urgent access to a medicine or an appliance that they have been previously prescribed on an NHS prescription. The service enables appropriate access to medicines or appliances out-of-hours via community pharmacy, relieving pressure on urgent and emergency care services by shifting demand from GP out-of-hours providers to community pharmacies. There must be an urgent need for the medicine or appliance and it must be impractical for the patient to obtain an NHS prescription for it without undue delay. This service is being commissioned as a national pilot advanced service until 31st March 2018.

The service is not live across Staffordshire at present due to the small number of pharmacy contractors that have currently registered to provide the service. However there is good coverage of a similar service (Emergency Supply) which is commissioned as a locally enhanced service across Staffordshire.

Map 12: Provision of Influenza Adult Vaccination Services in Staffordshire, 2016/17



Source: NHS England North Midlands

4.4 Enhanced and locally commissioned pharmacy services

Local commissioners (e.g. NHS England North Midlands and Staffordshire County Council) can commission additional services through service level agreements. Some services are also contracted by other providers, e.g. needle exchange through ADS One Recovery Staffordshire. Services that are commissioned in Staffordshire are shown in Table 15.

Table 15: Provision of local commissioned services in Staffordshire, July 2017

	Common ailments	Emergency supply	Urinary tract infections and impetigo	Emergency hormonal contraception	Supervised consumption	Needle exchange	Palliative care
Cannock Chase	21 (84%)	18 (72%)	16 (64%)	17 (68%)	20 (80%)	2 (8%)	2 (8%)
East Staffordshire	18 (75%)	17 (71%)	15 (63%)	15 (63%)	22 (92%)	1 (4%)	1 (4%)
Lichfield	16 (84%)	14 (74%)	10 (53%)	16 (84%)	12 (63%)	2 (11%)	3 (16%)
Newcastle-under-Lyme	22 (76%)	24 (83%)	19 (66%)	20 (69%)	17 (59%)	0 (0%)	4 (14%)
South Staffordshire	15 (75%)	13 (65%)	10 (50%)	14 (70%)	10 (50%)	0 (0%)	1 (5%)
Stafford	22 (81%)	18 (67%)	18 (67%)	22 (81%)	22 (81%)	0 (0%)	0 (0%)
Staffordshire Moorlands	18 (95%)	14 (74%)	14 (74%)	12 (63%)	9 (47%)	1 (5%)	1 (5%)
Tamworth	13 (68%)	9 (47%)	9 (47%)	13 (68%)	9 (47%)	1 (5%)	2 (11%)
Staffordshire	**145 (80%)**	**127 (70%)**	**111 (61%)**	**129 (71%)**	**121 (66%)**	**7 (4%)**	**14 (8%)**

Source: NHS England North Midlands, Staffordshire County Council and ADS One Recovery Staffordshire

Common ailments service - patients can be directed to community pharmacies for the self-management of a range of conditions. The service enables pharmacies to undertake consultations, provide advice and medications if appropriate for their condition similar to a consultation at a GP practice. Around a fifth of GP consultations are thought to related to minor ailments that could largely be dealt with by self-care and support from community pharmacies.

There are 145 Staffordshire pharmacies signed up to provide the service (Map 13) and 8,579 provisions were made during 2016/17 (average of 59 per pharmacy).

Findings from the common ailments service across Shropshire and Staffordshire during 2016/17 found:

- 59% of patients were under 20 compared with about a quarter being aged 50 and over
- The largest condition provided for were fever management (14%), colds and flu-like symptoms (12%), conjunctivitis (11%), cough (8%) and hay fever (8%)
- Around 87% of patients said they would have gone to their GP had the service not been available (Table 16)

Table 16: Where patients would have gone if common ailments service was not available in Shropshire and Staffordshire, 2016/17

Alternative consequence	Number	Percentage
Would have gone to GP	17,656	87.2%
Bought product over the counter	944	4.7%
Would have gone to Walk-in Centre	489	2.4%
Would have gone to out-of-hours medical service	147	0.7%
Gone without treatment	144	0.7%
Would have gone to A&E	115	0.6%
Contacted NHS 111	18	0.1%
Unsure/ not known	168	0.8%
Other	569	2.8%
Staffordshire and Shropshire	**20,250**	**100.0%**

Source: NHS England North Midlands

Emergency supply - this service enables pharmacies to issue up to 14 days' worth of medication to patients who had run out of their prescribed medication during the pharmacy's regular opening hours.

During 2016/17 there were 127 pharmacies signed up to provide the service in Staffordshire (Map 14) and 2,951 provisions being made during the year (average of around 23 per year).

Findings from the emergency supply service across Shropshire and Staffordshire during 2016/17 found:

- only 5% of patients were under 20 compared with over two-thirds being aged 50 and over
- Around 42% of patients would have gone without medication, which is not good for long-term condition management, whilst 28% would have contacted their out-of-hours GP had the service not been available (Table 22).

Table 17: Where patients could have gone if emergency supply service not available in Shropshire and Staffordshire, 2016/17

Alternative consequence	Number	Percentage
Gone without your medication	2,465	42.5%
Contacted Out of Hours GP	1,651	28.4%
Contacted GP practice	532	9.2%
Gone to a Walk In Centre	532	9.2%
Gone to A&E	498	8.6%
Other	126	2.2%
Shropshire and Staffordshire	**5,804**	**100.0%**

Source: NHS England North Midlands

Urinary tract infections (UTI) and impetigo - this service allows pharmacies to provide antibiotic treatment for urinary tract infections (UTI) for women aged 16-74 and impetigo in children and adults who meet the inclusion criteria following accreditation of pharmacists under a Patient Group Direction (PGD). There are 111 pharmacies in Staffordshire who are signed up to provide at least one of these services (Map 15).

During 2016/17 across Staffordshire and Stoke-on-Trent:

- There were 37 active providers for treatment of UTI with 588 provisions being made (average of 11 per active pharmacy). The majority of these were women aged 50-74 (51%) and 20-49 (43%)
- There were 37 active providers for treatment of impetigo with 91 provisions being made of which over three-fifths were to children under 13

Emergency hormonal contraception - this service allows pharmacies to provide emergency hormonal contraception (EHC) where appropriate in line with the locally agreed PGD. Evidence suggests that community pharmacy based EHC services provide timely access to treatment and are rated highly by women who use them. This is one of Staffordshire's strategies to support reducing teenage pregnancy rates across the County. EHC is provided in a number of settings of which pharmacy is one.

This service is commissioned by Staffordshire County Council and managed through a contract with Lloyds Pharmacy who sub-contracts with other community pharmacies in the area. The service is available when an accredited pharmacist is at the pharmacy and is generally available without an appointment. The service is confidential and available free of charge to women of all ages.

There is generally good availability of EHC from pharmacies (around 70% coverage) across the County which cover areas where there are higher teenage pregnancy rates (Map 16).

Supervised consumption - supervised consumption of prescribed medicines (methadone and buprenorphine) at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient, particularly for treatment of opiate dependence, patients with some mental health conditions and other vulnerable groups.

Around two-thirds of pharmacies in Staffordshire provide the supervised administrative service to drug misusers and there is a good spread of access to this service across the County (Map 17).

Needle and syringe exchange service - access to sterile needles and syringes, and sharps containers for return of used equipment. Pharmacies will also promote safe injecting practice and reduce transmission of infections by substance misusers through associated materials, for example condoms, citric acid and swabs. This service is commissioned by Staffordshire County Council from ADS One Recovery who has placed needle exchange services in seven pharmacies across the County to match local needs. Needle exchange is also available from One Recovery clinics.

Palliative care - this service support anticipatory prescribing and allows rapid access to medicines commonly prescribed in palliative care to enable a greater percentage of patients to have end of life treatment in a preferred place of care, such as the individual's home, and avoid unnecessary admissions to hospital. The service ensures that a network of community pharmacies hold stocks of palliative care medications to ensure patients have timely access to end of life medicines when required. There are currently 14 pharmacies in Staffordshire who provide this service (Map 18).

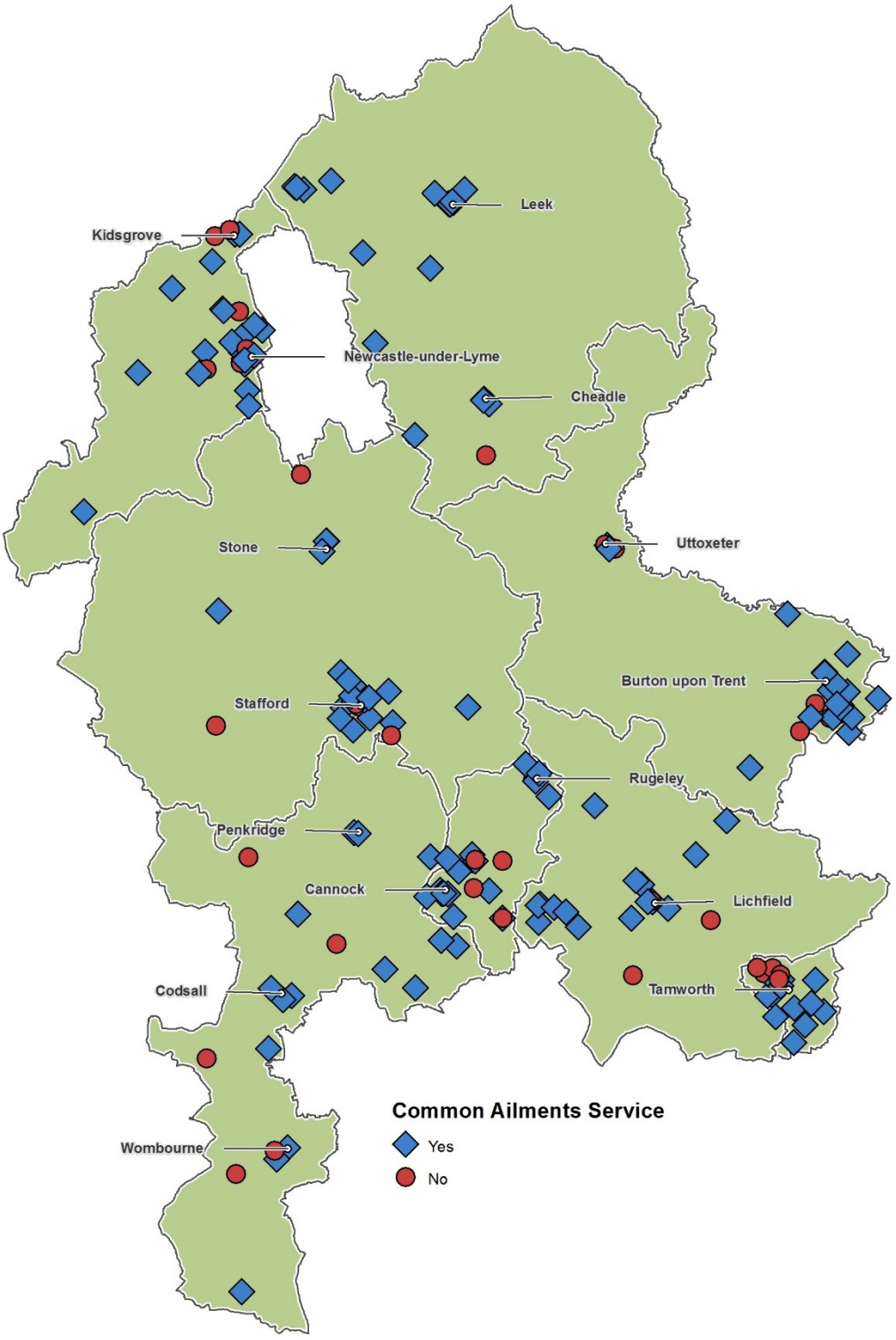
Other services - There are also a range of non-commissioned services that pharmacies provide. These are either privately arranged or are provided free of charge to their communities and include: home delivery service (excludes appliances), medicines assessment and compliance support services, care home service, diabetes screening, travel vaccines and contraceptive services

Based on the community pharmacy survey, pharmacies were also willing to provide: anticoagulant monitoring service, a range of disease specific medicines management services with the most common being heart failure, coronary heart disease, epilepsy, allergies, hypertension, Parkinson's disease and diabetes, obesity management and anti-viral distribution services.

Based on data from the engagement survey many respondents would like pharmacies to maintain their current services (53 respondents, 22%). Other responses included:

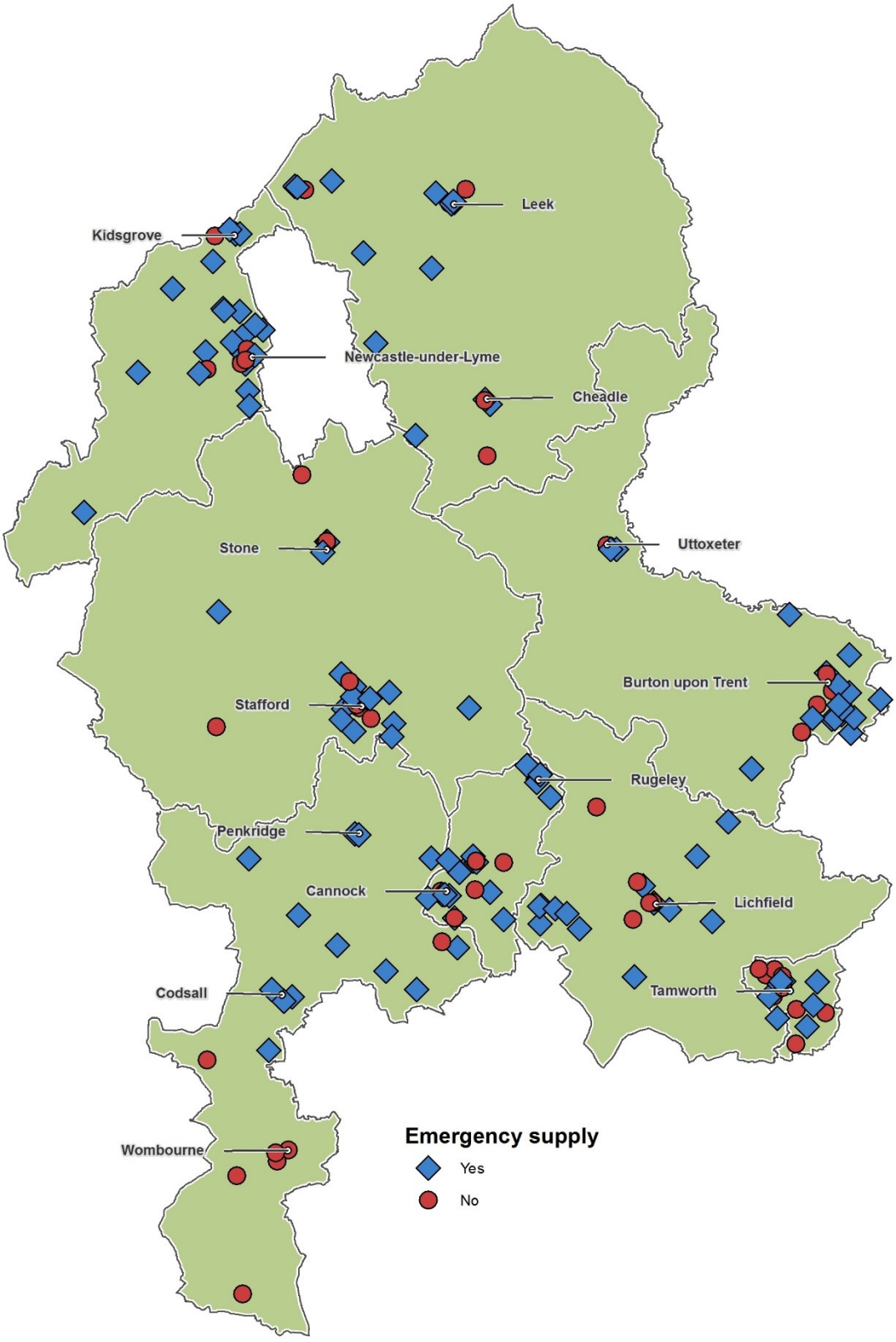
- Introduce basic testing such as blood pressure measurements, blood tests and holiday vaccinations (24 responses, 10%)
- Information and advice on the availability of other services (18 responses, 7%)
- Basic health appointments or clinics for certain conditions or lifestyle (11 responses, 5%)

Map 13: Provision of common ailment services in Staffordshire, July 2017



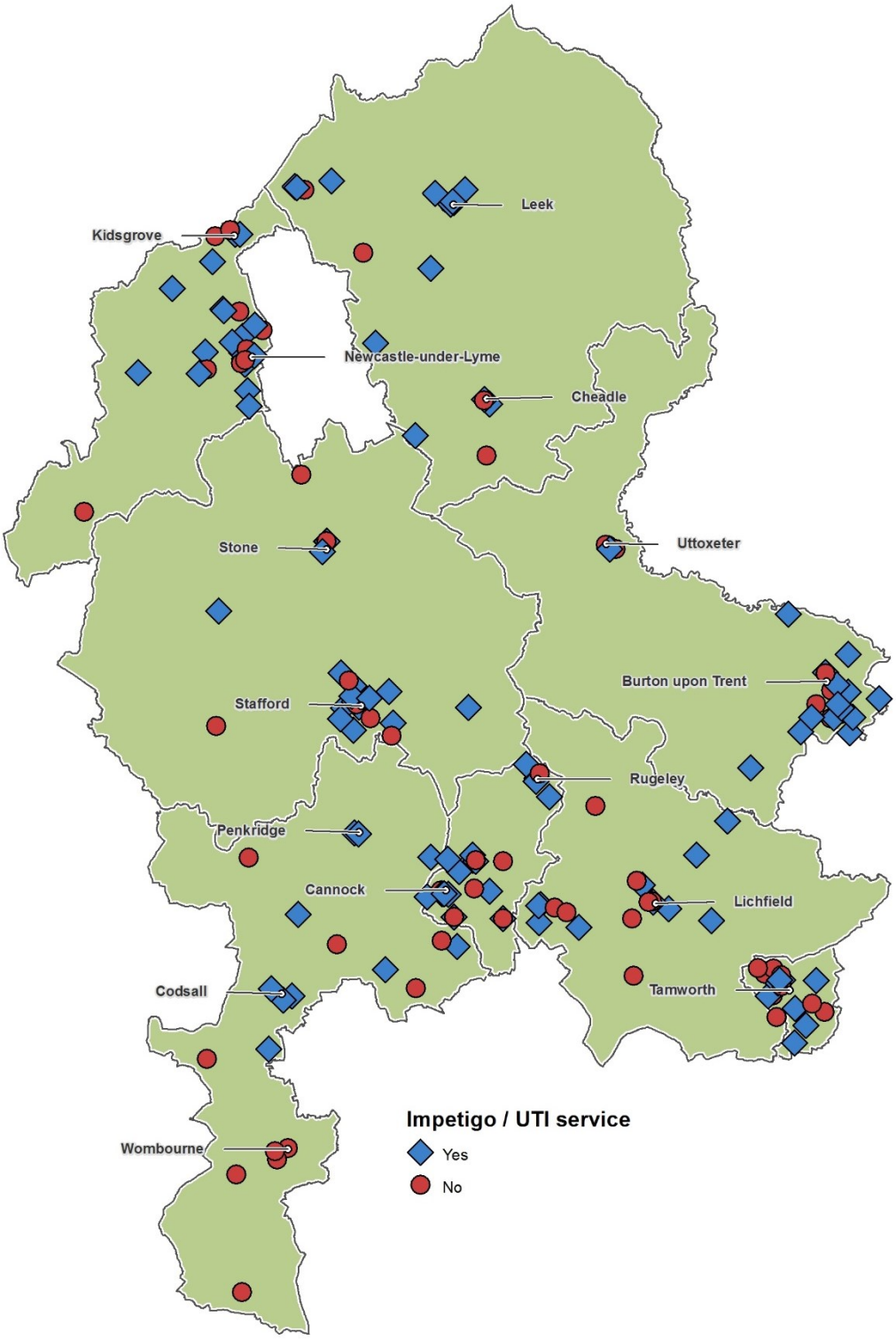
Source: NHS England North Midlands

Map 14: Provision of emergency supply services in Staffordshire, July 2017



Source: NHS England North Midlands

Map 15: Provision of urinary tract infections (UTI) and/or impetigo service in Staffordshire, July 2017



Source: NHS England North Midlands

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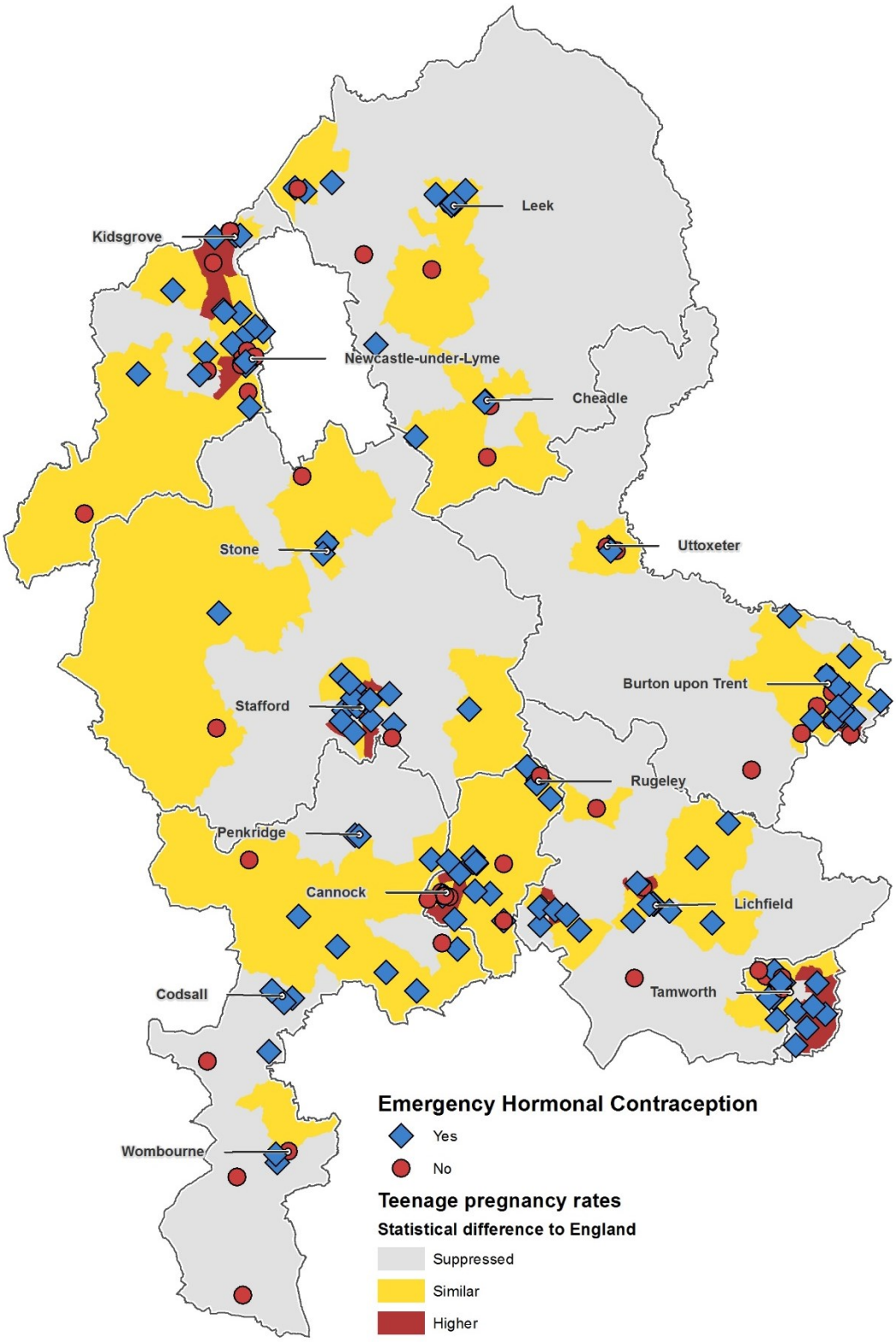
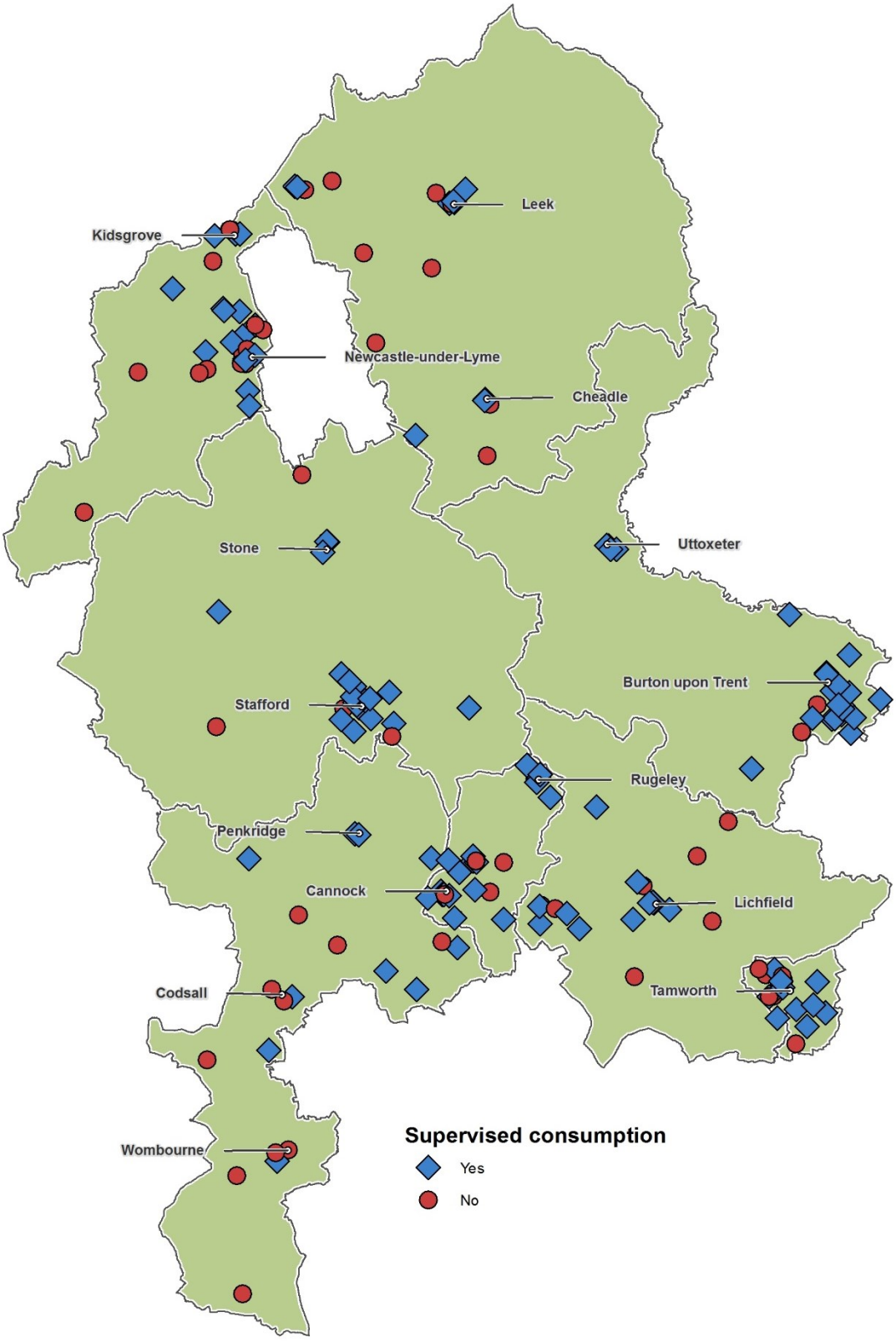
Map 16: Teenage pregnancy (under 18 conception rates 2012-2014) and emergency hormonal contraception provision in Staffordshire, July 2017



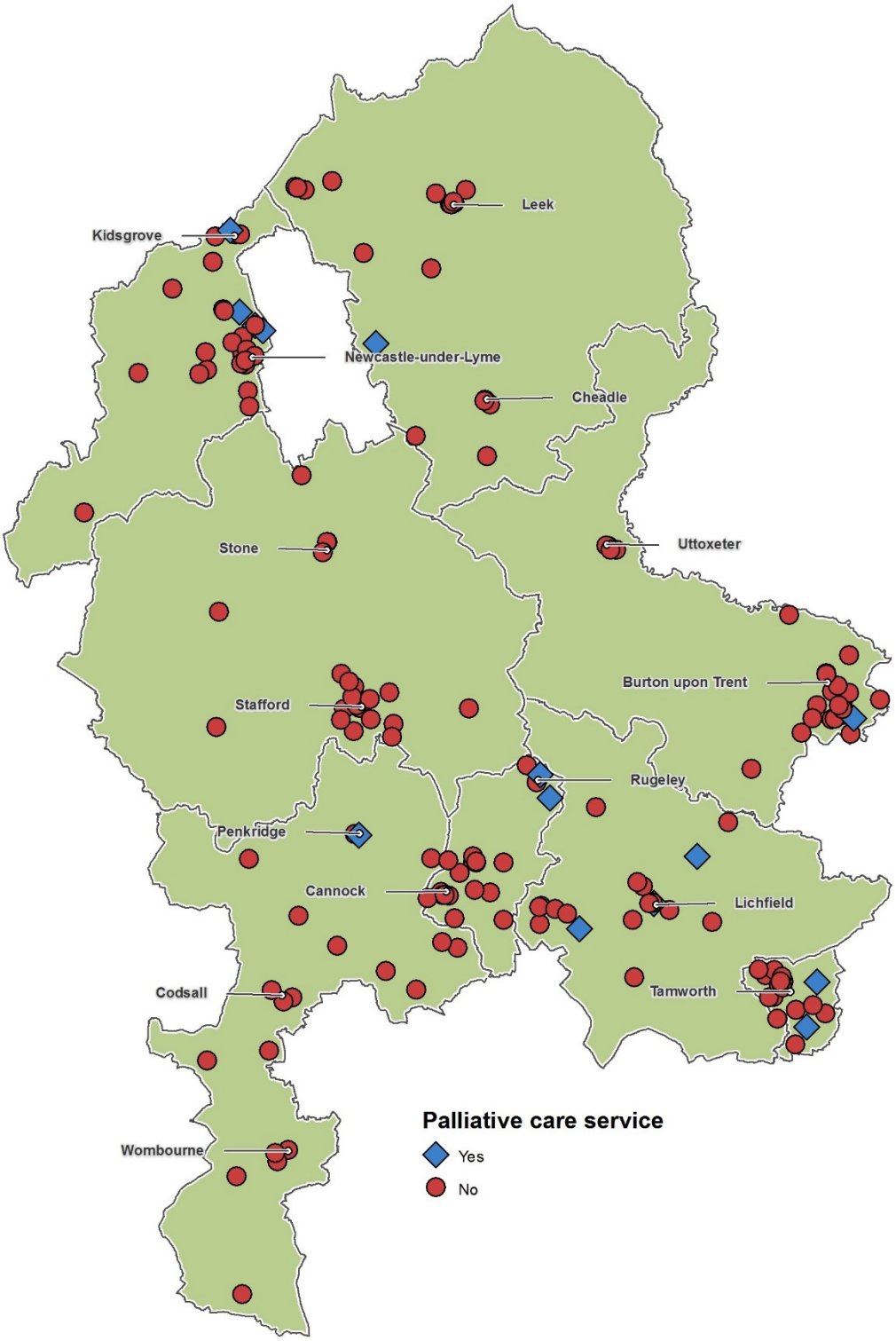
Source: Conception Statistics, Office for National Statistics and Staffordshire County Council

Map 17: Provision of supervised consumption in Staffordshire, July 2017



Source: ADS One Recovery Staffordshire and Staffordshire County Council

Map 18: Provision of palliative care services in Staffordshire, July 2017



Source: NHS England North Midlands

4.5 Healthy living pharmacies

The healthy living pharmacy (HLP) framework is a tiered commissioning framework which allows community pharmacies to provide a broad range of services to meet local need, improve population health and wellbeing and reduce health inequalities. HLPs are required to deliver a range of commissioned services based on local need and promote a healthy living environment to the communities they serve.

Level 1 is around promoting health, wellbeing and self-care which from July 2016 onwards changed from being a commissioner-led process to a profession-led self-assessment process. Achieving HLP level 1 (self-assessment) is also now a Quality Payment criterion as part of the 2017/18 Quality Payments Scheme of the pharmacy contract.[2]

Based on the pharmacy survey there were currently 56 pharmacies who identify themselves as being a HLP in Staffordshire and 76 who are working towards accreditation. The distribution by district varies with little relationship between rates of HLPs and deprivation; however there is stronger correlation for those working towards a HLP status and deprivation (Table 18).

Table 18: Self-reported healthy living pharmacy status in Staffordshire, July 2017

	Number of respondents	Number of HLPs (rate per 100,000 population)	Currently working towards HLP status (rate per 100,000 population)	Index of Multiple Deprivation Score 2015	Percentage of population in most deprived IMD 2015 quintile
Cannock Chase	22	5 (5.1)	16 (16.2)	20.9	13.8%
East Staffordshire	22	9 (7.7)	12 (10.3)	18.8	17.9%
Lichfield	18	9 (8.7)	8 (7.8)	12.7	3.9%
Newcastle-under-Lyme	16	6 (4.7)	9 (7.0)	18.5	11.3%
South Staffordshire	16	9 (8.1)	6 (5.4)	12.5	1.4%
Stafford	24	11 (8.2)	11 (8.2)	13.5	5.4%
Staffordshire Moorlands	7	2 (2.0)	5 (5.1)	15.2	4.6%
Tamworth	17	5 (6.5)	9 (11.7)	20.3	17.6%
Staffordshire	**142**	**56 (6.5)**	**76 (8.8)**	**16.4**	**9.2%**

Source: Staffordshire Survey of Community Pharmacies, PharmOutcomes, July 2017, Indices of Deprivation 2015, Communities and Local Government, Crown Copyright 2016 and 2015 mid-year population estimates, Office for National Statistics, Crown copyright

[2] Note: NHS England and Public Health England (PHE) agreed that contractors whose pharmacies become HLPs locally between 1st December 2014 and 24th November 2017 will not need to complete the profession led self-assessment process led by PHE to meet the quality criterion.

5 Access to pharmaceutical services

5.1 Geographical access

Large numbers of Staffordshire residents are disadvantaged in terms of geographical access to key services (as shown in Section 2.5) and around one in five people do not have access to a car meaning they are reliant on others or good accessible public transport to get around (Table 19).

Table 19: Number and proportion of households with no car or van, 2011

	Number	Percentage	Statistical difference to England
Cannock Chase	8,213	20.2%	Lower
East Staffordshire	10,123	21.4%	Lower
Lichfield	5,594	13.6%	Lower
Newcastle-under-Lyme	11,632	22.1%	Lower
South Staffordshire	5,879	13.2%	Lower
Stafford	9,742	17.5%	Lower
Staffordshire Moorlands	6,196	14.8%	Lower
Tamworth	6,514	20.6%	Lower
Staffordshire	**63,893**	**18.0%**	**Lower**
West Midlands	**566,621**	**24.7%**	**Lower**
England	**5,691,251**	**25.8%**	

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

However there is good geographical access to pharmaceutical services in Staffordshire:

- Over 40% of residents are within a 10 minute walk to their nearest pharmacy and 86% are within a 20 minute walk
- Around 88% of residents are within a five minute drive from their nearest pharmacy and 98% within 10 minutes
- Almost two-thirds of residents are within 10 minutes of their nearest pharmacy if using public transport and 89% within 20 minutes (Table 20).

Table 20: Access to nearest pharmacy by mode of transport for Staffordshire residents

	Walking	Driving	Public transport
0-5 minutes	10.0%	87.6%	16.1%
6-10 minutes	31.1%	10.1%	48.7%
11-15 minutes	26.7%	2.1%	17.3%
16-20 minutes	17.8%	0.2%	6.6%
21 minutes and over	0.0%	0.0%	2.4%
No access	14.4%	< 0.1%	8.9%
Good access (i.e. under 11 minutes	41.1%	97.7%	64.7%
Poor access (i.e. 21 minutes or over OR no access)	14.4%	< 0.1%	11.3%

Note: Numbers may not add up due to rounding

Source: Staffordshire County Council and Experian Public © 2015 Experian. All rights reserved

The method for calculating drive time, walking time and public transport along with maps are shown in Appendix 4.

5.2 Opening hours

There are 18 '100 hour' pharmacies across Staffordshire equating to around one in ten pharmacies, with all residents in the County with the exception of South Staffordshire, having access to a community pharmacy for at least 100 hours during the week.

Community pharmacies generally complement GP opening hours. In Staffordshire they open from 7am on Monday mornings and from 6:30am on Tuesday to Fridays. The majority are open by 9am when there is likely to be an increase in demand for dispensing of prescriptions generated by GP services. On a weekday most pharmacies close by 6.30pm in the evening with around one in seven open until 8pm and around a tenth of pharmacies across the County open during the week until at least 10pm.

Around four in five pharmacies are also open on Saturdays, the times ranging from 6.30am in the morning to on average around 4-5pm in the evening with 17 pharmacies open until at least 10pm (Map 19).

Around one in six pharmacies are also open on Sunday, which is an increase from the last PNA, with opening times starting from around 10am and most closing by around 4pm. The pharmacies that are open on Sundays tend to be aligned to out-of-hours medical practice (Map 20). There are three pharmacies across the County that are open after 5pm. Some of this is due to trading regulations which restricts opening hours for pharmacies located in supermarkets and shopping centres to six hours. All districts have at least one pharmacy open on Sundays and some patients also have access to nearby access to pharmacies in neighbouring areas such as Stoke-on-Trent or Wolverhampton.

Demand for dispensing services is much lower at weekends as GP surgeries are usually closed. In addition residents do have access to dispensing services on Sundays from alternative provision, for example walk-in-centres, minor injury units or from pharmacies in bordering areas.

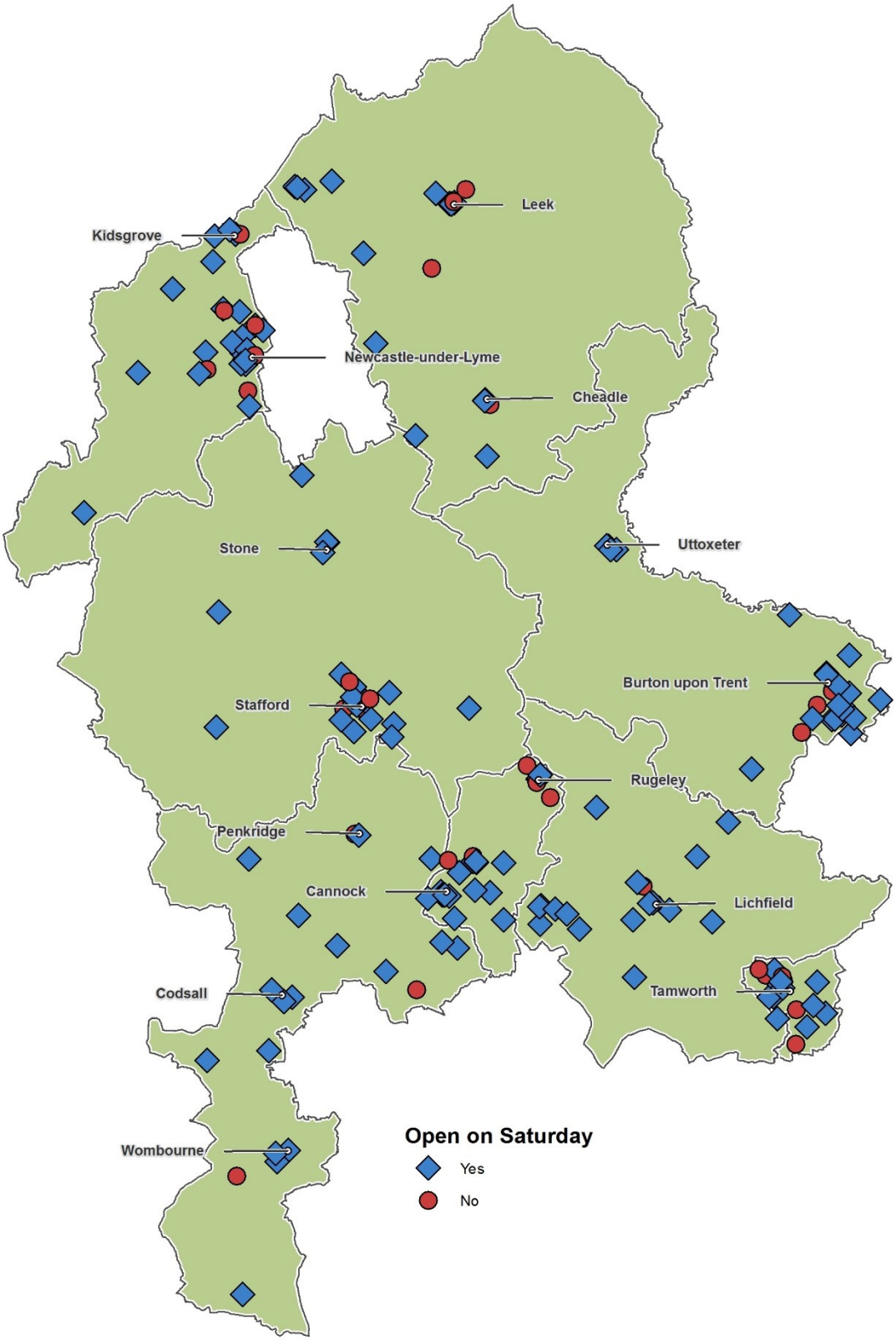
A number of pharmacies also now open on Bank Holidays with opening time on these days published by NHS England (https://www.england.nhs.uk/mids-east/our-work/pharm-info/).

NHS England North Midlands also commission community pharmacies to ensure there are adequate pharmaceutical services available on Christmas Day and Easter Sunday as these are the two days where pharmacies are still traditionally closed and those located in supermarkets and shopping centres unable to open due to current trading laws.

Information on the latest opening hours for every pharmacy is available at NHS Choices. http://www.nhs.uk/Service-Search/Pharmacy/LocationSearch/10. Pharmaceutical providers are required to keep these details updated as one of the Quality Payments criteria for the 2017/18 Quality Payments Scheme of the pharmacy contract.[3]

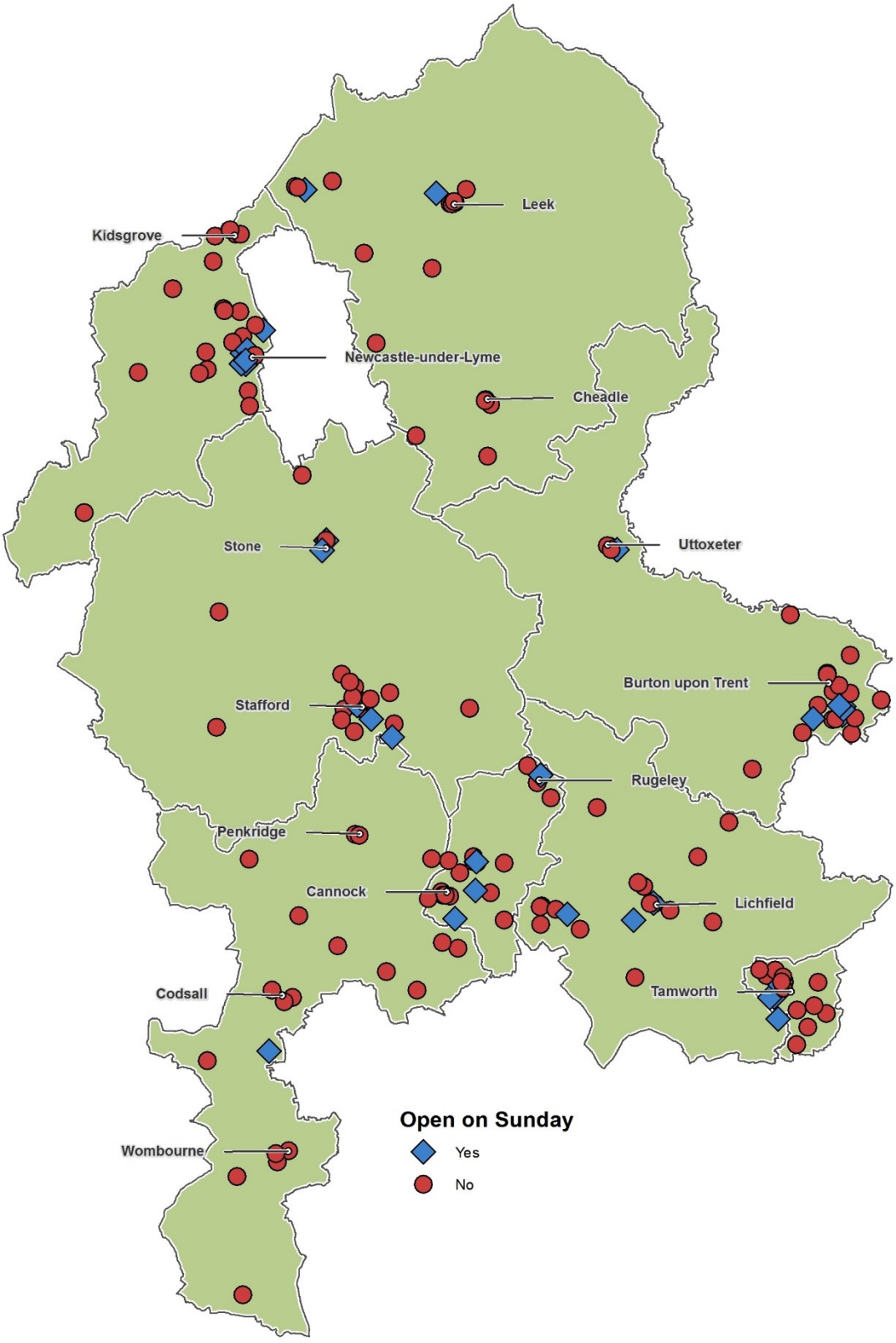
[3] http://psnc.org.uk/services-commissioning/essential-services/quality-payments-nhs-choices-entry/

Map 19: Pharmacies that are open on Saturdays, July 2017



Source: NHS England North Midlands

Map 20: Pharmacies that are open on Sundays, July 2017



Source: NHS England North Midlands

5.3 Access to pharmaceutical services for protected groups

The Equality Act (2010) protects people on the basis of nine protected characteristics. The equality duty covers the following nine protected characteristics: age, disability, gender (sex), gender reassignment, marriage and civil partnership, pregnancy and maternity, race (this includes ethnic or national origins, colour or nationality), religion or belief (this includes lack of belief) and sexual orientation.

The PNA regulations require that the HWBB considers the different needs of people who share protected characteristics. This section of the PNA summarises how these have been considered and addressed for each of the protected characteristics.

In addition all pharmacies are expected to comply with the provisions of the Equality Act 2010.

Age

The protected characteristic of age means a person belonging to a particular age or age-group (for example, 32 years) or being within an age group (for example, 30-39 years). This covers all ages, including children and young people.

It is important that pharmaceutical services meet the needs of all ages. National data suggests that families with young children and older people are more frequent users of pharmacy services. The ageing population has implications for the future demand for all health and care services, including those provided by community pharmacies, for example there may be an increased demand for pharmaceutical services in terms of dispensing of medicines and also additional need for supporting older people living independently for longer.

The age profile for Staffordshire residents has been described in Chapter 2.

Examples of where Staffordshire pharmacies are already supporting residents of all ages are:

- access to sexual health services such as emergency hormonal contraception for young people
- raising disease awareness, e.g. through a dementia awareness campaign
- supporting adults and in particular older populations through MURs and NMS in the management of long-term conditions
- treatment of minor ailments for families with young people and older people

Disability

A person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. Disabilities can have an impact on people of all ages and from all communities, and can be present from birth or acquired through accident, illness or as a consequence of ageing. Many people who are disabled may have more than one disability. Adults with learning disabilities or dementia and are most likely to have repeat adult protection referrals, as are those in a permanent care home and those in a mental health inpatient setting.

There is no complete dataset that contains the numbers of people with disabilities. Therefore a number of measures are presented to estimate levels of disability within Staffordshire:

Census data - the 2011 Census collected information on self-reported limiting long-term illness that can be used as a proxy for overall disease and disability. Based on these data around 162,600 Staffordshire residents (19%) have a limiting long-term illness which is higher than the average in England (as would be expected given the higher number of older people).

Disability benefit statistics - these provide a proxy for numbers of people who are disabled. Disability Living Allowance (DLA) is payable to people who are disabled and who have personal care needs, mobility needs or both, although it is not available for children under three. In Staffordshire 33,660 people claimed DLA (May 2014), which represents 3.9% of the population which is similar to the national average of 3.8%. DLA is a discretionary payment and claimants will typically experience significant barriers to full participation in local life.

GP disease registers - these provide the number of patients on clinical registers in general practice, which can then be used to calculate disease prevalence. The data are captured as part of the Quality and Outcomes Framework (QOF) which was introduced as part of the General Medical Services (GMS). In most cases GPs are only required to capture 80% of the population to achieve payment with some practices seeking to identify all patients who will benefit, and others stopping once the target level is achieved. Based on 2015/16 data, around 3,600 people were on learning disability registers in Staffordshire Clinical Commissioning Groups (CCGs) making up 0.4% of the population, which is lower than the England average but significantly less than that expected. In addition, around 5,800 people were on mental health registers (schizophrenia, bipolar disorder and other psychoses) which is 0.7% of the population and lower than the England average.

Estimates of people with sensory impairments - Information on the number of people who have a sensory impairment at a local level is limited. Some information is available from local registers held by social care. Registration of sensory impairment is voluntary and therefore these figures do not provide a complete picture of the numbers of people in Staffordshire who have a visual or hearing impairment.

- There were 1,950 people on the blind register in Staffordshire and a further 2,040 on the partially sighted register as at 31 March 2014. Around 1,355 people were on the deaf register and a further 2,175 on the hard of hearing register as at 31 March 2010.

- Based on national prevalence surveys, it is estimated there are around 340 adults aged 18-64 who have a serious visual impairment, 15,600 adults aged 65 and over who have a moderate or severe visual impairment and 5,100 adults aged 75 and over who have registerable eye conditions.

- Based on national estimates, there are around 2,100 adults with profound hearing loss in Staffordshire and a further 96,200 adults with moderate or severe hearing loss.

- People with hearing and vision impairment are more likely to be older people (aged 75 and over).

People with disabilities are however a high risk group and may require additional support in terms of services meeting their pharmaceutical needs. Some of the adjustments that pharmacies currently make include easy open containers and / or large print labels. Some pharmacies also have facilities to provide labels printed with Braille (and many original packs provided by manufacturers are now embossed with Braille). Pharmacies also need to continue to link in with carers where appropriate to enable vulnerable groups to meet their service needs.

The community pharmacy questionnaire included a question asking if any consultation facilities existed on site and if they included wheelchair access. The results showed that 89% of pharmacies (128 of 142 respondents to this question) have a consultation area with wheelchair access whilst 12 pharmacies (8%) did not have wheelchair access and two pharmacies did not have a consultation room.

Gender (sex)

Gender is being male or female. The wider social roles and relationships that structure men's and women's lives change over time and vary between cultures.

There are some services that are currently provided for women, e.g. EHC. National research indicates that men may be less frequent visitors of pharmacies and therefore some additional marketing may be required to ensure that men's pharmaceutical needs are met.

Gender reassignment

Gender dysphoria is a condition in which an individual's psychological experience of themselves as a man or woman is incongruent with their external bodily sexual characteristics. The individual's physical sex is not aligned to their gender identity. Sometimes, the distress/discomfort is sufficiently intense that an individual undergoes transition from one point on a notional gender continuum to another; this is most commonly from male-to-female or female-to-male. This typically involves changes to social role and presentation and may necessitate treatment with cross-sex hormones and/or having gender-related surgery. As a national service patients may be referred to a gender identity clinic for initial assessment and treatment before potentially being referred for sex reassignment surgery, although there is no specialist centre in the West Midlands providing these services.

Protection is provided where someone has proposed, started or completed a process to change their sex and this is referred to as gender reassignment in the legislation. It is estimated nationally that one in four thousand people are receiving medical help for gender dysphoria, which equates to around 220 people in Staffordshire. Reports suggest that there has been a growth in the number of people who have presented for treatment in the UK, although the West Midlands appears to have a low prevalence.

Pharmacies may be part of the care pathway for people who undergo gender reassignment. Their role is typically to ensure that medicines (e.g. hormone therapy) which form part of the treatment are available. Furthermore, pharmacies may offer MURs and NMS to help with adherence and to identify any medication-related issues as appropriate.

Marriage and civil partnership

Marriage is the legal union between a man and a woman, whilst civil partnership has the legal recognition of a same-sex couple's relationship. Civil partners must be treated the same as married couples on a range of legal matters.

Protection from discrimination for being married or in a civil partnership is provided in employment and vocational training only.

Data from the 2011 Census provide information on marital and civil partnership status at a local level. Around 51% of Staffordshire's population are married (Table 21). An additional 1,000 people are in a registered same-sex civil partnership making up around 0.1% of the population.

Table 21: Population by marital and civil partnership, 2011

	Staffordshire	West Midlands	England
Single (never married or never registered a same-sex civil partnership)	206,742 (29.6%)	1,517,613 (33.7%)	14,889,928 (34.6%)
Married	359,238 (51.4%)	2,141,698 (47.5%)	20,029,369 (46.6%)
In a registered same-sex civil partnership	1,000 (0.1%)	7,242 (0.2%)	100,288 (0.2%)
Separated (but still legally married or still legally in a same-sex civil partnership)	16,018 (2.3%)	117,396 (2.6%)	1,141,196 (2.7%)
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	63,061 (9.0%)	393,163 (8.7%)	3,857,137 (9.0%)
Widowed or surviving partner from a same-sex civil partnership	52,364 (7.5%)	330,293 (7.3%)	2,971,702 (6.9%)
All residents aged 16 and over	**698,423 (100.0%)**	**4,507,405 (100.0%)**	**42,989,620 (100.0%)**

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

There are no additional needs that have been identified by the PNA with respect to marriage and civil partnership.

Pregnancy and maternity

Maternity is defined as the period after giving birth. It is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, including as a result of breastfeeding. For all areas covered by the Act, a woman is protected from unfavourable treatment because of pregnancy or because she has given birth.

The protected status primarily applies to staff currently employed at pharmacies within Staffordshire.

There were 8,690 live births in Staffordshire in 2016. Community pharmacies are ideally placed to provide health promotion advice to women who are pregnant or planning on becoming pregnant. They are also ideally placed to provide information on antenatal care at the point of sale of pregnancy tests. They can also provide advice around diet and nutrition including vitamins.

Pharmacists also provide advice to women who are pregnant or breastfeeding about which medicines can be taken and those to avoid as they may be potentially harmful to their foetus or breast-fed baby.

Race and ethnicity

Race refers to a group of people defined by their colour, nationality, ethnic or national origins. A racial group can also be made up of two or more distinct racial groups.

People from some ethnic minority groups often experience poorer health outcomes. This may be as a result of multiple factors including genetic predisposition to certain diseases (e.g. diabetes, coronary heart disease and mental health), poor access to services, language barriers and cultural differences.

The ethnic profile of Staffordshire has been described briefly in Section 2.3. In terms of main language spoken, findings from the 2011 Census found that around 98% of Staffordshire residents stated English as their main language. Other common main languages spoken in Staffordshire were:

- Polish (0.6%)
- Punjabi (0.2%)
- Urdu (0.2%)

In those areas where there are higher proportions of people from minority ethnic groups (mainly Burton), pharmacies may need to consider how they communicate health messages effectively, and particular for those communities where English is not the first spoken language. Based on the 2011 Census data the most commonly spoken languages in Burton are Urdu, Polish and Punjabi.

The languages spoken by staff were collected through the community pharmacy questionnaire and shows that 71 of Staffordshire pharmacies have staff members who speak a variety of languages equating to 50% of all responding pharmacies and 39% of all community pharmacies. Common languages include: Punjabi (44 pharmacies), Urdu (27 pharmacies), Hindi (23 pharmacies), Polish (10 pharmacies) and Gujarati (nine pharmacies) spread across the County. There were no pharmacies who responded to the survey in East Staffordshire who had a staff member who spoke Polish despite 11 pharmacies reporting that Polish was spoken in the community.

Religion or belief

This area includes any religious or philosophical belief and includes a lack of belief, for example Humanism and Atheism. A belief need not include faith or worship of a God or Gods, but must affect how a person lives their life or perceives the world.

The 2011 Census found Christianity to be the majority religious affiliation in Staffordshire (Table 22). Over the last decade this proportion has dropped, with significant increases in people stating they had no religious affiliation over the same time period. Muslims are the next largest group in the County.

In terms of pharmaceutical needs, pharmacies should be able to provide additional medicine-related support, for example advice on whether an individual's medicines include ingredients from animals and/or during certain times of the year, e.g. during Ramadan.

Table 22: Population by religion, 2011

	Staffordshire	West Midlands	England
Christian	578,352 (68.2%)	3,373,450 (60.2%)	31,479,876 (59.4%)
Buddhist	2,017 (0.2%)	16,649 (0.3%)	238,626 (0.5%)
Hindu	2,773 (0.3%)	72,247 (1.3%)	806,199 (1.5%)
Jewish	299 (0.0%)	4,621 (0.1%)	261,282 (0.5%)
Muslim	10,817 (1.3%)	376,152 (6.7%)	2,660,116 (5.0%)
Sikh	3,086 (0.4%)	133,681 (2.4%)	420,196 (0.8%)
Other religion	2,783 (0.3%)	25,654 (0.5%)	227,825 (0.4%)
No religion	193,662 (22.8%)	1,230,910 (22.0%)	13,114,232 (24.7%)
Religion not stated	54,700 (6.4%)	368,483 (6.6%)	3,804,104 (7.2%)
Total	**848,489 (100.0%)**	**5,601,847 (100.0%)**	**53,012,456 (100.0%)**

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

Sexual orientation

Sexual orientation is whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

There is no hard data on the number of lesbians, gay men and bisexuals in the UK as no national census has ever asked people to define their sexuality. The official government figure is 5-7% of the population which Stonewall, a lesbian, gay and bisexual charity, feels is a reasonable estimate. HM Treasury and the Department of Trade and Industry completed a survey to help the Government analyse the financial implications of the Civil Partnerships Act (such as pensions, inheritance and tax benefits). They concluded that there were 3.6 million gay people in Britain - around 6% of the total population or one in 17 people.

In 2015, the Annual Population Survey (APS) found 1.7% of adults in the UK identified themselves as lesbian, gay or bisexual. Based on APS estimates for 2013-2015, around 0.8% of Staffordshire's population are estimated as lesbian, gay or bisexual.[4]

Both estimates are considerably lower than government estimates of 6%. This indicates that whilst there is a visible community of lesbian, gay and bisexual people in the County there will also be a significant invisible community which may need to be considered by both commissioners and pharmaceutical providers. There are no additional needs that have been identified by the PNA with respect to sexual orientation.

[4] Subnational sexual identity for 2013 to 2015, Office for National Statistics, Crown copyright, https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/datasets/sexualidentitysubnational

6 Are there any pharmaceutical gaps in Staffordshire?

Staffordshire has a resident population of 867,100 and covers a large geographical area of over 1,010 square miles. Similar to many other County areas, a major characteristic of Staffordshire is its ageing population with its population continuing to grow in both size and average age rapidly. It is a relatively affluent area but has notable pockets of high deprivation in some urban areas. However some of the remote rural areas in Staffordshire do have issues with hidden deprivation, and in particular around access to services. The increase in older populations is thought to be the single most significant factor in the increasing prevalence of rural isolation.

Overall people in Staffordshire are healthy, live longer compared with national life expectancy, and have positive experiences of the things that affect their lives and wellbeing. Staffordshire has shown large improvements in life expectancy and made significant progress in reducing overall mortality and preventable mortality over the last decade. However both men and women spend more time in poor health than the average retirement age and there remain large health inequalities across Staffordshire as evidenced by life expectancy and early death rates. 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.

There are a number of factors that can help prevent ill health or diagnose problems early to enable better treatment, especially immunisation and screening. Childhood immunisation rates and coverage of screening programmes in Staffordshire are generally better than average. However fewer Staffordshire adults who are eligible take up their offer of a NHS health check and a lower proportion of people aged 65 and over take up their offer of a flu or pneumococcal vaccination than average.

Around 40% of ill-health is thought to be preventable through healthier lifestyles. 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). Newcastle has a higher rate of children who are obese by the time they are in Year 6. Whilst adult smoking rates overall in Staffordshire have fallen there are large numbers of our population who drink too much over the life course, eat unhealthily and remain inactive

More people in Staffordshire report having a limiting long-term illness. By the time people reach 65 they will have developed at least one chronic condition and large proportions will also have developed two or three conditions. Of particular concern are the growing numbers of people with multiple or complex conditions.

Most care will occur in primary care or community settings. However a higher than average proportion in Staffordshire also occurs in hospital settings particularly young children and older patients. Older people are also higher users of social care. Admission rates in Staffordshire for acute conditions that could be managed effectively in primary care or outpatient settings are increasing more rapidly than average. In addition those that are admitted to hospital are often delayed from being discharged.

Pharmacy is the third largest healthcare profession, with a universally available and accessible community service. Pharmacies are well used and based on national estimates around seven million visits are made to a community pharmacy for health-related reasons annually in Staffordshire which equates to around 10 visits per person every year. Nationally 79% of people have visited a pharmacy at least once in the last year whilst 37% have visited at least once a month. Local data from a resident survey found around 14% of respondents used their pharmacy weekly and a further 58% monthly.

Staffordshire has 182 community pharmacies, of which seven are distance-selling and in rural areas there are 27 GP practices who can dispense to patients registered with their practice. The rate of community pharmacies and dispensing practices is 24 per 100,000 population which is similar to the national average but ranges between districts from 20 per 100,000 in South Staffordshire to 27 per 100,000 population in East Staffordshire although districts with low rates do also have nearby access to pharmacies in neighbouring areas such as Wolverhampton and Stoke-on-Trent.

A national patient survey indicated that the public value a variety of types of pharmacy. In terms of ownership around two-fifths of pharmacies in Staffordshire are owned by independent contractors whilst the remaining three-fifths are owned by multiple contractors.

Based on data from the latest *Feeling the Difference* survey, the majority of Staffordshire residents are satisfied with current pharmacy provision. The engagement survey also found that local pharmacy services met the needs of respondents. National research also indicates that 86% would trust advice from pharmacies on how to stay healthy.

Overall there are sufficient numbers and a good choice of pharmacy contractors to meet Staffordshire's pharmaceutical needs.

There is a gap as to the clarity of controlled localities and reserved locations. It is therefore proposed that NHS England North Midlands undertake further mapping of controlled localities, dispensing practice areas and reserved locations to provide assurance on the patients who fall into dispensing and prescribing groups for these practices, and clarity on the status of these areas, to support applications for new pharmacies or those considering relocations.

There is good geographical coverage across the County for pharmaceutical services and the majority of Staffordshire residents (98%) live within a 10 minute drive of their local pharmacy. Around 86% of residents can also access their local pharmacy within a 20 minute walk and almost two-thirds within 10 minutes using public transport.

In terms of opening hours, there are 18 '100 hour' pharmacies across Staffordshire equating to around one in ten pharmacies, with all residents in the County with the exception of South Staffordshire, having access to a community pharmacy for at least 100 hours during the week. Most residents have good access to a pharmacy during weekdays and Saturdays.

However there appears to be less provision and choice on Sundays and in particular on Sunday evenings. Around one in six pharmacies are open on Sunday from around 10am but tend to close by around 4pm; three pharmacies across the County are open after 5pm.

Some of the restricted provision is due to trading regulations which restricts opening hours for pharmacies located in supermarkets and shopping centres to six hours. However Staffordshire residents do have access to dispensing services on Sundays from alternative provision, for example walk-in-centres, minor injury units or from pharmacies in neighbouring areas such as Stoke-on-Trent or Wolverhampton.

A number of pharmacies also now open on Bank Holidays. NHS England North Midlands also commission community pharmacies to ensure there are adequate pharmaceutical services available on Christmas Day and Easter Sunday as these are the two days where pharmacies are still traditionally closed and those located in supermarkets and shopping centres unable to open due to current trading laws.

There appears to be a gap in service provision on Sunday evenings. However the demand for dispensing services is likely to be much lower at weekends compared to weekdays as GP surgeries are usually closed.

The STP may also want to consider commissioning extended pharmaceutical services on Sundays as one of the potential solutions to reducing A&E attendances.

In terms of the protected characteristics, pharmacies have a positive impact in meeting the needs of all people. Examples of this include:

- Antenatal and postnatal support to pregnant women and mothers
- At least two-fifths of pharmacies have staff members who speak a number of languages that are amongst the frequent main languages across the County
- Adjustments to medicines for disabled people as appropriate, for example large print labels. Most pharmacies also have a separate consultation room with wheelchair access
- Delivery of dispensed medicines to an individual's home

Findings from the engagement survey found that most people used pharmacies for collecting their prescriptions. Almost half of respondents also used their pharmacy for health advice or disposal of unwanted medicines. However very few respondents used their pharmacy for lifestyle advice (10%). Around a fifth of respondents would like pharmacies to maintain their current level of services with small proportions wanting to see the introduction of basic testing such as blood pressure measurements, blood tests and holiday vaccinations (10%), information and advice on the availability of other services (7%) and/or basic health appointments or clinics for certain conditions or lifestyle (5%).

National evidence suggests that between 5-8% of unplanned emergency admissions in adults are due to avoidable issues related to medicines. Overall there is good provision of advanced pharmacy services such as the Medicines Use Review (MUR) and New Medicine Service (NMS) across Staffordshire that help to deal with adherence to medicines and the management of people with long-term conditions.

However in terms of MURs, there is variation between pharmacies and some fall considerably below both the Staffordshire and national average. Provision of NMS also varies by district and pharmacy although this is dependent on the number of patients that start new medicines during the year.

Coverage of appliance use reviews and stoma appliance customisation services are low which is similar to the trend seen across England due to these services being a specialist area with many patients receiving the support they require either from a clinic or hospital or from a dispensing appliance contractor located in another area, for example Stoke-on-Trent.

An adult flu vaccination service was introduced as the fifth advanced service in September 2015. The number of pharmacies signed up to provide flu vaccination is high and there has been an increase in the number of flu vaccinations within community pharmacies with overall uptake per pharmacy higher than the national average. However provision across the County is variable.

Pharmacies falling considerably below the average number of MURs should be supported to increase the numbers of MURs, particularly in areas where there is an identified need, to help with the management of long-term conditions and reducing emergency admissions. This may be done by promoting the concept of MURs to the public so that they understand the differences between reviews done by GP and pharmacies. GP practices are also ideally placed to work with their local pharmacies to identify and refer on patients who require a MUR or NMS. Overall uptake of flu vaccination through community pharmacy across the County is better than the national average; however provision varies across the County and further work should support and market community pharmacies to increase the provision of flu vaccination in these areas. Commissioners should also consider the provision of pneumococcal vaccination within community pharmacy settings given the current low rates of coverage across the County.

There are also opportunities for pharmacies to support the health, wellbeing and care needs of Staffordshire residents through locally commissioned services. In Staffordshire there are a number of services that are currently provided by pharmacies alongside other providers helping to meet the health needs of local residents. These include provision of: common ailment service, emergency supply of medication, treatment of urinary tract infections and impetigo, emergency hormonal contraception, supervised administration, needle exchange and palliative care. Provision across the County is generally matched to needs.

NHS England North Midlands, Staffordshire County Council, and other local commissioners need to ensure there is equitable provision of locally commissioned services across Staffordshire. This could be coordinated through the STP.

Local commissioners, providers and key stakeholders such as LPCs and Local Medical Committees should continue to explore new ways in which community pharmacies could complement other primary and secondary care services and play a part in improving health and reducing inequalities, particularly around health and wellbeing strategic priorities. There is also a willingness from most community pharmacies to extend their roles to further support Staffordshire people to live healthier, self-care or live independently to meet local need. There is also ample national evidence to suggest that this could help alleviate current financial pressures on the NHS.

The STP should consider the wider role of pharmacies in commissioning strategies (e.g. primary care) so that opportunities to provide effective services are maximised locally.

The HWBB will continue to monitor any major developments (e.g. planned housing developments) and in line with regulations produce supplementary statements to the PNA where deemed necessary. They will also monitor any proposed changes to Government policy that could have an effect on the provision of pharmaceutical provision, for example extended opening of GP services.

The HWBB will continue to monitor any local or national policy development that impact on the provision of pharmaceutical services in the County and continue to publish supplementary statements where needed.

Appendix 1: Staffordshire STP's Pharmacy Plan

Vision

Our vision for Staffordshire and Stoke on Trent is to provide affordable care built and given locally around communities of 30,000 to 70,000 people. By doing this, services will be tailored to local need and, supported by less complicated locality and county wide arrangements, will allow us to give joined up care to people close to or in their own homes, with less need to go to hospital.

Overview

The Pharmacy Programme covers a population of over 1.1 million people registered with GPs across six CCGs, two acute hospitals, two mental health providers and one community provider.

Our system is experiencing increasing pressure, our modelling and financial challenges clearly shows that we need to reduce our cost base, improve our sustainability and enhance our offer to the public.

We have identified priorities for change, underpinned by transformational enablers, which together will help us to address our financial gap by 2020/21. In years one and two we will progress key initiatives to lay the foundations of our STP over the next five years.

All of our plans are and will be built on collaborative relationships and consensus amongst our system leaders which we will continue to develop to ensure the success of our STP, and which provide the foundations for an integrated health and social care system in the future.

Priorities for 2016/17-2017/18

1. **Reduce medication errors across the primary and secondary care interface**
   Implement digital solutions which allow electronic transfer of medication information between hospital and community pharmacy to help minimise medication errors

2. **Improve patient clinical outcomes by ensuring medicines are optimised at every opportunity**
   Increase the number of clinical pharmacists working in all care settings (including care homes) to undertake clinical medication reviews in addition to maximising utilisation of MURs and patient support under the new medicine service (NMS)

3. **Greater utilisation of the pharmacy expertise around medicines in the management of Long Term Conditions**
   Develop systems which allow pharmacists working in partnership with GPs to provide LTC support following diagnosis, monitoring and adjustment of treatments in accordance to patient care plans

4. **Promote community pharmacy as the first port of call for advice and treatment of common ailments**
   Fully integrate "pharmacy first" for non-emergency episodic care in all local urgent care pathways, including implementation of the national programme for NHS 111 referrals to community pharmacy

5. **Reduce waste around prescribed unused medicines**
   Develop and implement health economy wide systems to reduce pharmaceutical waste related to inappropriate repeat medicine ordering.

6. **Maximise pharmacy contribution to the health and wellbeing agenda**
   Develop community pharmacies into Heathy Living Pharmacies, becoming the" go-to" destination for support, advice and resources on staying well and living independently

An underpinning programme of transformational enablers includes:

- Becoming a system with a collective focus on the whole person.
- Developing communities so that people have the skills and confidence to take responsibility for their own health and care.
- Developing the workforce across our system so that it is able to deliver new models of care.
- Using technology to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency.
- Redevelop our services and estate to ensure patients have services closer to home.
- Ensuring full integration of pharmacy with GPs and other primary care providers

Appendix 2: Recommendations from Community Pharmacy Clinical Services Review

Extract from Community Pharmacy Clinical Services Review undertaken by Richard Murray, Director of Policy at the King's Fund published by NHS England on 14th December 2016.

With other parts of the NHS facing severe financial and operational challenges, there needs to be renewed efforts to make the most of the existing clinical services that community pharmacy can provide and to do so at pace. This may require national action through the national contractual framework, as well action at local level. Looking into the medium-term, there is a need to ensure that community pharmacy is integrated into the evolving new models of care alongside other primary care professionals. This will include enhancing the support they provide to people with long-term conditions and public health, but should not be limited to these. Progress here will necessarily be more local in nature, built around the needs of patients and localities, however, NHS England and Public Health England can support and encourage this progress, not least to overcome some of the barriers that have to date prevented full use of community pharmacy. To make progress on these broader priorities, there are a number of specific steps national bodies can make. Action should include, but not be limited to, these steps.

Services

1. Full use should be made of the electronic repeat dispensing service. Except for patients not yet stabilised on their medication, electronic repeat dispensing should become the default for repeat prescribing and its use should be incentivised both for community pharmacies and for GPs.

2. The existing Medicine Use Reviews (MURs) element of the pharmacy contract should be redesigned to include on-going monitoring and regular follow-up with patients as an element of care pathways. This redesign should ensure that they are an integrated part of a multifaceted approach to helping people with long-term conditions that includes medicines optimisation, providing advice and helping people stay well. Such a service should be able to utilise transfer of care and referral schemes and electronic repeat dispensing (ERD), and have a focus on patients at high risk and those with multiple co-morbidities as well as those with single conditions that are clinical priorities such as diabetes, hypertension and COPD where evidence is already strongest. It should also include consideration of appropriate prescription duration to optimise outcomes and convenience for patients. Ultimately MURs should evolve into full clinical medication reviews utilising independent prescribing as part of the care pathway. For these to be safe and effective they would require access to a patient's full medical record which may not be possible immediately in all situations.

3. There is now a commitment that a minor ailments scheme should be locally commissioned across England by April 2018. There is a debate over whether this needs to be a national service, or a service commissioned locally by CCGs. Either way, NHS England should set out how it intends to deliver on this commitment and this should include testing models that use patient registration to enhance take-up, building on the experience in Scotland. While this could take place within the Vanguard programme as new care models develop, progress toward the April 2018 commitment clearly needs to happen sooner.

4. Consideration should be given to smoking cessation services becoming an element of a national contract.

New models of care

5. Existing Vanguard programs and resources should be used, in conjunction with the Pharmacy Integration Fund, to develop the evidence base for community pharmacists within new models of care. This applies to all the Vanguard types that work in community settings but should also specifically include:

    - Integrating community pharmacists and their teams into long term condition management pathways which implement the principles of medicines optimisation for residents of care homes. This should include pharmacist domiciliary visits to care home patients and full clinical medication review utilising independent pharmacist prescribing.

    - Community pharmacists being involved in case finding programmes for conditions which have significant consequences if not identified such as hypertension and for which the pharmacist is able to provide interventions (including referral) to prevent disease progression.

    - Utilising existing contractual levers and developing new ways of contracting, with individual or groups of pharmacists, in order to provide clinical services that utilise their clinical skills in ways that mitigate any perceived conflict of interest whilst providing the incentives for more rapid uptake of independent prescribing.

In all cases, new models of care that integrate pharmacy should involve appropriate patient engagement to ensure that both the service offer is built around patient need and that any necessary marketing with potential new users is effective. As best practice in commissioning and delivering these additional services from community pharmacy becomes clear, NHS England, Public Health England and other national partners should look to roll these out at pace, given the opportunities to use community pharmacy better and the deep challenges facing other parts of the NHS. This should include consideration of any workforce training implications for community pharmacists, pharmacy technicians and their teams.

Overcoming barriers

6. Public Health England already plans to provide advice to local government and to STPs presenting the evidence base for action. More widely, NHS England and its national partners should consider how best to support STPs in integrating community pharmacy into plans and overcome the current complexities in the commissioning landscape alongside further support for local commissioners in contracting for services now. Specifically this should look at the changes necessary to make Local Pharmaceutical Services (LPS) Contracts easier to use.

7. Digital maturity and connectivity should be improved to facilitate effective and confidential communication between registered pharmacy professionals and other members of the healthcare team. This should include the ability for registered pharmacy professionals to see, document and share information with clinical records held by other healthcare professionals and allow the actions, recommendations and rationale for clinical interventions made by registered pharmacy professionals to be visible to the relevant wider healthcare team.

8. Regulations should be amended to allow registered pharmacy technicians to work under Patient Group Directions to allow better use of skill-mix in delivering clinical pharmacy services.

9. Community pharmacists should be actively engaged to help explore and develop pathway approaches that integrate community pharmacists and their teams into primary care, and make best use of their skills in the identification and management of patients who will benefit most from their expertise. The leaders of the profession both at national and local level should consider what support is needed to pharmacists to build their professional confidence and break down barriers to new ways of working.

10. The Royal Pharmaceutical Society, Royal College of General Practitioners, the British Medical Association and the Pharmaceutical Services Negotiating Committee should come together to explore the practical steps that could be taken to unravel professional boundary issues and promote closer working between the professions. This would include consideration of professional responsibility and accountability, as well as how to conceptually put the patient at the centre of both professional worlds in a way that allows common objectives to be focused on patient outcomes. Initiatives involving pharmacists working in General Practice, and in some case becoming partners in those practices, should be encouraged and expanded as a way of contributing towards achieving this objective.

11. New evidence becomes available, circumstances change and new barriers can appear. Community pharmacy leaders and trade bodies across the sector, such as Pharmacy Voice, should come together with NHS England and Public Health England as a formal group to keep oversight of progress and recommend further action where necessary.

Appendix 3: Findings from the engagement survey

An engagement survey was conducted with Staffordshire residents by Healthwatch during June and July 2017 to capture their views on local pharmacy services. The survey aimed to capture people's experience and satisfaction with the use and whether there is anything you would wish to change about local pharmacy services to inform the PNA.

An online and paper survey were available to capture people's views. This was done by sending the survey out by email to 200 organisations for dissemination to their members and 1,750 people who are on Healthwatch's database. The survey was also taken to Healthwatch's AGM and available online through their website, Facebook and Twitter with reminders two weeks before the closing date. Paper copies were also taken to Katherine House, an older people's service in North Staffordshire and a pharmacy in East Staffordshire.

On average, how often do you use your local community pharmacy (chemist)?

Local data from the engagement survey found that around 14% of respondents used their pharmacy on a weekly basis whilst 58% of respondents used their pharmacy monthly.

	Number	Percentage
At least once a week	33	14%
At least once a month	139	58%
Several times a year	44	18%
Once a year	8	3%
Rarely	12	5%
Never	3	1%
Total respondents	**239**	**100%**

To what extent does your pharmacy meet your needs?

Most people felt that their pharmacy met their needs a great deal (65%) or a fair amount (29%) with only 10 respondents (4%) feeling that it didn't meet their needs very much.

	Number	Percentage
A great deal	156	65%
A fair amount	70	29%
Not very much	10	4%
Don't know	3	1%
Total respondents	**239**	**100%**

86% (or 206 of respondents overall) commented on why they had rated how they had. Respondents commonly remarked on the prescription service and how this meets their needs. Views on the usefulness of the advice shared by pharmacists was also expressed. Respondents additionally shared their views on other staff, stock and the general reliability of the pharmacy service.

- **Prescriptions (89 responses)** - The majority who shared views on prescriptions (79 respondents or 89% of those commenting) were generally extremely positive about their experiences commenting that their pharmacy provides them with *"exactly what they need, when they need it".* Prescriptions are *"ready on time and correct"* and *"the prescription link between GP and pharmacy works very effectively".* Respondents applauded their pharmacist for *"taking the time to fully explain their prescription and to offer guidance on suitable over the counter options".*
  Some respondents did not feel that their pharmacy had met all their needs. For example, on occasion, *"prescriptions were not always correct"*, the *"prescription link"* between GP and pharmacy does not always work and there was evidence of some difficulty with *"prescription release from pharmacy to care homes"* as well as a *"lack of stock"* making a second trip necessary on occasion. This can be particularly difficult for *"disabled service users".*

- **Advice (85 responses)** - Pharmacists were *"trusted"* and *"always on hand to give excellent and friendly advice"*. They were regarded as *"extremely knowledgeable"* and *"a valued source of information",* both for *"prescription drugs"* and for *"common ailments which might not require a GP".* They were also *"good for advising on what over the counter medications work with prescription medications".* One respondent felt they needed clarification on what pharmacists can and cannot advise upon to enable them to understand when they *"can help"* and *"when they should seek the advice of their doctor".*

- **Staff (57 responses)** - Respondents spoke very highly about their pharmacy staff describing them as *"professional", "caring", "confident", "friendly", "efficient"* and *"always happy to help".*

- **Reliability (52 responses)** - Pharmacies were generally described as ***"****efficient"* in the dispensing of their medication and providing *"a good supporting service to GP's",* with *"convenient opening hours".* Some respondents who needed to use their pharmacy regularly applauded the *"personal touch"* appreciating the fact that their pharmacy knows their *"requirements".* However a small number of respondents commenting on reliability (six respondents or 12% of those commenting) had experienced issues including *"prescriptions not being quite right" or "on time".*

- **Stock (45 responses)** - For the majority of respondents the stock requirements more than met their needs (31 respondents). For example my pharmacy carries *"large stocks"* and they always have *"what I need in stock".* However stock was an issue for some respondents as outlined under the prescriptions theme.

- **Additional responses** - Pharmacies were also described as useful because they are *"nearby"* (19 responses), provide *"over the counter medication"* (19 responses), *"support people without the need for a GP/or when people can't get a GP appointment"* (13 responses) and *"for picking up other toiletries"* (11 responses).

What services do you use at the pharmacy?

Findings from the engagement survey found that most people used pharmacies for collecting their prescriptions. Almost half of respondents also used their pharmacy for health advice or disposal of unwanted medicines. However very few respondents used their pharmacy for lifestyle advice (10%).

	Number	Percentage
Dispensing of prescriptions	228	95%
Health advice	115	48%
Disposal of unwanted medicines	107	45%
Home delivery	26	11%
Lifestyle advice	24	10%
Other	32	13%
Dispensing of prescriptions	228	95%

What other services would you like to see at your local pharmacy?

57% (or 136 of respondents overall) commented on this theme with commonly mentioned comments including the need to maintain the current service. There was also some support for the introduction of other services as well as the provision of information and advice. More details on the above most frequently mentioned themes were:

- **Maintain the current service (53 responses)** - It was most common for respondents to confirm that their pharmacy meets *"all their current needs"* and they just wanted to see *"this level of service being effectively maintained".* Some respondents felt that the introduction of other services within their local pharmacy could *"compromise"* the *"quality of the existing service".*

- **Introduce basic testing (24 responses)** - Other respondents would like to see more services at their local pharmacy and these included being able to visit their pharmacy for basic testing and vaccinations for *"blood pressure", "blood tests", "cholesterol checks*", *"weight measurement", "holiday vaccinations*" and *"flu jabs".*

- **Information and advice (18 responses)** - Some respondents would like to see information on the availability of other services e.g. *"social care", "wellbeing"* and "healthy lifestyles" in their local pharmacy. Also *"advice on self-care and prevention".*

- **Basic health appointments or clinics (11 responses)** - These respondents were keen to see the introduction of *"basic health appointments"* or *"clinics"* for certain conditions or lifestyle. For example for *"chiropody", "nutrition*", *"diet", "weight loss"* and *"smoking".*

- **Additional responses** - Additional responses were received on *"opening hours"* (four responses), *"electronic services"* (three responses) and the need to ensure pharmacy staff have enough *"time"* for their clients (three responses).

What if anything, prevents you from using services at your local pharmacy?

57% (136 respondents) commented on this question. Respondents were most likely to indicate that *"nothing"* prevents them from using services at their local pharmacy (79 respondents or 56% of those commenting). Reasons given included *"good accessibility"* and *"a good service".*

Some respondents said something did prevent them from accessing their local pharmacy. Reasons given included the *"service"* provided by staff (13 responses), *"opening hours"* (12 responses), *"queues"* (seven responses), *"disabled access"* (six responses) and *"parking"* (four responses).

Other comments

One third of respondents overall (32%) or 77 respondents shared additional comments. The majority of these were reflective of those themes already documented in the responses above. These have not been repeated here. Additional themes not previously documented included the need to recognise pharmacies for the *"assets"* which they are (22 responses) and to recognise that some people feel *"reliant"* upon the services which their local pharmacy provides (eight responses).

Appendix 4: Access to pharmaceutical providers in Staffordshire by mode of transport

Methodology for accessibility

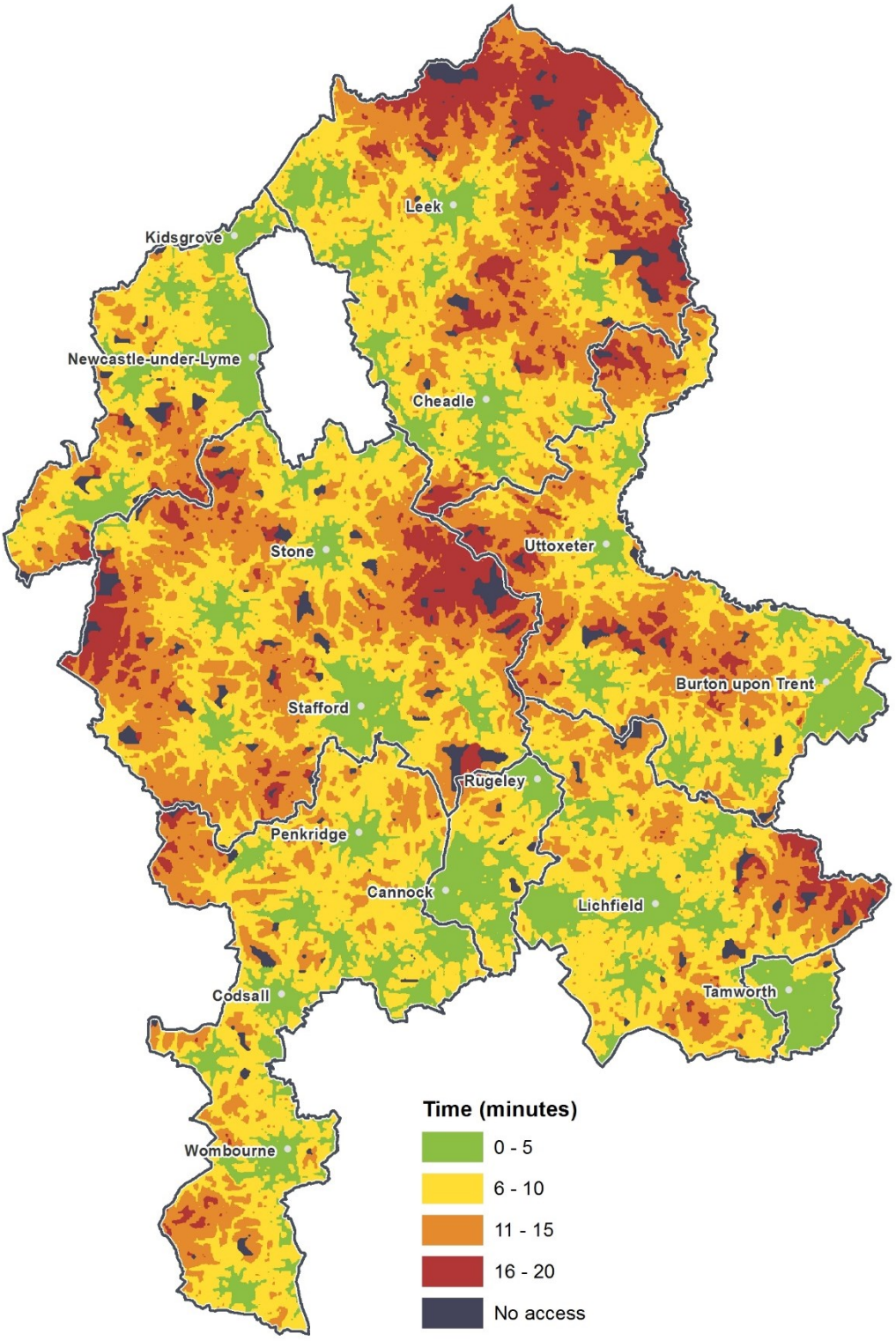
Visography TRACC accessibility planning software supersedes Accession which was developed by Basemap for the Department for Transport to enable local authorities to measure and monitor local accessibility as part of the accessibility strategy in their local transport plans. Visography TRACC calculates journey times based upon public transport timetable data, road network information and a range of user-defined parameters. The results for the accessibility calculations for each mode are shown as travel time contours. The data represents the shortest travel time that can be made from each origin point to any pharmacy within the destination set. In addition to all pharmacies within Staffordshire, all pharmacies within a buffer of three to four miles were included in the analysis.

Car accessibility - Car based calculations utilise the Ordnance Survey Integrated Transport Network (ITN) data and use Trafficmaster road speed data based on actual journey times made during the morning peak period 08:00-09:00 using 2014/15 data. The maximum connection distance to the road network is 350m; if the road network cannot be reached within this distance then a result of "no access" is returned. The maximum travel time was set at 20 minutes.

Walk accessibility - Walking calculations make use of the Ordnance Survey ITN and Urban Paths data which in combination provide the entire road network, off road footpaths and pedestrians shortcuts. Parameters have been set to define the maximum walk distance to access the walking network as 350m. If the network cannot be reached within this distance then a result of "no access" is returned. Walking speed has been defined as 4.8kph. The maximum travel time was set at 20 minutes.

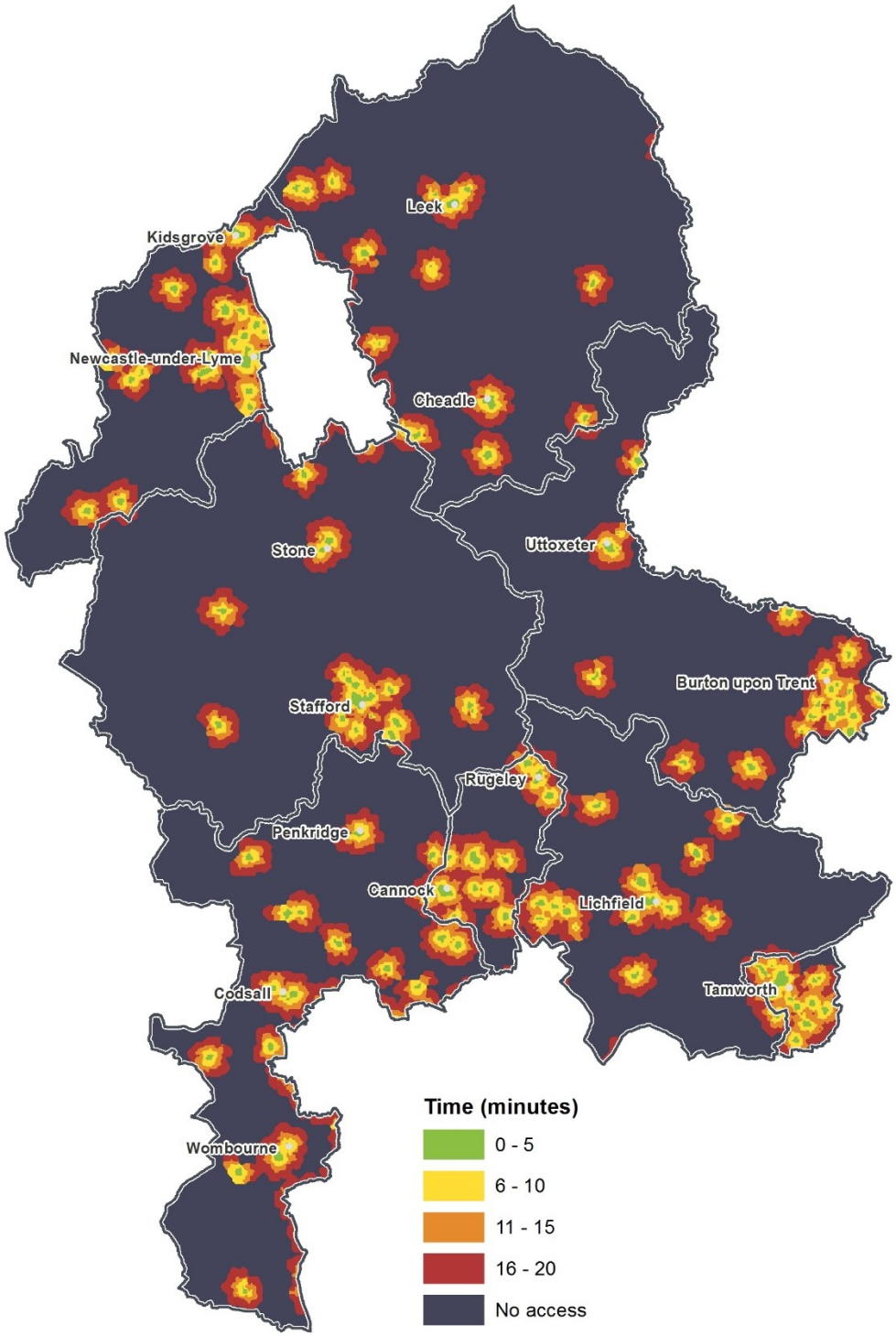
Public transport accessibility - Public transport accessibility included bus and/ or rail services. The timetables used were dated July 2017 and May 2016 for bus and rail respectively. When calculating accessibility for public transport, the software takes into account walk time to a bus stop/station, wait time for the service, in vehicle travelling time and walk time to the destination. It also allows for interchange between services and modes such as bus and rail. The software includes a five minute interval between changes of services to model passenger acceptance of service interchange. Calculations were made for the time period 08:00 to 10:00 on an average Wednesday. Parameters have been set to define the maximum walk distance to access a public transport stop as 350m. Access to the bus stops is calculated on a crow-flies basis with a correctional factor to acknowledge that this is not possible. If a public transport stop cannot be reached within this distance then a result of "no access" is returned. The maximum travel time was 60 minutes in total. For public transport, the average speed of walking will vary between individuals (the assumption used within the analysis is a pace of 4.8km per hour). The destinations supplied were based on postcodes of the pharmacy which could have an impact on the public transport calculation as this relies on a 350m distance to access the destination, so if the postcode centroid is outside of this distance it may not show access by public transport, where in reality the exact location of the pharmacy may be within 350m walk distance of a bus stop.

Map 21: Access to community pharmacies – car



Source: Staffordshire County Council and NHS England North Midlands

Map 22: Access to community pharmacies – walking



Source: Staffordshire County Council and NHS England North Midlands

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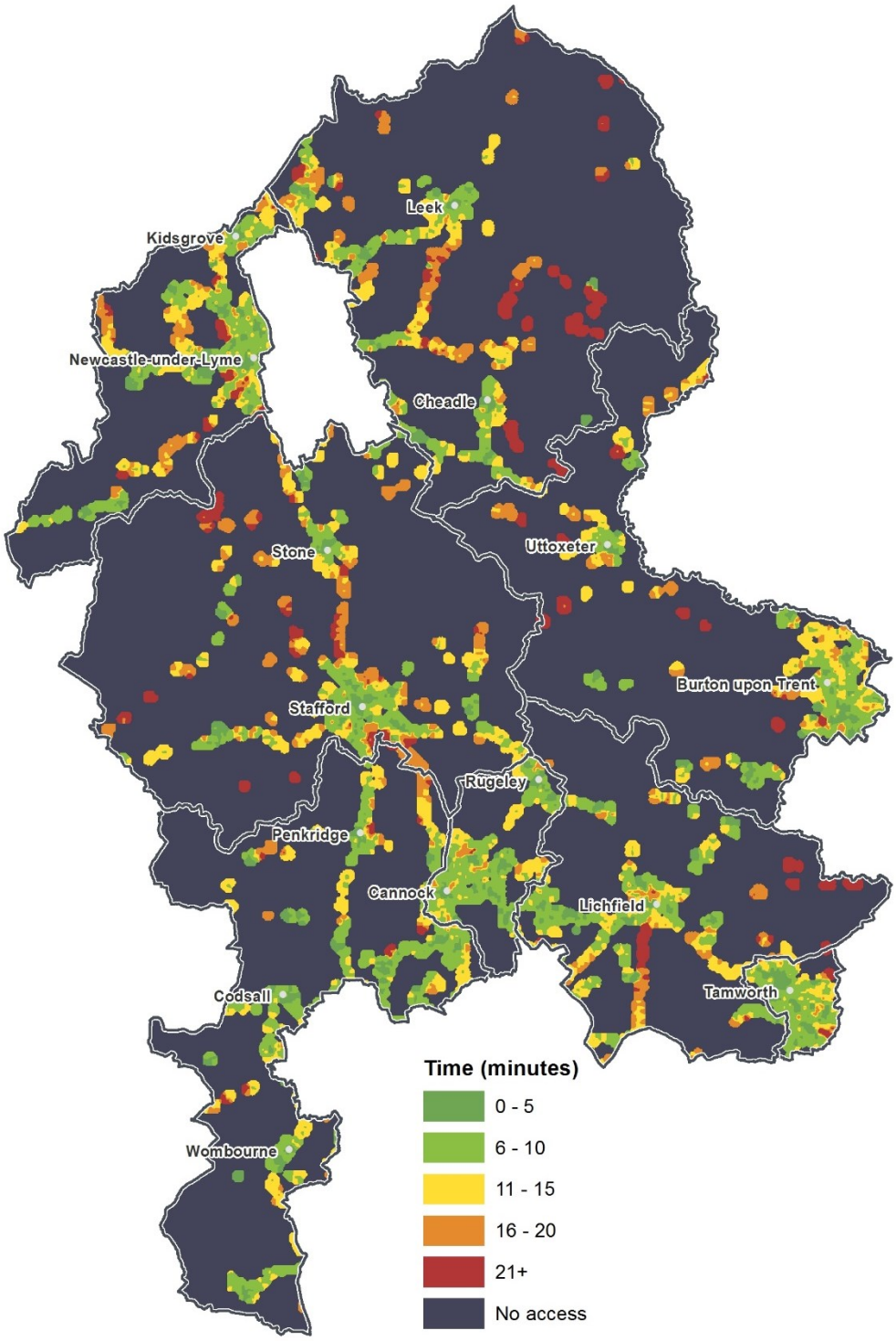
Note: Calculations include those origins which are in unpopulated areas and where there are no roads, footpaths or bus services, these will therefore result in there being 'areas of no access'. The calculations carried out are at a very strategic level and should only be used to give an indication of areas of accessibility; any areas of concern would need to be looked at in greater detail.

Map 23: Access to community pharmacies – public transport



Source: Staffordshire County Council and NHS England North Midlands

Note: Calculations include those origins which are in unpopulated areas and where there are no roads, footpaths or bus services, these will therefore result in there being 'areas of no access'. The calculations carried out are at a very strategic level and should only be used to give an indication of areas of accessibility; any areas of concern would need to be looked at in greater detail.

Appendix 5: Individual pharmacy by service provision and locality, July 2017

	Medicines Use Review Service	New Medicine Service	Appliance Use Review Service	Stoma Appliance Customisation Service	Influenza Adult Vaccination Services	Common ailments	Emergency supply	Urinary tract infections and impetigo	Emergency hormonal contraception	Supervised consumption	Needle exchange	Palliative care
Cannock Chase												
Bains Pharmacy , 160 - 162 Hednesford Road, Heath Hayes, Cannock, WS12 3DZ	✓	✓			✓	✓	✓	✓	✓			
Boots The Chemist, 1 - 7 Park Road, Cannock, WS11 1JN	✓	✓			✓	✓				✓		
Boots The Chemist, 5 Brook Square, Rugeley, WS15 2DT	✓	✓			✓	✓			✓	✓		
Boots The Chemist, Unit 9, Orbital Retail Park, Voyager Drive, Cannock, WS11 8XP	✓	✓			✓	✓			✓	✓		
Boots The Chemist, 1 Church Street, Cannock, WS11 1DE	✓	✓			✓	✓				✓		
Co-op Pharmacy, Co-op Supermarket, Anglesey Street, Hednesford, WS12 1AS	✓	✓			✓	✓	✓	✓	✓	✓		
Cornwells Chemists, 235 Cannock Road, Chadsmoor, Cannock, WS11 2DD	✓	✓				✓	✓	✓	✓	✓		
Lloyds Pharmacy, 11 Upper Brook Street, Rugeley, WS15 2DP	✓	✓		✓	✓	✓	✓	✓	✓	✓		
Lloyds Pharmacy, Sandy Lane Health Centre, Sandy Lane, Rugeley, WS15 2LB	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Lloyds Pharmacy, Unit 2b, Victoria Shopping Centre, Victoria Street, Hednesford, WS12 1BT	✓	✓		✓	✓	✓	✓	✓	✓	✓		
Lloyds Pharmacy, Hednesford Valley Health Centre, Station Road, Hednesford, WS12 4DH	✓	✓		✓		✓	✓	✓	✓	✓		
Lloyds Pharmacy, Voyager Drive, Orbital Retail Centre, Cannock, WS11 8XP	✓	✓			✓	✓	✓	✓	✓			
Morrisons Pharmacy, Morrisons Supermarket, Market Street, Rugeley, WS15 2JJ	✓	✓			✓	✓	✓			✓		✓
Northwood Pharmacy, Springfields Health & Wellbeing Centre, Lovett Court, Rugeley, WS15 2FH	✓	✓				✓	✓	✓	✓	✓		
Northwood Pharmacy Brereton, 88 Main Road, Brereton, Rugeley, WS15 1DU	✓	✓				✓	✓	✓	✓	✓		✓
Nucare Pharmacy, 3 Hamilton Lea, Brownhills Road, Norton Canes, Cannock, WS11 9SY	✓	✓					✓			✓		
Pyramid Pharmacy, 29 Market Hall Street, Cannock, WS11 1EB						✓	✓	✓				
Rawnsley Pharmacy, Rawnsley Road, Rawnsley, Cannock, WS12 1JF	✓											
Tesco Instore Pharmacy, Heath Way, Heath Hayes, Cannock, WS12 3YY	✓	✓			✓				✓	✓		
Tesco Instore Pharmacy, Victoria Shopping Park, Victoria Street, Hednesford, WS12 1BT	✓	✓			✓				✓			
Well Pharmacy, Norton Canes Health Centre, Brownhills Road, Norton Canes, Cannock, WS11 9SE	✓	✓			✓	✓	✓	✓	✓	✓		
Well Pharmacy, 57 - 59 Market Place, Cannock, WS11 1BP	✓	✓			✓	✓	✓	✓	✓	✓	✓	
Well Pharmacy, 7 Devon Court, Bideford Way, Cannock, WS11 1NP	✓	✓			✓	✓	✓	✓		✓		
Well Pharmacy, 2 Festival Court, Pye Green Road, Hednesford, WS11 5RP	✓	✓			✓	✓	✓	✓	✓	✓		
Well Pharmacy, 62 Hednesford Street, Cannock, WS11 1DJ	✓	✓			✓	✓	✓	✓		✓		

	Medicines Use Review Service	New Medicine Service	Appliance Use Review Service	Stoma Appliance Customisation Service	Influenza Adult Vaccination Services	Common ailments	Emergency supply	Urinary tract infections and impetigo	Emergency hormonal contraception	Supervised consumption	Needle exchange	Palliative care
East Staffordshire												
All Saints Pharmacy, 28 All Saints Road, Burton upon Trent, DE14 3LS	✓						✓			✓		
Asda Pharmacy, The Octagon Centre, Orchard Street, Burton upon Trent, DE14 3TN	✓	✓			✓	✓	✓	✓	✓	✓		
Balance Street Pharmacy, Balance Street Health Centre, Balance Street, Uttoxeter, ST14 8JG	✓				✓	✓	✓	✓	✓	✓		
Boots The Chemist, 1 Cooper Square, Burton upon Trent, DE14 1DG	✓	✓			✓	✓			✓	✓		
Boots The Chemist, 6 High Street, Uttoxeter, ST14 7HT	✓	✓			✓	✓			✓	✓		
Branston Pharmacy, Main Street, Branston, Burton upon Trent, DE14 3EY	✓							✓				
Carlton Pharmacy, 118 Calais Road, Burton upon Trent, DE13 0UW	✓					✓			✓	✓		
Carters Pharmacy, Unit 2 , Carters Square, Uttoxeter, ST14 7FN	✓	✓								✓	✓	
Dean & Smedley , 67 Horninglow Street, Burton upon Trent, DE14 2PR	✓	✓			✓	✓	✓	✓	✓	✓		
Dean & Smedley , 16 High Street, Tutbury, Burton upon Trent, DE13 9LP	✓	✓			✓	✓	✓	✓	✓	✓		
Dean & Smedley , Unit 1 Main Street, Stretton, Burton upon Trent, DE13 0DZ	✓	✓			✓	✓	✓	✓	✓	✓		
Dean & Smedley , 35 - 36 St Peters Street, Stapenhill, Burton upon Trent, DE15 9AW	✓	✓			✓	✓	✓	✓	✓	✓		✓
Healthcare At Home Ltd, Fifth Avenue, Centrum 100, Burton upon Trent, DE14 2WS												
Lloyds Pharmacy, Instore Sainsbury's , Union Street, Burton upon Trent, DE14 1AA	✓	✓			✓	✓	✓	✓	✓	✓		
Manor Pharmacy, 14 Wetmore Road, Burton upon Trent, DE14 1SN	✓	✓			✓	✓	✓	✓	✓	✓		
Manor Pharmacy, 171 Calais Road, Burton upon Trent, DE13 0UN	✓	✓			✓	✓	✓	✓		✓		
Manor Pharmacy, 251 Branston Road, Burton upon Trent, DE14 3BT	✓	✓			✓	✓	✓	✓	✓	✓		
Morrisons Pharmacy, Morrisons Supermarket, Wellington Road, Burton upon Trent, DE14 2AR	✓	✓			✓	✓	✓	✓	✓	✓		
Peak Pharmacy, Melbourne Avenue, Winshill, Burton upon Trent, DE15 0EP	✓	✓			✓	✓	✓	✓	✓	✓		
Tesco Instore Pharmacy, Tesco Superstore, Brookside Road, Uttoxeter, ST14 8AU	✓	✓			✓		✓			✓		
Tesco Pharmacy, Tesco Superstore , St Peters Bridge, Burton upon Trent, DE14 3RJ	✓	✓			✓		✓		✓	✓		
Waterloo Pharmacy, 172 Waterloo Street, Burton upon Trent, DE14 2NQ	✓					✓				✓		
Well Pharmacy, Fyfield Road, Stapenhill, Burton upon Trent, DE15 9QD	✓	✓			✓	✓	✓	✓		✓		
Well Pharmacy, 52 - 54 Main Street, Barton under Needwood , Burton upon Trent, DE13 8AA	✓	✓			✓	✓	✓	✓		✓		
Lichfield												
Alrewas Pharmacy, Main Street, Alrewas, DE13 7AE	✓	✓			✓	✓	✓	✓	✓			
Boots The Chemist, Langton Medical Centre, Eastern Avenue, Lichfield, WS13 7FA	✓	✓				✓			✓	✓		
Boots The Chemist, 67 New Armitage Road, Armitage, Rugeley, WS15 4AA	✓	✓			✓	✓				✓		
Boots The Chemist, 4 - 8 Tamworth Street, Lichfield, WS13 6JJ	✓	✓			✓	✓			✓	✓		

	Medicines Use Review Service	New Medicine Service	Appliance Use Review Service	Stoma Appliance Customisation Service	Influenza Adult Vaccination Services	Common ailments	Emergency supply	Urinary tract infections and impetigo	Emergency hormonal contraception	Supervised consumption	Needle exchange	Palliative care
Boots The Chemist, c/o Waitrose Store, Stonnyland Drive, off Sainte Foy Avenue, Lichfield, WS13 6RX	✓	✓			✓	✓			✓	✓		
Chasetown Pharmacy, 23 High Street, Chasetown, WS7 3XE	✓	✓				✓	✓	✓	✓	✓	✓	
Co-op Pharmacy, 3 Boley Park Shopping Centre, Ryknild Street, Lichfield, WS14 9XU	✓	✓			✓	✓	✓	✓	✓	✓		
Co-op Pharmacy, Greenhill Health Centre , Church Street, Lichfield, WS13 6JL	✓	✓				✓	✓	✓	✓	✓	✓	✓
Day Night Pharmacy, Unit 4, Swan Island Shopping Precinct, Chase Road, Burntwood, WS7 0DW	✓	✓			✓	✓	✓		✓	✓		
Fazeley Pharmacy, 11 Coleshill Street, Fazeley, Tamworth, B78 3RB	✓					✓	✓		✓	✓		
Fradley Pharmacy, Unit 6, The Stirling Centre, Tye Lane, Fradley, Lichfield, WS13 8ST	✓	✓			✓	✓	✓	✓	✓			✓
Boots Pharmacy, St Chads Health Centre, Dimbles Lane, Lichfield, WS13 7HT	✓	✓				✓	✓	✓				
Boots Pharmacy, 7 Lichfield Road, Burntwood, WS7 0HH	✓	✓			✓	✓	✓	✓	✓	✓		✓
Lloyds Pharmacy, 4 Rugeley Road, Chase Terrace, Burntwood, WS7 1AQ	✓	✓		✓		✓	✓	✓	✓			
Lloyds Pharmacy, Unit 3, Burntwood Shopping Centre, Burntwood, WS7 1JR	✓	✓		✓	✓	✓	✓	✓	✓	✓		
M & J's Chemist, 10 Morley Road, Burntwood , Walsall, WS7 9AZ	✓	✓			✓	✓	✓		✓			
Shenstone Pharmacy, 33b Main Street, Shenstone, Lichfield, WS14 0LZ	✓						✓					
Tesco Pharmacy, Tesco Superstore, Church Street, Lichfield, WS13 6DZ	✓	✓			✓				✓	✓		
Whittington Pharmacy, 13b Main Street, Whittington , Lichfield , WS14 9JU	✓	✓					✓	✓	✓			
Newcastle-under-Lyme												
Asda Pharmacy, Asda Superstore, Wolstanton Retail Park, Wolstanton, Newcastle under Lyme, ST5 0AY	✓	✓			✓	✓	✓		✓			✓
Boots The Chemist, 60 - 62 High Street, Newcastle under Lyme, ST5 1QL	✓	✓			✓	✓			✓	✓		
Bradwell Pharmacy, 111 Hanbridge Avenue, Bradwell, Newcastle under Lyme, ST5 8HX	✓	✓					✓		✓	✓		✓
Butt Lane Pharmacy, 147 Congleton Road, Butt Lane, Kidsgrove, Stoke on Trent, ST7 1LL	✓				✓				✓	✓		
Cornwells Chemist, 5 - 9 High Street, Newcastle under Lyme, ST5 1RB	✓	✓			✓	✓	✓	✓	✓	✓		
Cornwells Chemist, 5 The Parade, Silverdale, ST5 6LQ	✓	✓				✓	✓	✓	✓	✓		
DIMEC Pharmacy, Unit 13-21 ICI, Keele University Science Park, Keele, ST5 5NB	✓											
Higherland Pharmacy, 3 Orme Road, Poolfields, Newcastle under Lyme, ST5 2UE	✓											
Hollowood Chemists Ltd, Kingsbridge House, Kingsbridge Avenue, Clayton, Newcastle under Lyme, ST5 3HP	✓				✓	✓	✓	✓		✓		
Inspire Pharmacy, Unit 10 , Croft Road Ind Estate, Newcastle under Lyme, ST5 0TW	✓											
Lloyds Pharmacy, 117 - 119 High Street, Wolstanton, Newcastle under Lyme, ST5 0EP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Lloyds Pharmacy, 42 Market Street, Kidsgrove, Stoke on Trent, ST7 4AB	✓	✓		✓		✓	✓	✓	✓	✓		
Lloyds Pharmacy, Ashfields New Road, Newcastle under Lyme, ST5 2AF	✓	✓				✓	✓	✓				
Lloyds Pharmacy, 1 - 2 High Street, Wolstanton, Newcastle under Lyme, ST5 0EP	✓	✓		✓		✓	✓	✓	✓			

	Medicines Use Review Service	New Medicine Service	Appliance Use Review Service	Stoma Appliance Customisation Service	Influenza Adult Vaccination Services	Common ailments	Emergency supply	Urinary tract infections and impetigo	Emergency hormonal contraception	Supervised consumption	Needle exchange	Palliative care
Lloyds Pharmacy, 7 The Westbury Centre, Westbury Road, Clayton, Newcastle under Lyme, ST5 4LY	✓	✓		✓	✓	✓	✓	✓	✓	✓		
Loggerheads Pharmacy, 9 Eccleshall Road, Loggerheads, Market Drayton, Shropshire, TF9 4NX	✓	✓				✓	✓					
Millers Chemist, Newcastle Road, Middle Madeley, Nr Crewe, Shropshire, CW3 9JP	✓	✓			✓	✓	✓	✓	✓			
Milwards (Chemist) Ltd, 65 Milehouse Lane, Cross Heath, Newcastle under Lyme, ST5 9JZ	✓	✓			✓	✓	✓	✓	✓	✓		
Morrells Pharmacy, Milehouse Primary Care Centre, Millrise Village, Lymebrook Way, Milehouse, Newcastle under Lyme, ST5 9GA	✓	✓			✓	✓	✓	✓	✓	✓		
Morrisons Pharmacy, Morrisons Supermarket, Goose Street, Newcastle under Lyme, ST5 3HY	✓	✓			✓	✓	✓	✓	✓			
Tesco Pharmacy, Liverpool Road East, Kidsgrove, ST7 1DX	✓	✓			✓		✓					✓
W S Low, 101 High Street, Wolstanton, Newcastle under Lyme, ST5 0EP	✓						✓		✓	✓		✓
Well Pharmacy, 21 - 23 London Road, Chesterton, Newcastle under Lyme, ST5 7EA	✓	✓			✓	✓	✓	✓	✓	✓		
Well Pharmacy, Jamage Road, Talke Pits, Stoke on Trent, ST7 1QD	✓	✓			✓	✓	✓	✓				
Well Pharmacy, London Road (Instore), Chesterton, Newcastle under Lyme, ST5 7DY	✓	✓			✓	✓	✓	✓	✓	✓		
Well Pharmacy, Mount Road, Kidsgrove, Stoke on Trent, ST7 4AY	✓	✓			✓	✓	✓	✓	✓	✓		
Well Pharmacy, 58 - 60 King Street, Newcastle under Lyme, ST5 1HX	✓	✓			✓	✓	✓	✓		✓		
Well Pharmacy, Audley Health Centre, Church Street, Audley, ST7 8EW	✓	✓			✓	✓	✓	✓	✓	✓		
Well Pharmacy, Unit 4, Student Building, Keele University Science Park, Newcastle under Lyme, ST5 5BG	✓	✓			✓	✓	✓	✓	✓			
South Staffordshire												
Bills Pharmacy, 29 High Street, Kinver, Stourbridge, DY7 6HF	✓	✓				✓						
Boots The Chemist, High Street, Wombourne, Wolverhampton, WV5 9DP	✓	✓			✓	✓						
Boots The Chemist, 5 - 6 Giggetty Lane, Wombourne, Wolverhampton, WV5 0AW	✓	✓			✓	✓			✓	✓		
Colliery Pharmacy, Colliers Way, Huntington, Cannock, WS12 4UD	✓	✓				✓	✓	✓	✓	✓		
Cornwells Chemists, 126 Wardles Lane, Great Wyrley, Walsall, WS6 6DZ	✓	✓			✓	✓	✓	✓	✓	✓		
Coven Pharmacy, 25 Brewood Road, Coven, Wolverhampton, WV9 5BX	✓				✓		✓		✓			
Hawthorne Chemist, Essington Community Centre, Hobnock Road, Essington, WV11 2RF	✓					✓	✓		✓	✓		
I-Meds Pharmacy, Kartar Farm, New Road, Swindon, South DY3 4PP												
Lloyds Pharmacy, Broadgate House, 6 Market Place, Brewood, ST19 9BS	✓	✓			✓	✓	✓	✓	✓			
Lloyds Pharmacy, 8 Bilbrook Road, Codsall, Wolverhampton, WV8 1EZ	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Lloyds Pharmacy, 2 - 3 Anders Square, Perton, Wolverhampton, WV6 7QH	✓	✓		✓	✓	✓	✓	✓	✓	✓		
Lloyds Pharmacy, 86 Wolverhampton Road, Codsall, Wolverhampton, WV8 1PE	✓	✓		✓	✓	✓	✓	✓	✓			
Lloyds Pharmacy, Irvine House, 9 - 11 Church Road, Codsall, Wolverhampton, WV8 1EA	✓	✓		✓	✓	✓	✓	✓	✓			

	Medicines Use Review Service	New Medicine Service	Appliance Use Review Service	Stoma Appliance Customisation Service	Influenza Adult Vaccination Services	Common ailments	Emergency supply	Urinary tract infections and impetigo	Emergency hormonal contraception	Supervised consumption	Needle exchange	Palliative care
Millstream Pharmacy, The Avenue, Featherstone, Wolverhampton, WV10 7AX	✓				✓	✓	✓	✓	✓	✓		
Northwood Dispensing Chemists, Pinfold Lane, Penkridge, Stafford, ST19 5AP	✓	✓			✓	✓	✓	✓	✓	✓		
Pattingham Pharmacy, 1 Meadow View, High Street, Pattingham, Wolverhampton, WV6 7BD												
Stevensons Chemists, 3 High Street, Cheslyn Hay, Walsall, WS6 7AB	✓	✓			✓	✓						
Wheaton Aston Pharmacy, 36 High Street, Wheaton Aston, ST19 9NP	✓						✓			✓		
Whitehouse Pharmacy, Market Street, Penkridge, Stafford, ST19 5DH	✓					✓	✓	✓	✓	✓		✓
Wombourne Pharmacy, 45a Planks Lane, Wombourne, Wolverhampton, WV5 8DX	✓								✓			
Stafford												
Asda Pharmacy, Asda Superstore, Queensway, Stafford, ST16 3TA	✓				✓	✓			✓	✓		
Birchill & Watson , 16 High Street, Stone, Stafford, ST15 8AW	✓	✓			✓	✓	✓	✓	✓			
Boots The Chemist, Queen's Retail Park, Silkmore Lane, Stafford, ST17 4SU	✓	✓			✓	✓			✓	✓		
Boots The Chemist, 10 - 14 Market Square, Stafford, ST16 2BD	✓	✓			✓	✓			✓	✓		
Boots The Chemist, 18 - 20 High Street, Stone, Stafford, ST15 8AW	✓	✓			✓	✓			✓	✓		
Cornwells Chemists, Holmcroft Road, Stafford, ST16 1JG	✓	✓			✓	✓	✓	✓	✓	✓		
Cornwells Chemists, 51 Bodmin Avenue, Weeping Cross, Stafford, ST17 0EF	✓	✓			✓	✓	✓	✓	✓	✓		
Cornwells Chemists, Weston Road, Stafford, ST18 0BF	✓	✓			✓	✓	✓	✓	✓	✓		
Eccleshall Pharmacy, 8 High Street, Eccleshall, Stafford, ST21 6BZ	✓	✓			✓	✓	✓	✓	✓	✓		
Gnosall Pharmacy, Gnosall Health Centre, Brookhouse Road, Gnosall, Stafford, ST20 0GP												
Haywood Pharmacy , 3 Trent Close, Great Haywood, Stafford, ST18 0SS	✓	✓				✓	✓	✓	✓	✓		
Kitsons Chemist, 8 Orchard Place, Barlaston, Stoke on Trent, ST12 9DL												
Lloyds Pharmacy, 9 -10 Burton Square, Rising Brook, Stafford, ST17 9LT	✓	✓		✓		✓	✓	✓	✓	✓		
Lloyds Pharmacy, Millbank Surgery, Millbank, Stafford, ST16 2AG	✓	✓		✓		✓	✓	✓	✓	✓		
Lloyds Pharmacy, Chell Road, Stafford, ST16 2TF	✓	✓			✓	✓	✓	✓	✓	✓		
Rowlands Pharmacy, 161 Marston Road, Stafford, ST16 3BS	✓	✓		✓	✓	✓	✓	✓	✓	✓		
Stafford Health and Wellbeing Pharmacy, Whitgreave Court, Stafford, ST16 3EB	✓	✓				✓			✓	✓		
Stone Pharmacy, 5 - 7 High Street, Stone, Stafford, ST15 8AJ	✓	✓			✓	✓	✓	✓		✓		
Superdrug Pharmacy , 18 Greengate Street, Stafford, ST16 2HS	✓	✓			✓	✓	✓	✓	✓	✓		
Tesco Instore Pharmacy, Newport Road, Stafford, ST16 2HE	✓	✓			✓				✓	✓		
Walton Pharmacy, 46 Eccleshall Road, Walton, Stone, ST15 0HN	✓	✓			✓	✓	✓	✓	✓	✓		
Well Pharmacy, Castle Way, Newport Road, Stafford, ST16 1BS	✓	✓			✓	✓	✓	✓	✓			

	Medicines Use Review Service	New Medicine Service	Appliance Use Review Service	Stoma Appliance Customisation Service	Influenza Adult Vaccination Services	Common ailments	Emergency supply	Urinary tract infections and impetigo	Emergency hormonal contraception	Supervised consumption	Needle exchange	Palliative care
Well Pharmacy, Burton Square, Rising Brook, Stafford, ST17 9LT	✓	✓			✓	✓	✓	✓	✓	✓		
Well Pharmacy, 128 West Way, Highfields, Stafford, ST17 9YF	✓	✓			✓	✓	✓	✓	✓	✓		
Weston Road Pharmacy, 65 Weston Road, Stafford, ST16 3RL	✓	✓			✓	✓	✓	✓	✓	✓		
Wildwood Pharmacy, The Co-operative Centre, Cannock Road, Stafford, ST17 4RA	✓	✓			✓		✓					
Wolverhampton Road Pharmacy, 112 Wolverhampton Road, Stafford, ST17 4AH	✓	✓						✓		✓		
Staffordshire Moorlands												
Blythe Bridge Pharmacy, 240 Uttoxeter Road, Blythe Bridge, ST11 9LY	✓				✓	✓	✓	✓	✓	✓		
Boots The Chemist, 13 Derby Street, Leek, ST13 6HT	✓	✓			✓	✓				✓		
Boots The Chemist, 47 High Street, Cheadle, ST10 1AR	✓	✓			✓	✓			✓	✓		
D McMullen Pharmacy, Alder House, 22 Station Road, Endon, Stoke on Trent, ST9 9DR	✓	✓				✓	✓					
Leek Pharmacy, 55 Queen's Drive, Leek, ST13 6QF	✓	✓			✓	✓		✓	✓	✓		
Lloyds Pharmacy, Churnet Works, Macclesfield Road, Leek, ST13 8YG	✓	✓				✓	✓	✓	✓			
Lloyds Pharmacy, 15 Fountain Street, Leek, ST13 6JS	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Lloyds Pharmacy, The New Pharmacy Unit, Park Medical Centre, Buxton Road, Leek, ST13 6QR	✓	✓		✓	✓	✓	✓	✓	✓	✓		
Rodlers Chemist, 165 Cheadle Road, Cheddleton, Stoke on Trent, ST13 7HN	✓				✓	✓	✓	✓				
Ratcliffe Pharmacy, 42 Ashbourne Road, Cheadle, ST10 1HQ	✓	✓			✓	✓	✓	✓				
Ratcliffe Pharmacy, 44a High Street, Cheadle, ST10 1AF	✓	✓			✓	✓	✓	✓	✓	✓		
Tean Pharmacy, 19 High Street, Tean, ST10 4DY	✓											
Well Pharmacy, 16 - 18 Ball Haye Street, Leek, ST13 6JW	✓	✓			✓	✓	✓	✓				
Well Pharmacy, Biddulph Primary Care Centre, Wharf Road, Biddulph, Stoke on Trent, ST8 6AG	✓	✓			✓	✓	✓	✓	✓	✓		
Well Pharmacy, 62 High Street, Biddulph, Stoke on Trent, ST8 6AS	✓	✓			✓	✓	✓	✓		✓		
Well Pharmacy, 46 - 48 Derby Street, Leek, ST13 5AJ	✓				✓	✓	✓	✓	✓			
Well Pharmacy, 396 New Street, Biddulph Moor, Stoke on Trent, ST8 7LR	✓	✓			✓	✓	✓	✓	✓			
Well Street Pharmacy, Well Street, Biddulph, ST8 6EZ	✓					✓			✓			
Werrington Pharmacy, 339 Ash Bank Road, Werrington, Stoke on Trent, ST9 0JS	✓	✓			✓	✓	✓	✓	✓			✓
Tamworth												
Aldergate Pharmacy, 75 Upper Gungate, Tamworth, B79 8AX		✓										
Asda Pharmacy, Asda Superstore, Ventura Park, Tamworth, B78 3HB	✓	✓				✓	✓		✓	✓		
Boots The Chemist, Unit A, Ventura Retail Park, Tamworth, B77 1EA	✓	✓			✓	✓			✓			
Boots The Chemist, 18 - 24 Ankerside, Tamworth, B79 7LQ	✓	✓			✓	✓				✓		

	Medicines Use Review Service	New Medicine Service	Appliance Use Review Service	Stoma Appliance Customisation Service	Influenza Adult Vaccination Services	Common ailments	Emergency supply	Urinary tract infections and impetigo	Emergency hormonal contraception	Supervised consumption	Needle exchange	Palliative care
Claire Healthcare Ltd, 146 Masefield Drive, Leyfields, Tamworth, B79 8JA	✓								✓	✓		
Click 2 Chemist, Unit 14, Sovereign Centre, Neander, Tamworth, B79 7XA	✓	✓										
Dosthill Pharmacy, GP Surgery, Cadogan Road, Dosthill, Tamworth, B77 1PQ	✓	✓				✓		✓	✓			
Eason Pharmacy, 215a Watling Street, Wilnecote , Tamworth, B77 5BB	✓	✓			✓	✓	✓	✓	✓	✓		✓
Exley Pharmacy, Unit 4, Exley Centre, Belgrave, Tamworth, B77 2LA	✓				✓	✓		✓	✓	✓		
Lloyds Pharmacy, In Store Sainsbury's Superstore, Bonehill Road, Tamworth, B78 3HD	✓	✓			✓	✓	✓	✓	✓			
Magrath Pharmacy, 68 Caledonian, Glascote , Tamworth, B77 2ED	✓					✓	✓		✓	✓		
POP Direct (online), 30 Hospital Street, Tamworth , B79 7EB	✓											
Peak Pharmacy, 266 Tamworth Road, Amington , Tamworth , B77 3DQ	✓	✓			✓	✓	✓	✓	✓	✓		✓
Peel Court Pharmacy, 2 Aldergate, Tamworth, B79 7DJ	✓					✓	✓	✓				
Prescription Care Services, Mariner House, Lichfield Road Industrial Estate, Tamworth , B79 7UL												
Primary Care Pharmacy, 30 Hospital Street, Tamworth , B79 7EB	✓	✓			✓		✓	✓	✓	✓	✓	
Rowlands Pharmacy, 54 Albert Road, Tamworth, B79 7JN	✓	✓		✓		✓	✓	✓	✓			
Stonydelph Pharmacy, 29 Ellerbeck, Stonydelph, Tamworth, B77 4JA	✓	✓			✓	✓			✓	✓		
Well Pharmacy, 1 - 5 Church Street, Tamworth, B79 7DH	✓	✓			✓	✓	✓	✓	✓			

Staffordshire Health and Wellbeing Board	
Title	Strategic collaboration between Burton Hospitals NHS Foundation Trust and Derby Teaching Hospitals NHS Foundation Trust
Date	07/09/2017
Board Sponsor	Dr Charles Pidsley
Author	Burton Hospitals NHS Foundation Trust
Report type	For Debate

Summary

1. The boards of Burton Hospitals NHS Foundation Trust and Derby Teaching Hospitals NHS Foundation Trust have now approved an Outline Business Case for a proposed merger between the two organisations.

2. The Outline Business Case which the Boards of both Trusts have now approved is the product of an intensive programme of work delivered in partnership to set out a vision for how the two organisations can bring the best together for patients and staff.

3. The focus lies in building a partnership of equals that will provide sustainable hospital services for patients and their families. Together the Trusts are passionate about providing quality services that are better, safer and conveniently accessible for local people and that offer opportunities for our staff to develop and thrive in their careers.

4. For Burton Hospitals, this will be a partnership founded on the principle of retaining a vibrant district general hospital in Burton, which includes A&E, and with a commitment to keep improving those services in Burton.

5. For Derby Hospitals, the proposed collaboration means access to a wider population base, enabling the organisation to sustain and expand specialist services, such as cancer surgery and spinal services, with clear benefits to local people across Derbyshire and Staffordshire.

6. For the community hospitals in Lichfield and Tamworth and London Road, Derby, the Trusts want to maximise their use by making them a focus for the new models of care which are centred on the local “place” people live, which are being developed as part of the Sustainability and Transformation Plans in Derbyshire and Staffordshire.

7. This is not just about clinical care – although commitment to patients remains paramount – this partnership also offers opportunities to develop shared corporate and non-clinical services into a high quality offer that brings the best of Burton’s and Derby’s skills together to support clinicians in delivering the very best in care.

8. Burton Hospitals is a full member of the Staffordshire and Stoke-on-Trent STP and, as such, the Chief Executive, Helen Scott-South, sits on the Health and Care Transformation Board that oversees the STP from a strategic perspective. Helen also acts as SRO for the Urgent and Emergency Care workstream of the STP, leading county-wide efforts to reduce reliance on acute sector emergency activity. As such, we consider ourselves fully embedded within the leadership of the Staffordshire and Stoke-on-Trent STP and with strong links to partners across the county footprint.

9. The matter of the proposed merger with Derby Teaching Hospitals is one that has been discussed many times within the STP Executive Forum, although these is not consensus or agreement from all STP partners in support of the proposed merger. However, the commissioners from both Southern Derbyshire and East Staffordshire CCGs have been clear regarding their support for the proposed merger. The Trust's view is that there are benefits for Staffordshire of a) acting to secure sustainable clinical services at Burton and b) providing opportunities for residents of Lichfield and Tamworth to benefit from specialist outpatient and day case services by merging formally with Derby (and therefore helping to also repatriate work to Staffordshire from outside of county, i.e. from Birmingham). The Trusts believe that the goals of the proposed merger are consistent with the aims of the STP and share a common vision of reducing acute sector activity and supporting people with place-based care. The quality and financial benefits to the STP have not yet been fully quantified, however, the savings achieved from the merger will help to reduce the financial challenge in both Staffordshire and Derbyshire STPs.

10. The Trusts believe the proposed merger to be a necessary enabler for the clinical sustainability of core services in East and Southern Staffordshire, which will benefit the county as a whole. The STP does not currently advocate a move to a single Acute Provider for the county of Staffordshire and that given the geographical spread of patient flows across a large county, that model would not be the most appropriate. Therefore, the Trusts view the proposed merger as a sensible option for ensuring the sustainability of services at Burton, and which would enable the STP to execute its vision for transformation of local health care into a place-based approach.

11. The partnership between Burton Hospitals and Derby Teaching Hospitals is a long-standing one, due to the meaningful proximity of Derby to our core population in Burton and it should be noted that there are already existing joint services in place which benefit the Staffordshire population, such as Breast Surgery, Oncology and Maxillo-Facial Surgery. The Trusts are committed to extending these patient benefits as part of the proposed merger, yet at the same time, this does not preclude them from continuing with partner working across the county, and their links with SSOTP and SSSFT for community and mental health, as well as pursuing the common goals of the STP.

12. The creation of three Alliance Boards across the county is a move that the Trusts are supportive of and hope will be an enabler for the local implementation and delivery of the STP as it empowers providers to work together for the common

good and towards a collective vision of place-based care. This is not dependent on changes to organisational form.

Recommendations to the Board

13. To note the continued commitment and progress being made towards the proposed merger and the Trusts' commitment to the goals of the Staffordshire STP.

Background / Introduction

14. A closer collaboration would help to retain a vibrant district general hospital in Burton, including A&E, secure specialist services in Derby for a wider population, and ensure appropriate and relevant use of our community hospitals facilities.

15. Both Trusts are facing a number of challenges relating to staff, sustainability of some clinical services and finances. The proposed merger would mean that both Trusts would be able to make some savings through sharing good practice, removing duplication and reorganising and developing certain services. The key aims are to improve the quality of the care we offer patients, and to improve the health of our local populations by dealing effectively with the challenges the Trusts face on a daily basis.

16. For Queen's Hospital in Burton, the fundamental principle is to retain a vibrant district general hospital in the town, keeping and improving the core services we offer as part of that, including our A&E. In Lichfield and Tamworth, there will be an opportunity for our community hospitals facilities to offer some different services that are more relevant locally. These services will result in us working more closely than ever with our local GPs. There is not yet a shared view on the role of these community hospitals between Burton Hospitals NHS Foundation Trust, the CCGs and other STP partners, however the development of these community hospitals as a hub for locally developed 'place-based' care, as well as an enabler for the repatriation of Staffordshire patients and resources is a key part of the merger proposal.

17. We firmly believe that by working together we can ensure a strong future for local healthcare. Both Trusts are passionate about providing quality services locally. We are entering into this partnership as true equals and hope to bring the best of the two Trusts to a wider population across East and South Staffordshire and Southern Derbyshire and Derby. Together, we are exploring how we deliver corporate services efficiently, effectively and at scale, freeing up more money for front-line patient care, whilst ensuring high quality support services.

Current activity

18. A robust and continuing programme of stakeholder engagement has been set out across Staffordshire and Derbyshire, which was initiated in August 2016 at the start of the formal collaboration discussions and ahead of the production of the Strategic Outline Case for a proposed partnership between the two Trusts.

19. This programme has involved Committees at County and District/Borough level, as well as CCG governing body meetings and local MPs, amongst others. The Trusts recently presented at the Health Select Committee as part of this programme and took away valuable feedback which will be considered as they develop plans further, as will feedback from other stakeholder, patient, public and staff engagement activities that are being implemented as part of this programme of work and as part of their joint commitment to open dialogue and transparency.

20. The Trusts have also engaged heavily with Healthwatch Staffordshire, Derby and Derbyshire, and are working with them collaboratively on a number of public and patient engagement events and activities. These bodies sit on the Patient Reference Steering Group, which was convened to ensure the patient voice was included in discussions and in shaping the future, and the Trusts are also working closely with Healthwatch Staffordshire as part of the formal engagement workstream for the Staffordshire and Stoke-on-Trent STP. The Trusts recently presented to the Healthwatch Staffordshire public Annual General Meeting, held in Burton on 4 July 2017, and again, took away many pieces of valuable feedback and insight from the public about the plans for the merger, which will be considered as we move forward. The Trusts will continue with an inclusive engagement approach throughout the life of this project.

Options & Issues

21. Neither Trust is financially sustainable on its own. Some general services at Burton Hospitals NHS Foundation Trust are not clinically sustainable and some specialist services at Derby Teaching Hospitals NHS Foundation Trust do not have a sufficiently large catchment population to make them secure under current specialised commissioner criteria.

22. The two Trusts have considered the options for securing their future sustainability and believe that a formal strategic collaboration between the two Trusts, in the form of a merger, is likely to be the best way to address their specific sustainability challenges, and enable them to continue to provide a full range of services for their local populations.
23. A Full Business Case will now be developed, with engagement and input from staff, governors, patients and the public, over the coming months. The Full Business Case will then be considered by both Trust boards in late autumn 2017.

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

24. To ensure the Health and Wellbeing Board remains fully briefed and involved in the ongoing development and delivery of the proposed merger.

Staffordshire Health and Wellbeing Board	
Title:	Families Strategic Partnership Highlight Report
Date:	7 September 2017
Board Member:	**Helen Riley,** Chair of the Families Strategic Partnership Board and Deputy Chief Executive and Director of Families and Communities, Staffordshire County Council **Glynn Luznyj,** Vice-Chair of the Families Strategic Partnership Board, Director of Prevent and Protect, Staffordshire Fire and Rescue Service
Authors:	**Mick Harrison,** Chair of the Families Partnership Executive Group and Commissioner for Safety Children and Families, Staffordshire County Council **Alex Birch,** Vice Chair of the Families Partnership Executive Group and Senior Commissioning Manager for Maternity and Children's Services, Clinical Commissioning Group Members of the **Families Strategic Partnership Board (FSPB)** and **Families Partnership Executive Group (FPEG)** have contributed to the contents of the report
Report Type:	For Debate

1. Introduction

1.1. The report provides an overview of activity undertaken by the Families Strategic Partnership Board (FSPB) and supported by the Families Partnership Executive Group (FPEG). The partnership is aiming to deliver sustainable long-term solutions to effectively manage demand of services and ensure help is provided at the earliest opportunity.

2. Recommendation

2.1. The Health and Wellbeing Board note the contents of the report.

2.2. The Health and Wellbeing Board support and endorse the work undertaken by the FSPB and FPEG, and endorse the direction of travel of partnership activity undertaken within the FSP (see Section 3).

2.3. The Health and Wellbeing Board approve the delivery plan and outcomes framework detailed in Appendix 1 and 2.

2.4. The Health and Wellbeing Board endorse that Mental Health and Wellbeing (across the life course) is identified as the priority area to undertake further in-depth research that support (including access to information) will be required across all the key stakeholders (providers, commissioners and key partnership forums). Section 5 details the rationale for the in-depth research to focus on the lower end of the spectrum and centre on root cause (e.g. social isolation, health, debt).

2.5. The Health and Wellbeing Board acknowledge that the successful delivery of the initiatives delivered below require the 'whole family' approach from the

majority of initiatives the Health and Wellbeing Board has oversight over, for example, Sustainability Transformation Plans (STPs). No matter whether the needs are identified initially through children or adults services, agencies need to work together to provide effective holistic support.

3. FPEG Workstream Activities

3.1. Early Help Strategy Implementation

3.1.1. Following the proposed development of the Place-Based Approach, the Early Help Strategy Implementation Group have revised the implementation plan that is also aligned to the DCLG Troubled Families Transformation Maturity Model Self Assessment.

3.1.2. The Staffordshire Safeguarding Children Board (SSCB) Early Help Strategy has been updated to reflect Earliest Help and is more in line with the Children and Families System direction of travel. The strategy now further encourages partners to work together to provide support at the earliest stage rather than waiting for needs to escalate to meet a formal threshold. The revised strategy can be viewed on the following page: https://www.staffsscb.org.uk/Professionals/Staffordshire-Early-Help-Strategy/Staffordshire-Early-Help-Strategy.aspx

3.1.3. Discussions are taking place with the SSCB to undertake a joint Early Help campaign to further embed the principles of Earliest Help and Early Help across Staffordshire.

3.1.4. Organisations across the FSP are continuing to develop their own response to Earliest Help and Early Help in line with the SSCB Early Help Strategy. The Early Help Steering Group is looking to recognise this valuable work through appropriate reporting mechanisms. The Steering Group are developing a performance framework to monitor progress. On completion, the FSP outcomes framework will be reviewed to ensure it is appropriately monitoring the Early Help activity.

3.1.5. The work undertaken by this workstream is closely aligned to the Place Based Approach (PBA) and we will be looking to accelerate a range of activities undertaken by this workstream in Newcastle-under-Lyme and Tamworth (PBA Pilot Areas). Both Early Help and PBA would seek to shape communities to be self-sufficient and resilient and where needs arise, support would swiftly be deployed to avoid (where applicable) escalation to higher tier services. It has been recognised that support does not necessarily have to be a public sector service, it includes digital responses (e.g. self-help tools) and communities as well as families. In addition, businesses have a 'social value' role to play in supporting local communities.

3.2. Building Resilient Families and Communities (BRFC)

3.2.1. The DCLG target for Staffordshire in 2015 to 2020 is 4680 families. So far Staffordshire has supported the following:
Year 1: 1075 families
Year 2: 1414 families (DCLG target was 1370)

Year 3: The target is 1160 and 612 families have been identified.

3.2.2. To date Phase 2 of identified families have received a total of 3101 interventions. The cumulative total, to date, for successful Payment by Results (PbR) Claims in Phase 2 is 453, with 402 of those being made in 2016/2017. An estimate of a further 608 successful claims to be made by 30th September 2017 has been given to DCLG.

3.2.3. Staffordshire County Council currently deliver and commission Family Support Work through three different sources:

- Local Support Teams;
- Building Resilient Families and Communities Accreditation Scheme; and
- Children's Centre Family Support.

3.2.4. As part of the children's transformation the latter two areas have been looking to bring together these two programmes to deliver a district based family support service, which would be provided through a countywide framework with district based providers. The intention is for this contract to go out to market in 2018.

3.2.5. The BRFC Family Intervention Projects (FIPs) are District/Borough multi-agency teams that work intensively with identified BRFC families on the cusp of care, adopting a whole-family approach to their support. The FIPs are showing evidence of preventing families entering higher tier services.

3.2.6. DCLG visited 16th May to further develop their understanding of the current BRFC delivery model and to advise on the opportunities in the mainstreaming of the programme into the Children and Families System Transformation.

3.2.7. In addition, Staffordshire is one of six local authorities that have been asked to participate in a peer review of the implementation and assessment of the transformation Matrix. The pilot will inform the peer review process that will be rolled out to support all areas with their assessments and continued progress across the maturity model.

3.3. **Children and Families Voice**

3.3.1. A mapping exercise is underway to understand the current mechanisms in place that seek views, opinions and experiences of children, young people and families in Staffordshire.

3.3.2. The outcome of the mapping exercise will inform the development of the Children and Families Voice Strategy and Delivery Plan. A multi-agency Strategic Children and Families Network, led by SCVYS, will oversee the delivery of the strategy and delivery plan. On completion, the FSP delivery plan will be reviewed to ensure it is appropriately reflects the Children and Families Voice activity.

3.4. **Hidden Harm/Neglect**

3.4.1. In an analysis of 139 serious case reviews, between 2009-2011 (Brandon et al 2012), – investigations showed that in over three quarters incidents (86%) where children were seriously harmed or died one or more of a “toxic trio” – mental illness, substance misuse and domestic abuse – played a significant part. These have all been identified as common features of families where harm to women and children occurs.

3.4.2. Work in this area has shown that there is large overlap between these parental risk factors and impact on outcomes for children into adulthood through the research into Adverse Childhood Experiences (ACE).

3.4.3. It is vital for services that support adults who have access to children to ensure that children’s basic needs are being met at the earliest opportunity. Should there be any concern about a child’s welfare, adults and children’s services must work together to ensure children are being effectively supported as the adults receive help. The Health and Wellbeing Board have a role to play to ensure the children’s voice is not being lost in the system.

3.4.4. It has been agreed in April 2017 that following a handover from the current chair, the SSCB will work alongside FPEG to establish a way forward with the Hidden Harm agenda. One of the key actions is to update the SSCB Neglect Strategy to cover Hidden Harm so we have one strategic document in place. This will also help to strengthen reporting arrangements to the SSCB from those agencies responsible for services supporting parents with substance misuse, mental ill health and domestic abuse.

3.4.5. The SSCB is currently receiving focused updates against the current Neglect Strategy. The focus during the last SSCB meeting was substance misuse, this is also a key theme in the Hidden Harm agenda. Since the Alcohol and Drug Executive Board (ADEB) was formed in 2012, the single area where greatest progress has been made has been child safeguarding, key issues include:

- The integrated One Recovery contract, which commenced in July 2014, replaced 35 contracts with 15 different treatment providers. This new treatment pathway simplified and strengthened the relationship between children’s services and drug/alcohol services, making referrals in both directions and joint working much easier.
- ADEB also monitors the number of children subject to child protection plans as one of the Board’s key performance metrics, which ensures that safeguarding is now prioritised strategically alongside health and offending as one the three main outcome areas.
- This prioritisation led to the formation of the Integrated Family Support Service (IFSS) which specifically targets families on the edge of the care system where parental drug/alcohol use is a key risk factor. IFSS has been operating since April 2016 and appears to be delivering highly encouraging results. So far 91 families with 194 children have completed the programme; of which 165 (85%) have remained united with their families.
- There are plans to expand the service to also work with families of Children In Need – a social impact bond application has been submitted to Cabinet Office and the first two stages of the process have been

successfully achieved, resulting in a development grant of £35k to help further compile the new operational and financial model. The full application has now been successfully confirmed with Department for Digital, Culture, Media and Sport (who have taken over responsibility from Cabinet Office) and outcome payments of £1.89m have been agreed in principle over 7 years. However, agreement has still yet to be reached with a social investor – the outcome of this process is likely to be known around October 2017.

- Despite significant reductions to the drug/alcohol budget in 2016/17, funding for the specialist young people's service has been wholly maintained.

3.4.6. The SSCB will continue to receive updates from focus areas, such as Domestic Abuse and Mental Health. As there are a number of overlaps with the Hidden Harm and Neglect agenda, the SSCB and FPEG will work together to establish the appropriate way forward to deliver the neglect / hidden harm work whilst also reducing duplication of conversations and activities in the partnership arena. As the SSCB lead on the Neglect strategy, the decision-making on neglect / hidden harm will remain with the SSCB.

3.5. Integrated Commissioning

3.5.1. An evaluation of existing Integrated Commissioning arrangements have evidenced areas of good practice that have happened organically, usually when individuals/organisations have identified opportunities to collaborate to deliver improved outcomes as well as achieve value for money (for example, Domestic Abuse, and Child Sexual Abuse and Missing).

3.5.2. Following the approval of the Delivery Plan and Outcomes Framework (see Section 4), work will commence to review the document and identify potential opportunities to integrate commissioning activity going forward.

3.5.3. One to one sessions have commenced across the partnership with Staffordshire County Council, Stoke City Council, Office of the Police and Crime Commissioner and Clinical Commissioning Groups to agree mechanisms to evaluate good practice above and agreed methods of working together in future. Opportunities will be explored and more alignment will be made to other transformation work including Children's System Transformation and CAMHS Transformation.

3.6. Placed Based Approach

3.6.1. A separate report has been produced for the Health and Wellbeing to review during the September 2017 meeting.

3.7. Personal, Social, Health and Economic (PSHE) Education

3.7.1. The Office of the Police and Crime Commissioner (OPCC) are working with partners to co-ordinate PSHE support pan-Staffordshire (including Stoke-on-Trent). The initial phase of the work will focus on Staffordshire.

3.7.2. There is a recognition that there is a gap in the co-ordination and delivery of PSHE particularly around vulnerable areas, such as Child Sexual Exploitation. There are some areas of good practices but delivery is ad hoc.

3.7.3. The following steps will be undertaken to take this work forward.

- The OPCC will identify a lead organisation to co-ordinate this work area and engage with partners. The lead organisation will engage with schools on the proposed project scope and assess the appetite for and type of support required. Following engagement, the lead organisation will produce an 'offer of support' for schools.
- To ensure the most is made of existing funding in relation to prevention, the OPCC and lead organisation will continue to work with Staffordshire Youth Offending Service (YOS) and Staffordshire Fire and Rescue Service (FARS).
- The OPCC will provide financial assistance to the lead organisation to enable the recruitment of a dedicated member of staff to undertake this work with schools.
- The lead organisation will develop an action plan for this work and seek approval from FPEG.
- Although overall governance for this work area will sit with the FPEG, information will be provided, at regular intervals, to the SSCB.

3.8. Children and Young People's Emotional Health and Wellbeing

3.8.1. In order to deliver the Mental Health Five Year Forward View priorities, the FSP have agreed to the following proposals:

- Producing a single plan to 2021 that will cover both north and south Staffordshire delivery and align plans as much as possible. The plan should:
  - meet the requirements for the CAMHS Local Transformation Plan and the children and young people's emotional health and wellbeing strategy.
  - Incorporate consideration of Thrive model but recognising that there are challenges to commissioning and delivery based on this model.

3.8.2. Further updates will be delivered at the FSPB and FPEG as this work progresses.

4. Outcomes Framework and Delivery Plan

4.1. A Delivery Plan and Outcomes Framework has been produced to provide a mechanism to monitor the delivery of the Staffordshire's Children, Young People and Families Strategy 2016 – 2026 (www.staffordshire.gov.uk/fsp).

4.2. Following discussions at both the FSPB and FPEG, further work was undertaken to ensure there is a golden thread between the strategy and the delivery plan and outcomes framework.

4.3. During the FSP workshop in March 2017, partners reviewed the Joint Strategic Needs Assessment (JSNA) and agreed that the priorities in the strategy are still relevant.

4.4. In addition to the discussions detailed above, the following key stakeholders were consulted with to inform the development on the documents: Delivery Plan leads, teams that collect key information (Insight Team and Families First Performance Team) and FSP representatives that offered to provide support.

4.5. The Health and Wellbeing Board are asked to review and approve the delivery plan and outcomes framework detailed in Appendix 1 and 2.

5. Joint Strategic Needs Assessment (JSNA) Prioritisation Exercise

5.1. Following the production of the JSNA in April 2017 (https://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx), the Insight Team undertook a prioritisation exercise based on the H&WBB outcome indicator prioritisation method based on JSNA information. There was a recognition that information across the full set on indicators was not available, e.g. children's views, strength of the evidence for intervention, return on investment, etc.

5.2. The following themes were identified as top priority for Staffordshire:

1. Reducing number of children living in low income families
2. Mental health and wellbeing (across the life course)
3. Domestic abuse
4. Education
5. Demand on hospital and social care
6. Infant mortality
7. Risky lifestyles behaviours
8. Children with special education needs or disability

5.3. Out of the top three areas identified by Staffordshire County Council Insight Team, research is underway by the Local Enterprise Partnership (LEP) to address child poverty (priority 1) and an in-depth research report has been produced on Domestic Abuse (priority 3) for the Office of the Police and Crime Commissioner (OPCC). No in-depth multi-agency research has taken place for Mental Health and Wellbeing Being (across the life course) (priority 2). Research on mental health could be beneficial to many partnership forums (for example, the Staffordshire Safeguarding Children Board (SSCB) are looking at Parental Mental Ill Health as part of the Neglect Strategy).

5.4. The FSPB have requested that as the Clinical Commissioning Groups (CCGs) are leading a piece of work that is looking at acute mental health, that the focus of the in-depth research on mental health will be on the lower end of the spectrum and centre on root cause (e.g. social isolation, health, debt).

5.5. Following the production of the Sustainability Transformation Plans (STP) profiles, the Insight Team will analyse these documents and compare with

the list above to identify common areas. Findings will be discussed at the FPEG and FSPB.

6. Communications Update

6.1. Improved information flow is the foundation of supporting the children's workforce to understand the changes being made and then advocating/engaging with the change.

6.2. Recognising that resources within communications teams are overstretched, it has been agreed that in the short-term, that the county council co-ordinate electronic partnership updates on a quarterly basis to enable the FPEG (virtually) and FSPB to approve key messages. Contents will be created by communications teams colleagues across the partnership and will be hosted on webpages owned by relevant partner organisations.

6.3. Further discussions are currently underway with communication representatives across the partnership to agree the process of how this will work in practice.

6.4. Further conversations are required with communications teams to understand if/how communications fits with the local STP.

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Appendix 1: Family Strategic Partnership Strategy – Delivery Plan

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
Voices 1 Children Young People & Families Voices	Establish a multi-agency Strategic Children & Families Voice Network, led by SCVYS, to oversee the work stream and underpin future work in relation to Children & Families Voice on behalf of the Families Strategic Partnership.	• Organisations across the Families Strategic Partnership have a coordinated and targeted approach to Children & Families Voice, ensuring that engagement is not duplicated and thereby maximising efficiencies. • The priorities of the Families Strategic Partnership are reflective of the views, opinions and experiences of children, young people and families and there are effective mechanisms for ensuring such insight is actively used across the partnership to improve outcomes.	Phil Pusey	Children & Families Voice Strategic Network	Established in April 2017
Voices 2 Children Young People & Families Voices	Undertake a mapping exercise across the Families Strategic Partnership in order to develop a deeper understanding of mechanisms currently in existence for seeking the views, opinions and experiences of children, young people and families in Staffordshire in addition to identifying insight currently accessible across the	• The Families Strategic Partnership has a deeper understanding of mechanisms currently facilitated across the partnership in relation to Children & Families Voice and is aware of the insight which is currently accessible across the partnership.	Phil Pusey	Children & Families Voice Strategic Network	Completed mapping exercise presented to FSP/FPEG in Summer 2017.

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
	partnership.				
Voices 3 Children Young People & Families Voices	The development of a Families Strategic Partnership Children & Families Voice Strategy (2017 – 2020).	• By June 2017, organisations across the Families Strategic Partnership have a consistent approach to Children & Families Voice with an agreed set of common standards for community engagement, ensuring children, young people and families receive the same standard of engagement regardless of the organisation.	Phil Pusey	Children & Families Voice Strategic Network	Strategy approval in June 2017.
Voices 4 Children Young People & Families Voices	The development of a high level Families Strategic Partnership Consultation & Engagement Delivery Plan (2017 – 2020).	• Organisations across the Families Strategic Partnership have a coordinated and targeted approach to Children & Families Voice, ensuring that engagement is not duplicated and thereby maximising efficiencies.	Phil Pusey	Children & Families Voice Strategic Network	Delivery plan developed and approved by the end of Summer 2017.
CC1 **Community Capacity**	To build on the learning from early implementers of the Place Based Approach (PBA) pilots and roll out across Staffordshire.	• Agree and develop local governance arrangements for delivering a PBA. • Develop mechanism are in place to ensure appropriate data is collated, and intelligence/insight gathered to improve, and develop the quality and offer of the place based approach.	Mick Harrison	Strategic Delivery Managers	Agreement and sign off by HWBB Sept 2017 Local LSP action planning October 2017 Roll out of PBA

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
		• Develop local performance measures to assess success factors • Produce a community engagement strategy and plan. • Manage current demand in a more cohesive manner and develop effective pathways			workshops and governance arrangements September 2017 to April 2018
CC2 **Community Capacity**	Define, identify and increase the availability of community capacity in Staffordshire.	• Understand current community assets operating across communities and identify gaps • To identify learning from the 8 Children's' pilots and share across the wider partnership • Develop community capacity and resilience in the community.	Janene Cox	Tilly Flanagan	Quarterly updates
CC3 **Community Capacity**	Utilise existing contracts to build and develop community capacity within local communities	• Develop an action plan as part of the VCSE contract to target activity that focusses on gaps • Embed the role of social prescribing through existing and new contracts • Ensure the Early Years Coordinators maximise the value added by the community including volunteers, peer support, parent led groups	Tilly Flanagan	Natasha Moody	April 2018
EH 1 Early Help Strategy	To deliver the actions set out in the Early Help Strategy Implementation	• Families trust their keyworker and feel "plugged in" to a range of support through them. They are	Phil Pusey/Jennie Hammond	Natasha Moody	June 2017: Revised Early Help Implementation Plan

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
Implementation: The Family Experience	Plan in relation to the Family Experience in order to enable Staffordshire to achieve the “Maturing” level of the DCLG Transformation Maturity Matrix.	confident to access services independently when their keyworker no longer works with them, and they have been supported to access a range of community and voluntary based services that meet their medium/long term need. • Family keyworker is clearly able to work across services to deliver support that’s needed for the family - the service the family get is no longer dependent on which agency provides it. • The families needs and circumstances are captured in one assessment and one family plan, with the family keyworker having access to all of the information that’s relevant to provide support to the family. • The family are able to “own their own road to change” and are positive about the future.			agreed by the Staffordshire Children’s Safeguarding Board. Six Weekly Progress Updates to FPEG. Quarterly Early Help Strategy Implementation Performance Report.
EH 2 Early Help Strategy Implementation: Leadership & Strategy	To deliver the actions set out in the Early Help Strategy Implementation Plan in relation to Leadership & Strategy in order to enable Staffordshire to achieve the “Maturing” level of the DCLG	• All senior leaders in core partners have a demonstrable focus on services that best meet local need for families; • There is a common purpose across all partners in the statutory, community and voluntary sector to commission outcome based	Phil Pusey/ Jennie Hammond	Phil Pusey	June 2017: Revised Early Help Implementation Plan agreed by the Staffordshire Children’s Safeguarding Board. Six Weekly Progress Updates to FPEG.

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
	Transformation Maturity Matrix.	services that have whole family working at their core. • Strong governance arrangements underpin common purpose with clear plans in place to manage future demand, deliver value for money and achieve cost saving with a clear approach to using evidence and analysis to understand demand and inform commissioning of services. • Leaders demonstrate a shared purpose to deliver services for families that are locally determined but at the same time have clear links to wider local and national priorities. • There is a clear commitment to integrated family focussed, outcome based services is embedded in strategic plans for all partners. Sustainability of services after 2020 is part of the area's strategic ambition. • Strategic commitment informs integrated commissioning of services which is based on evidence of what works and on the needs of the local population. • Strategic plans reflect the local landscape, adapted as necessary to the needs of localities and neighbourhoods, whilst			Quarterly Early Help Strategy Implementation Performance Report.

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
		demonstrating clear links to wider transformation programmes. • Strategic plans clearly set out ambition for families including for financial stability and resilience.			
EH 3 Early Help Strategy Implementation: Culture	To deliver the actions set out in the Early Help Strategy Implementation Plan in relation to Culture in order to enable Staffordshire to achieve the "Maturing" level of the DCLG Transformation Maturity Matrix.	• There is a clear shared vision and ambition across all partners which is effectively communicated to and embraced by staff. • An understanding of demand and commitment to transform the way public services work with families with multiple problems and an understanding of why integrated whole family working and shared priority delivers sustained outcomes for families across the 6 key problem headings of the programme. • This vision and ambition is evidenced through all tiers of staff and elected members, across all partners, and they are communicated to the community. Staff take personal responsibility and ownership to work across boundaries to support families with complex needs.	Phil Pusey/ Jennie Hammond	Liz Mellor	June 2017: Revised Early Help Implementation Plan agreed by the Staffordshire Children's Safeguarding Board. Six Weekly Progress Updates to FPEG. Quarterly Early Help Strategy Implementation Performance Report.
EH 5 Early Help Strategy Implementation:	To deliver the actions set out in the Early Help Strategy Implementation	• Workforce development is embedded in practice across all agencies depth and breadth of	Phil Pusey/ Jennie Hammond	Joe Sullivan	June 2017: Revised Early Help Implementation Plan

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
Workforce Development	Plan in relation to Workforce Development in order to enable Staffordshire to achieve the “Maturing” level of the DCLG Transformation Maturity Matrix.	opportunities. There is clear consistency of opportunity for training and development, with recognition of different agency cultural starting points. Training is provided both for the core family team and to lead workers across partners. Development is informed by evidence based practice. Impact of workforce development is evaluated and impact informs future workforce development plans. • There are shared performance objectives and training opportunities across professions. Core principles and behaviours of family working are shared and understood across agencies. • Promotion routes are linked to integrated working and not contained within agency. Promotion opportunities are visible and recruitment is transparent with cross organisational equal opportunity values embedded in recruitment policy and practice. Strong links exist with the voluntary and community sector to support complex families in the community. • Frontline staff have a clear understanding of the impact of			agreed by the Staffordshire Children’s Safeguarding Board. Six Weekly Progress Updates to FPEG. Quarterly Early Help Strategy Implementation Performance Report.

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
Page 140		their work. They have access to the right training at the right time – including evidence based programmes and training from a range of partners. Frontline staff are support to common purpose by structures, governance and clear direction from managers and have access to promotion and development opportunities that are clearly communicated to them. Workers from different agencies have shared priorities and access to pooled budgets for families. Frontline staff have a clear understanding of the principles of family working (FI factors) and a clear sense of a focus on a family assessment, plan and outcomes for families. Frontline staff are supported by regular development reviews. Peer support opportunities and opportunities for reflective practice.			
EH 6 Early Help Strategy Implementation Delivery Structures and Processes	To deliver the actions set out in the Early Help Strategy Implementation Plan in relation to Delivery Structures and Processes in order to enable Staffordshire to achieve the “Maturing” level of the DCLG	• Organisational structures enable professionals from different disciplines work together to shared priorities. High quality whole family assessments take an agreed single form and understanding of whole family assessments is embedded across partners.	Phil Pusey/ Jennie Hammond		June 2017: Revised Early Help Implementation Plan agreed by the Staffordshire Children’s Safeguarding Board. Six Weekly Progress Updates to FPEG.

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
Page 141	Transformation Maturity Matrix.	• Partners have shared integrated data systems underpinned by robust data sharing agreements. Core partners can access one single data system to access case management information. Data systems are picking up early indications of need and moving towards use of predictive analytics. • There is a clear commitment by all partners to shared analysis of what works and how to meet future demand for services for families. • Professionals from different disciplines use shared whole family approach and evidence-based tools to deliver a shared vision for early intervention. Outcomes evidence is used effectively to drive delivery and improve performance; evaluation is integrated within delivery and used to reform services.			Quarterly Early Help Strategy Implementation Performance Report.
PSHE	Develop and deliver a co-ordinated approach to school based Personal Social and Health Economic Education	• Identify a lead organisation to co-ordinate PHSE and engage with partners including schools to develop a project scope. • To work collaboratively with partners to identify funding and resources to deliver PHSE this works ensure the most is made of existing funding in relation to	Jennie Hammond	YOS, FARS	

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
		prevention.			
ICG 1 Commission joint ways of working	Identify Intelligence gaps	• To utilise the Children's JSNA and soft intelligence to identify any data and intelligence gaps. • To develop a research programme based on agreed priority areas • Embed intelligence led practice within case management (BRFC).	Kate Waterhouse Barbara Hine	Divya Patel	Quarterly reports to FPEG
ICG 2 Commission joint ways of working	Develop a partnership approach to commissioning	• Agree joint commissioning intentions across the partnership based on the priorities outlined in the JSNA and the delivery plan. • Review current joint commissioning arrangements and gain greater understanding of what works well and what could be improved. • Identify all future opportunities and agree mechanisms to work together to share resource, outcomes and impact.	Janene Cox	Liz Mellor	Quarterly reports to FPEG
ICG 3 Commission joint ways of working	Redesign the BRFC accreditation Scheme in line with increased tare set by DCLG	• Continue to work with the voluntary and community sector to develop capacity to provide key work interventions for 500 families	Barbara Hine	Natasha Moody	End of year Review March 2018
ICG 4 Commission joint ways of working	Implementation of the Recommendations set out in the National Maternity Review 'Better Births'	• Develop and deliver a pan Staffordshire Maternity Transformation programme by 2020	Alexandra Birch		Potential full roll out by 2020

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
		• Work across commissioners and providers to ensure synergy and alignment of children's services			
ICG 5 Commission joint ways of working	Delivery of an integrated 0-19 Healthy Child programme offer	• Procure a new service • Work with stakeholders to mobilise integrated Healthy Child Programme provision • Undertake research with service users and provider to identify and develop digital options for alternative service delivery • Work with stakeholders to embed the new delivery model across the children's system • Work with the provider to mobilise and integrate Children Centre provision	Tilly Flanagan	Natasha Moody Kate Sutcliffe	October 2017 Oct 17- April 18 Oct 17- April 18 April 2018- March 2022 April 2019-March 2020
ICG 6 Commission joint ways of working	Developing the future model of children's community services Pan-Staffordshire (aligned to the STP and Place based approach)	• Develop a sustainable model for children's health services that deliver effective and high quality acute care. • Roll out Big 6 work programmes to improve quality of care and outcomes for children	Alexandra Birch		To be completed by June 17 for implementation in Nov 17
ICG 7 Commission joint ways of working	Deliver the Mental Health Five Year Forward View priorities and improve mental health outcomes for children and young people	• Review current CAMHS strategies and agree footprint and approach for future CAMHS and Children's System Transformation Plans • Produce a single plan to 2021 that will cover both north (including	Roger Graham Sheila Crosbie	Jill Mogg/Paula Willman	Quarterly reports to FPEG

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
		Stoke CC) and south Staffordshire delivery and align plans as much as possible. • The plan should meet the requirements for the CAMHS Local and Children's System Transformation Plans and the Children and Young people's as reflected in the Emotional Health and Wellbeing strategy. • Utilise the Thrive model recognising the opportunities for commissioning across the partnership			
ICG 8 Commission joint ways of working	Improve outcomes in early years	• Review governance and partnership working of Early Years Board • Better use and alignment of the EYAB and local DABs to deliver lifestyle and prevention elements of the maternity transformation plan	Tilly Flanagan	Natasha Moody	TBC
ICG 9 Commission joint ways of working	Delivery of a jointly commissioned county wide Child Sexual Exploitation (CSE) and Missing children and young people service	• Work with the provider and stakeholders to mobilise the service ready for service go live 1st Sept 2017 • Develop a strong strategic relationship with the provider in order to work jointly with commissioners re: learning, emerging ideas/themes, gaps	Liz Mellor/Carolyn Higgs	Sally Ellis	June – Sept 2017 Ongoing from June 2017

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
Page 145		• Delivery of a CSE and missing service that seeks the views, opinions and experiences of children, young people and families to inform and shape delivery • Awareness raising and upskilling of the workforce and communities in relation to CSE and missing in order to build community capacity and resilience so that support is available locally for those at low risk • CSE and missing themes/ trends, gaps are gained from the service intelligence, data and insight this will inform service delivery and will be shared with stakeholders and communities to ensure a coordinated response is achieved • Improved outcomes for children and young people accessing the service:- ○ Children are not victims of CSE ○ Children are protected from CSE by parents /carers, communities, professionals and businesses ○ Children are not perpetrators of CSE ○ Children are protected from the adverse consequences of			Ongoing from 1st Sept 2017 Ongoing from 1st Sept 2017 Ongoing from 1st Sept 2017 Will be reported at the CSE Joint Commissioning Group

No.	Actions	Outcomes	Accountable Lead	Delivery Lead	Key Milestones
		going missing			
ICG 10 Commission joint ways of working	Delivery of a jointly commissioned county wide Domestic Abuse service	• Office of Police & Crime Commissioner, Stoke on Trent City Council and Staffordshire County Council to commission countywide domestic abuse service provision by 2018. • Delivery of domestic abuse support services that addresses the needs of victims, children, perpetrators and families. In relation specifically to children and young people, the service is intended to deliver the following outcomes: • increased resilience / protective factors; • Increased knowledge of domestic abuse-related issues; • Increased knowledge of positive relationships; • Increased knowledge of support services; • Increased safety; • Identified needs met; • Improved health and well-being; • Increased attendance at school.	OPCC, SoT City Council, SCC		TBC

Appendix 2: Family Strategic Partnership Strategy - Outcome Framework

Strategic Outcome	Description of outcome	Contributing outcomes	Deliverables (delivery plan)	Plan Code	Overarching Indicators (draft)
Happy and Healthy	All children and young people are resilient, happy and healthy making choices that support wellbeing.	Children, young people and their families are in good physical, mental and emotional health	• Implementation of the Recommendations set out in the National Maternity Review 'Better Births' • Developing the future model of children's community services Pan-Staffordshire (aligned to the STP and Place based approach) • Utilise the EYAB and local DABs to deliver lifestyle and prevention elements of the maternity transformation plan and the obesity compact • Delivery of an integrated 0-19 Healthy Child programme offer • Deliver the Mental Health Five Year Forward View priorities and improve mental health outcomes for children and young people	ICG4	Life expectancy and healthy life expectancy at birth (leading causes of death) (CCG / SCC)
				ICG4 ICG5	Infant mortality and child mortality rates (CCG / SCC)
				ICG5	Mothers with postnatal depression *(data source to be confirmed)*
				ICG9	Smoking in pregnancy (CCG / SCC)
				ICG5 ICG9	Breastfeeding initiation and prevalence (CCG / SCC)
				ICG4	Low birthweight of term babies (CCG)
				ICG5 ICG9	Excess weight at Reception (aged four to five) (CCG / SCC)
				ICG5	Childhood immunisation (CCG)
				ICG5	Tooth decay in children aged five (PHE)
				ICG8	Hospital admissions due to self-harm (ages 10-24) (CCG)
				ICG10	Unplanned hospital admission rates for children under 19 for long-term conditions (CCG)

Strategic Outcome	Description of outcome	Contributing outcomes	Deliverables (delivery plan)	Plan Code	Overarching Indicators (draft)
		To make positive life choices and have a sense of control over one's life	• Establish a multi-agency Strategic Children & Families Voice Network • Identify mechanisms for seeking the views, opinions and experiences of children, young people and families in Staffordshire • The development of a Families Strategic Partnership Children & Families Voice Strategy • The development of a high level Families Strategic Partnership Consultation & Engagement Delivery Plan • Develop and deliver a co-ordinated approach to school based Personal Social and Health Economic Education • Delivery of an integrated 0-19 Healthy Child programme offer **Captured through other partnerships/Boards** **1 Alcohol and Drugs**	ICG5	Under 18 teenage conceptions (SCC)
				ICG5	Smoking prevalence in 15 year olds (CCG / SCC)
				NA	Alcohol-specific hospital admissions (under 18) (CCG)1
				Voices 1,2,3&4	***(Additional outcomes around voice to be added)***

Strategic Outcome	Description of outcome	Contributing outcomes	Deliverables (delivery plan)	Plan Code	Overarching Indicators (draft)
			Executive Board		
Feel safe and belong	All children and young people feel safe in their community and at home, are safeguarded from harm and have a sense of belonging, form friendships and are part of a stable family unit	Families look after their children well	To deliver the Early Help Strategy Implementation Plan with a focus on: • Family Experience • Leadership & Strategy • Culture • Workforce development • Implementation, delivery structures and processes	EH1,2,3&4	A child who has been identified as needing early help – children identified as having social, emotional and mental health problems (SCC)
				EH1,2,3&4	A child who has been assessed as needing early help – Repeat referrals to Children's Social Care (SCC)
				EH1,2,3&4	Rates of early help assessments, children in need, child protection plans or looked after children (SCC)
		Communities are safe places to live and free from environmental and personal harm e.g. homes and roads whereby children and young people are good to others in the community	• To build on the two Place Based Approach pilots and roll out across Staffordshire. • Deliver the Mental Health Five Year Forward View priorities and improve mental health outcomes for children and young people • Identify a lead organisation to co-ordinate PHSE and engage with partners including schools to develop a project scope. • To work collaboratively with partners to identify funding	Voices 1,2,3&4	Proportion of young people who feel safe in their community (SCC)
				NA	Children aged under 18 who are killed or seriously injured on the roads (Fire service)[2]
				ICG8	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)
				NA	Young people (aged 0-17 years) making repeat calls to Police by aggrieved or perpetrator (SCC and Staffordshire Police)[3]
				NA	Rate of children who are victims of

Strategic Outcome	Description of outcome	Contributing outcomes	Deliverables (delivery plan)	Plan Code	Overarching Indicators (draft)
			and resources to deliver PHSE this works ensure the most is made of existing funding in relation to prevention • Delivery of a jointly commissioned county wide Child Sexual Exploitation (CSE) and Missing children and young people service **Captured through other partnerships/Boards** **2 Road Safety Partnership** **3 Community Safety partnership** **4 Offender management and Commissioning Board**		crime (Staffordshire police)[3]
				EH1,2,3&4	A child (aged 0-18 years) who has received an anti-social behaviour intervention (or equivalent) in the last 12 months (SCC)
				NA	First time entrants to the Youth Justice System aged 10 -17 (SCC)[4]
				NA	Number of children (aged 10-18 years) who has been convicted of a proven offence in the previous 12 months (SCC)[4]
				NA	Reoffending rates for children aged 10-17 (MOJ/SCC)[4]
		Resilient individuals and community, strong family units, good self-esteem and worth	• Define, identify and increase the availability of community capacity in Staffordshire • Utilise existing contracts to build and develop community capacity within local communities		Indicators to be developed

Strategic Outcome	Description of outcome	Contributing outcomes	Deliverables (delivery plan)	Plan Code	Overarching Indicators (draft)
		Accessible, empowered community groups, support networks with respect for the individual, family and community	• Define, identify and increase the availability of community capacity in Staffordshire • Utilise existing contracts to build and develop community capacity within local communities		Indicators to be developed
Achieve and contribute	All children and young people achieve their potential including a good education and employment and are supported to make a positive contribution to communities.	Families understand and can receive help to support developmental milestones of children	• Delivery of an integrated 0-19 Healthy Child programme offer • Review and develop governance and partnership arrangements to improve outcomes in early years	ICG5 ICG9	Improved outcomes for those who take up offer of early provision / children's centres (e.g. Early Years Foundation Stage, EYFS) (SCC)
				ICG9	School readiness (measured through EYFS) – all children / vulnerable, e.g. FSM / SEN (SCC)
				EH1,2,3&4	Pupil absence (SCC)
				EH1,2,3&4	Worklessness households (SCC)
				EH1,2,3&4	Eligible families benefitting from the childcare element of Working Tax Credit (SCC)
		Children and young people achieve their educational milestones and potential	**Captured through other partnerships/Boards** **4 Education Trust** **5 SEND Partnership Board**	NA	Achievement at key stages – all children / vulnerable, e.g. FSM / SEN (SCC)[4]
				NA	GCSE achievement -– all children / vulnerable, e.g. FSM / SEN / LAC (SCC)[4]

Strategic Outcome	Description of outcome	Contributing outcomes	Deliverables (delivery plan)	Plan Code	Overarching Indicators (draft)
				NA	Ofsted standards of schools and settings including prepared for SEN (SCC)[4&5]
		Children and young people have access to further education and jobs	**Captured through other partnerships/Boards**	NA	A young person (aged 16-18) who is about to leave school with no planned education, employment or training (i.e. at risk of becoming NEET)[4]
				NA	Young people not in education, employment or training (SCC)[4]

Staffordshire Health and Wellbeing Board	
Title	Together We're Better (TWB): update on progress
Date	7th September 2017
Board Sponsor	Dr Richard Harling
Author	Simon Whitehouse, TWB Director
Report type	For Debate

Summary

1. The Health and Wellbeing Board is advised of:
    - the Sustainability and Transformation Plan's (STP) three priorities for the remainder of the 2017/18 year
        - bringing the finances under control
        - improving performance
        - managing winter better
    - progress on the five key TWB programmes
    - review of governance
    - stakeholder engagement
    - the setting up of a re-deployment team to match existing staff with vacancies across Staffordshire and Stoke-on-Trent.

Recommendations to the Board

2. The Health and Wellbeing Board is asked to consider what it can do to support the three priorities as detailed.

3. The Chair and Vice Chair of the Health and Wellbeing Board are invited to attend a Health and Care Transformation Board governance workshop to explore and shape how the system moves into delivery mode.

4. Members of the Board are invited to consider making their respective organisational vacancies accessible to displaced health and care staff through the re-deployment team.

Background / Introduction

5. Together We're Better (TWB) has been discussed by the Health and Wellbeing Board previously. A new Director (Simon Whitehouse) has been appointed with the remit of driving delivery. This report provides the Health and Wellbeing Board with a review of the programme since it was last discussed.
6. The Committee is reminded that Together We're Better has one vision, three aims and five priorities.
    - *One vision*: Staffordshire and Stoke-on-Trent will be vibrant, healthy and caring places where people will be as independent as possible and able to live healthy lives; getting high quality health and care support when required.
    - *Three aims*: improved health and wellbeing, transformed quality of care delivery and sustainable finances.

- *Five priorities*: simplified urgent and emergency care system, mental health, focused prevention, enhanced primary and community care, effective and efficient planned care.

Current activity

The priorities for the remainder of the year

7. The health regulators (NHS England and NHS Improvement) have identified three priorities for Together We're Better:
   - Bringing the finances under control
   - Improving A&E performance
   - Managing winter better as a system

8. The Health and Wellbeing Board is asked to consider what it can do to support these three priorities.

9. It is important to recognise that there is a shift of responsibility nationally through to STPs but that the system will need to balance the operational responsibilities with need for system transformation.

10. The focus is very simple though – we have a collective responsibility to improve the health and care offer for our local population in a way that is affordable and fit for the future. We need to avoid over complicating this message and the Health and Well Being Board has a key role to play in ensuring we maintain a clear focus in this regard.

Bringing the finances under control

11. The financial position of the local health and care system remains exceptionally challenging. At month two the local NHS was reporting a deficit position of £30m – note this does not include social care.

12. The month two position and potential full year deficit for the local NHS of £161m is a deterioration against the 2016/17 performance and the base STP position.

13. The year to date and forecast positions are unsustainable and both in year and recurrent actions will be required to address the financial position across all organisations. The system did not end 2016/17 where it had planned to do and this failure impacts on future year's delivery.

Improving performance

14. On July 21st 2017, NHS England and NHS Improvement released the first progress dashboard for all 44 Sustainability and Transformation Partnerships. They used four bandings; outstanding, advanced, making progress and needs most improvement. Staffordshire and Stoke-on-Trent was rated as 'needs most improvement'.

15. Together We're Better was one of only five placed in this category. The dashboard is a measure of the current system performance and not a measure of the plan or the Partnership. Clearly this is not what we aspire to for our local population and we have a collective responsibility to do better.

16. While the overall result is disappointing, it is worth noting that we were the best in the country for Improving Access to Psychological Therapies (IAPT) recovery rates.

17. At the end of the last financial year, the STP position in relation to the percentage of patients admitted, transferred or discharged from A&E within 4 hours was 85.4% compared to a target of 95%. No one agrees that this is acceptable but it requires a system response and a collective focus to bring about improvement.

18. The publication of the dashboard signals the national direction of travel, which is to hold the system leaders to account for the performance of the system. Improving services and outcomes in Staffordshire and Stoke-on-Trent will not be achieved by organisations acting alone or in isolation. The solutions lie in the whole health and care system working together. The indicators contained within this dashboard will be the focus of future performance reports to the Health and Care Transformation Board and will help prioritise our work programme for the year ahead.

Managing Winter Better

19. NHS England requires Together We're Better to have a system wide winter plan by the beginning of September and work on this has started. This includes primary care, community and acute providers undertaking a full review of case mix and modelling of bed and workforce requirements to share across the system, risk identification and risk mitigation and a review of the escalation process.

20. Regardless of the season, the Partnership continues to focus on simplifying the urgent and emergency care offer. We aim to provide greater clarity to the population presenting to the system urgently. If appropriate, they will be directed to the most appropriate expertise to meet their specific needs; easing the inappropriate over-burdening of A&E departments. Underpinning this is a commitment to maintaining urgent care as close to home as possible.

21. Burton Hospitals NHS Foundation Trust has been awarded capital funds to facilitate a reconfiguration of their emergency department to accommodate an on-site GP streaming service. This is a nationally-mandated model and in other areas has resulted in an improvement in A&E performance. Our local model of care is looking to treat people in primary care managed services rather than hospital based ones.

Update on progress on the five key programmes

22. We will continue to deliver the five priority programmes while focusing on these three issues. The five priority programmes are
    - effective and efficient planned care,
    - enhancing primary and community care,
    - focused prevention,
    - mental health and
    - simplifying urgent and emergency care.

23. Each programme has a Senior Responsible Officer (SRO) who is a Chief Executive or Accountable Officer for an organisation in the Partnership. They are supported by a Programme Director, Programme Manager, clinical lead and finance lead. They each operate a programme board which reports into the Health and Care Transformation Board.

Effective and efficient planned care

24. The primary focus has been on ophthalmology and orthopaedics as these two areas account for 30% of all planned activity. In orthopaedics, the pathways for hip, knee, shoulder, low-back and radicular pain have been reviewed and are with a wider clinical community for comment before being finalised. Opportunities to standardise procurement of hip prosthetics are being explored. In ophthalmology, the pathways for cataract and Wet Age-related Macular Degeneration (AMD) have been reviewed and proposals will be made about how these pathways need to change.

Enhancing primary and community care

25. This programme includes community hospitals, long-term conditions and frailty, pharmacy, optometry and dentistry, voluntary sector and the new model of care at a local level (including sustaining general practice).

26. The Community Hospitals Programme covers a population of over 1.1m people registered with GPs across six CCGs, two acute hospitals, two mental health providers and one community provider. The ambition is that the person's home should always be the preferred place of care, wherever possible.

27. The focus of the work around long-term conditions has been falls, respiratory disease and diabetes.

28. Twenty-three locality groupings have been identified across Staffordshire and Stoke-on-Trent. These bring together a number of general practices and the community and voluntary sector services provided to that population.

Focused prevention

29. Together We're Better has three aims (improved health and wellbeing, transformed quality of care delivery and sustainable finances). The focused prevention workstream seeks to address 'improved health and wellbeing; it

recognises that the greatest gains in health and well-being are achieved through influencing the environmental, economic and social determinants of health as well as individual interventions. Our populations need to take greater responsibility for their own health through their lifestyle choices – but we need to help them make those choices and ensure that there are options for them to choose. Where individuals are at risk of reduced life chances and a reduced life expectancy, targeted interventions will be offered with increasing levels of intervention to groups with increasing risk of ill health or dependency. Both for children and adults, identification and support for these individuals will adopt a place based approach, linked to the development of the twenty-three locality groupings, and co-ordinating action at a local level.

Mental health

30. The key priority areas are:
    - Children and Young People
    - Perinatal
    - Adult Mental Health
        - Common Mental Health Problems
        - Community, Acute and Crisis Care
        - Secure Care Pathway
    - Health and Justice
    - Suicide Prevention

31. This includes a focused piece of work in the north of the county on reviewing complex patients placed out of area. There has been an increased in funding for psychiatric liaison at Royal Stoke.

32. Learning Disabilities and Dementia have been added to the work programme.

Simplifying urgent and emergency care

33. This programme is working on a refinement of the strategic intent articulated as part of the STP submission. It is also developing a clear framework within which those enhanced primary and community based services will develop to meet the challenge of moving activity from the acute hospitals into the community.

Review of governance

34. NHS England and NHS Improvement have reviewed the governance arrangements of STPs nationally and have issued their findings to the leads. This is being used to shape a workshop for the Health and Care Transformation Board in the first week of October. We would like to invite the Chair and Vice Chair of the Health and Wellbeing Board to attend and explore how we move the system to one that is focussed on delivery and delivering the system changes that are required. The workshop is being designed to refresh the current arrangements and to ensure we have an approach that supports the clear shift to delivery. It will review five areas: system leadership, joint decision-making, accountability, collaboration and delivery.

Stakeholder Engagement

35. The engagement of clinicians is key to delivering the transformation at the scale and pace required. Together We're Better is recruiting both a secondary care clinician and a primary care clinician as joint Medical Directors. A Director of Nursing is also being recruited. All three will be charged with developing a structure that engages all professions, including those within social care in order to develop a strategy for the local area.

36. At the December meeting of the Health and Wellbeing Board, Members were asked that consideration be given to how the District and Boroughs Councils would be involved in the planning and governance arrangements going forward as well as the prevention workstream. The deputy programme director has been working with colleagues at Tamworth Borough Council. A workshop was held in May, the objectives of which were:
    - Develop a shared understanding: To review progress through a Tamworth lens on the STP programmes and achieve consensus where each programme would benefit from Borough Council input
        - Prevention and Wellbeing
        - Enhanced Primary and Community Care
        - Urgent and Emergency Care
        - Planned Care
    - Sharing Intelligence: To ensure participants have a clear understanding of the way in which intelligence is being used to support plans, and how we might triangulate this between partners to support better planning and delivery
    - Shared Opportunity: To identify where there may be opportunities to maximise synergies between the work being developed through the STP and the work being planned for and delivered by the Borough Council and other stakeholders
    - Shared Approaches: To develop our next steps regarding Prevention, Wellbeing and Earliest Help to support the delivery of purposeful transformation and effective utilisation of resources and approaches

37. The public of Staffordshire and Stoke-on-Trent had the opportunity to attend one of ten events hosted by Healthwatch between November and December of last year. The reports from these events have been received by the Health and Care Transformation Board.

38. Engaging Communities Staffordshire has been commissioned to host an ambassadors scheme, which has so far recruited 80 people to seek feedback from their communities. Their first report has also been received by the Health and Care Transformation Board.

39. Two of the five priority programmes have established community reference groups; these were part of the consultation and engagement compact agreed with Healthwatch which stated "overseeing the engagement process should be a reference group with strong representation from patients and the public (at least 5 individuals who represent communities where there will be an impact). Work is ongoing to develop their role.

Re-deployment Team

40. The transformation of health and care is going to result in people needing to change roles. The retention of key skills and competencies is a priority of the local area.

41. There are currently around 1,500 NHS vacancies across a range of bands and specialisms including nursing, medical consultants, allied health professionals, administration and a range of support roles.

42. A centralised NHS re-deployment team has been funded for 12 months. The team maintain a central redeployment register and manage each person on the register, proactively matching the member of staff at risk with potential suitable employment, arranging for them to be interviewed and then collating feedback from interview panels.

43. Since its inception in June of this year, the service has already managed a redeployment list of approximately 200 people and has so far secured redeployment opportunities for a number of them that has resulted in savings in excess of £500,000 in redundancy cost. This has already covered the annual cost of the team.

44. Members of the Board are invited to consider making their vacancies accessible to displaced health and care staff.

Staffordshire Health and Wellbeing Board	
Title	Physical Inactivity Sub-Group
Date	7th September 2017
Board Sponsor	Dr Richard Harling
Author	Jude Taylor/Ben Hollands
Report type	For Debate

Recommendations

1. The Board is asked to:
   a) Comment on and endorse the work of the sub-group to date.
   b) Continue to take a leadership role in the development of a collaborative approach to physical inactivity in Staffordshire.
   c) Identify physical activity as a priority for the HWBB going forward.
   d) Ensure physical activity is embedded into local policy.

Summary

2. On 09 March 2017 The Health & Wellbeing Board (HWBB) elected to adopt sub-group of the Board who would be tasked with understanding and combatting physical inactivity in Staffordshire. In April, this group acted as the lead applicant for a consortia bid to the Sport England Local Delivery Fund. The premise of the bid was to tackle physical inactivity in older adults within six geographical areas across Staffordshire. In June, Sport England communicated that although Staffordshire's application could be commended for its strong sense of place, logical approach and clarity of purpose, they had decided not to take it through to the final stage of assessment.

3. Through the process of bid development, it become apparent that there was an urgent need for a collaborative approach to inactivity. The sub-group is now in the process of developing a clear vision, priority outcomes and associated work programme, evaluating what can be achieved without the significant investment of the Local Delivery Fund.

4. A further application has been made to Sport England by Sport Across Staffordshire and Stoke-on-Trent (SASSOT) for a dedicated staff resource to support the work of the sub-group.

Background / Introduction:

5. The latest data from the 'Active Lives' Survey illustrates the scale of the challenge facing the HWBB and its partners. Staffordshire is ranked as the fifth worst performing county in terms of sport and physical activity participation nationally. In fact, four of Staffordshire's local authority areas feature in the 50 most inactive places (Cannock, Newcastle, Tamworth, Staffordshire Moorlands). Analysis of the Active People Survey shows that only 20.6% of people aged 55-65 participate in sport regularly which is significantly lower than a national average of 25.3% for this age group. These figures demonstrate that this older population segment are not only the least active locally but are amongst the least active anywhere in England. These high levels of inactivity

make a significant contribution to the unprecedented demand being placed on our health and social care system.

6. In response to these issues the Physical Inactivity sub-group developed a bid that sought to understand and address these challenges. Feedback from Sport England regarding the application outlined key strengths and weaknesses. The application scored highly in three areas: story of place, understanding the process of change, and willingness and passion. Areas of weakness included: audience knowledge (that is, lack of qualitative insight into the motivations, behaviours and attitudes of people in our target localities), place selection (rationale for selecting these localities and the popularity of these places) and finally leadership (in particular the HWBB track record of leading preventative strategies in Staffordshire).

7. The group has now begun the process of deciding what might be achievable without the significant financial resource of the Local Delivery Fund, and how we might collaborate with other work streams such as the children's system review and obesity agendas.

8. It was determined by the group that creating a standalone strategy for physical activity would add an unnecessary layer of bureaucracy. To this end a vision, set of outcomes and focused work programme will be developed in order to drive the agenda forward. This process is underway with the first stages of a logic-modelling exercise having been completed. This has led to agreement of the following vision:

"Influencing people and places to embrace and value physical activity"

9. The following key principles have also been agreed
   - Combine a high level influencing role with the delivery of targeted interventions. This means positioning physical activity within relevant policy alongside attracting external resources that will facilitate local delivery.
   - Focus on the places where we have the highest levels of inactivity, initially this will be the six localities identified in the bid.
   - Strengthen our insight via community consultation and engagement.
   - Take a multi-agency /collaborative approach.

10. The next steps are for the group to agree a clear set of priority outcomes and develop a focused work programme around these taking into consideration available resources and relevance to other strategic drivers such as the prevention strand of the STP and the Health and Wellbeing Board Strategy. To track progress, we will identify clear outputs and proxy measures.

11. SASSOT have submitted an application to Sport England for an Extended Workforce Officer; if successful, this member of staff would be employed by SASSOT and tasked with supporting the work of the group. We expect to hear the outcome in September.

Current activity

- Sub-group have held two meetings.
- Logic-modelling exercise undertaken to agree vision and outcome themes.
- Bid submitted via SASSOT to the Sport England extended workforce role.
- Committed to joining Sport England's community of learning.

Options & Issues:

- Ownership – through the whole system and across sectors.
- Resources – both physical and in-kind, to move this forward at pace.
- Establishing and agreeing priorities.

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

12. The sub-group are seeking the continued support of the HWBB to progress this agenda in four key areas.
    - Where possible identify potential resources for this work.
    - Ensure that physical activity is embedded in relevant policies.
    - HWBB members champion this work within their own individual networks.
    - Once complete, endorse vision, outcomes and work plan.

Staffordshire Health and Wellbeing Board	
Topic:	Place Based Approach
Meeting Date:	7 September 2017
Board Member:	**Helen Riley,** Chair of the Families Strategic Partnership Board and Deputy Chief Executive and Director of Families and Communities, Staffordshire County Council **Glynn Luznyj,** Vice-Chair of the Families Strategic Partnership Board, Director of Prevent and Protect, Staffordshire Fire and Rescue Service
Authors:	**Mick Harrison,** Chair of the Families Partnership Executive Group and Commissioner for Safety Children and Families, Staffordshire County Council **The following organisations have contributed to the contents of this report:** • Clinical Commissioning Groups • Newcastle-under-Lyme Borough Council • South Staffordshire District Council • Staffordshire Council of Voluntary Youth Services • Staffordshire County Council • Staffordshire Fire and Rescue Services • Staffordshire Office of the Police and Crime Commissioner • Staffordshire Police • Tamworth Borough Council In addition, members of the **Families Strategic Partnership Board (FSPB)** and **Families Partnership Executive Group (FPEG)** have contributed to the contents of the report.
Report Type:	**For Debate**

1. Introduction

1.1. This report provides a summary of the partnership discussions undertaken to date and provides an overview of the Place Based Approach (PBA) concept and how this is being developed at a local level. It is a partnership approach that brings together strategic and operational system leadership at both a County and District/Borough level as well ensuring we're making best use of public sector and community assets within localities. Partners have agreed to pilot the PBA concept in Newcastle-under-Lyme and Tamworth. The learning from these pilots will support the Districts/Boroughs when PBA is rolled out across Staffordshire.

1.2. The aim of PBA is to make best use of public sector and community assets to:

- reduce demand to higher tier services,
- improve outcomes for children, young people, families by providing support as early as possible,
- build resilience and encourage independence within communities, and
- provide high quality statutory services when required.

2. Recommendations

2.1. The Health and Wellbeing Board note and endorse the contents of the report, particularly the concept, definition and principles of the PBA detailed in Appendix 3.

2.2. The Health and Wellbeing Board note that the PBA will have a core approach (see Appendix 3) that will be the same across Staffordshire however the PBA will enable local flexibility dependent on local need and resource availability. The PBA should offer a consistent method of approach to services that are not exclusively based locally and provide services either Staffordshire-wide or have alternative boundaries (e.g. Clinical Commissioning Groups).

2.3. The Health and Wellbeing Board will provide the strategic direction and ensure initiatives are appropriately aligned to meet the needs of the community as well as make best use of public and community resources. That other initiatives, for example: the Sustainability Transformation Plan (STP) prevention work stream, Public Health Social Model and Multi-Agency Risk Assessment Conference (MARAC) review are aligned to PBA (see section 5).

2.4. The Health and Wellbeing Board acknowledge that the successful delivery of PBA requires the 'whole family' approach from the majority of initiatives the Health and Wellbeing Board has oversight over, for example, substance misuse, adult mental ill health, etc. No matter whether the needs are identified initially through children or adults services, agencies and services need to align and work together to provide effective holistic support. In addition, the Health and Wellbeing Board recognise and ensure that the needs of children are recognised in partnership action plans, for example, the STP.

2.5. The Health and Wellbeing Board agree that:

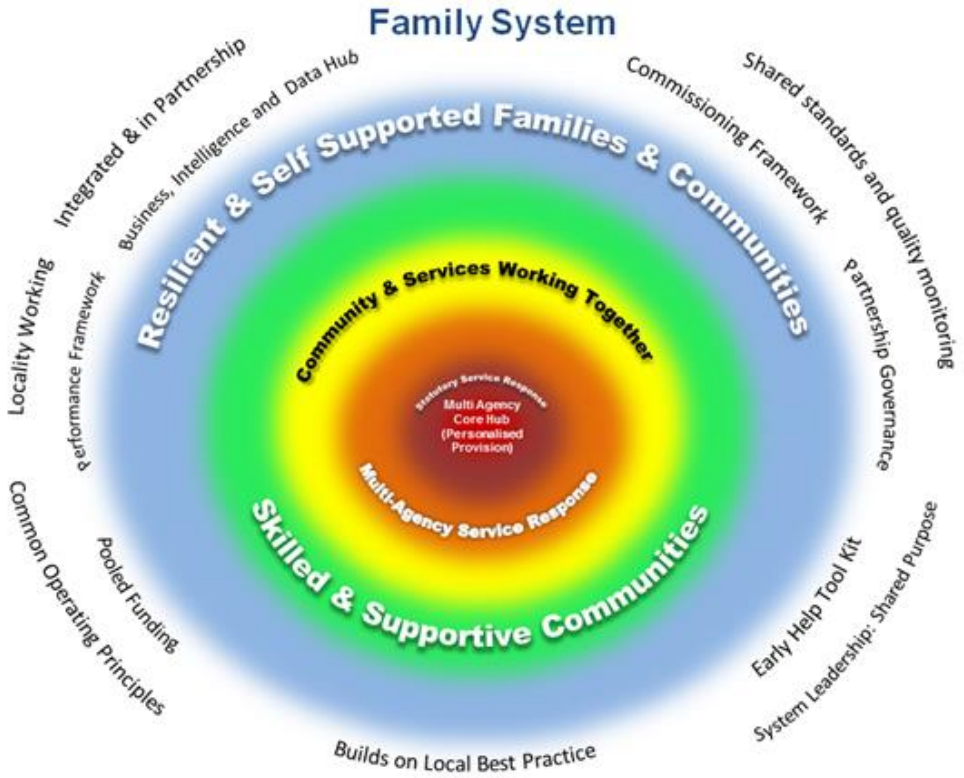
- The Health and Wellbeing Board work with partners to ensure that the definition and principles of this model of working are adhered to as work moves forward.
- The Health and Wellbeing Board recognise that the models need to be designed by local stakeholders to ensure it is effectively owned and delivered.
- The Health and Wellbeing Board agree that the PBA pilots be evaluated regularly to monitor progress and assist with sharing learning that other Districts/Boroughs could benefit from.

3. Background and Context

3.1. During the Summer of 2015, partners at a District/Borough level across Staffordshire explored how we commission support for Staffordshire's families to build a foundation for the future and in doing so, have an opportunity to improve outcomes and make better use of our collective

resources. The diagram below illustrates the model that emerged through the partnership conversations.

3.2. Diagram 1: Family System



3.3. The different layers of the model are described below (a detailed description can be viewed in Appendix 1):

	What?	Who for?
Resilient and self-supported families and communities	Families and communities support themselves.	The community
Skilled and Supportive Communities (Earliest Help)	Communities that have the skills and knowledge on how to access resources/support when a family needs additional help.	All children, young people and families and the people they interact with in their community
Community and Services Working Together (Earliest Help)	An environment where communities and services work together to find solutions and support children, young people and their families.	• Children and Families where there is a risk of escalation • Children and Families where issues have occurred • Children and Families de-escalated from targeted support • Localities that are struggling (who have multiple risk factors)

	What?	Who for?
Multi-agency services responses (Early Help)	An environment that identifies and engages promptly with children, young people and their families in need of support to enable them to maintain an independent family life. A 'whole system' partnership approach that considers the whole family. Robust information sharing and professionals working more effectively and efficiently together to support families.	• Children and Families where there is a risk of escalation • Children and Families where multiple issues have occurred • Children Families de-escalated from the statutory services • Localities that have long term, ingrained challenges
Statutory Service responses	An environment where vulnerable children, young people and their families are supported for the right time by the right services, in order to return, where possible and appropriate, to independent family life as quickly as possible	Covers children, young people and families in the statutory parts of the social care (Children in Need – S17 Children Act definition; LAC; safeguarding; adoption), mental health, SEND (a proportion of) and YOS systems and partners statutory responses for vulnerable people (e.g. Police, Housing, DWP)

3.4. Following the District/Borough conversations, eight pilots were initiated by partners across Staffordshire. The aims of these were to explore and test different aspects of the model detailed in paragraph 3.2 and 3.3. Further details of these pilots can be found in Appendix 2.

3.5. Each of the pilots have focused upon the delivery of 'Earliest Help' within a community setting and creating an environment where communities and services work together to find solutions and support one another. The key aim was to test whether by working differently, through community providers at a very local level, could we begin to stem demand into higher tier statutory services.

3.6. The pilots are now fully mobilised and each has taken a different approach. To date we are beginning to evidence positive outcomes particularly within the Tamworth, Cannock, Lichfield and East Staffordshire pilots.

3.7. In July 2016, the Families Strategic Partnership (FSP) held a workshop to further progress the Children and Families agenda in Staffordshire. All partners recognised the significant challenges, of reducing finances and increasing demand which all organisations will face over the next few years. Partners agreed that a system/operating model that is 'fit for the future' needs to be designed and decided to explore the PBA concept with partners.

3.8. Newcastle-under-Lyme and Tamworth were identified as two Districts/Boroughs where the PBA concept could be explored and potentially

piloted at a locality level. The FSP agreed that an understanding of collective demand across the partnership in the two localities and more importantly common areas of demand, was required. This would provide legitimacy to develop a model which utilises all our collective resources, assets and is truly owned by partners and communities.

3.9. PBA is a geographical area where public and community resources work closely together in a cohesive manner. The workforce in a PBA would have extensive knowledge of local needs and resources available in the area and would have a joint action plan to co-ordinate multi-agency activity that addressed root causes. PBA would seek to shape communities to be self-sufficient and resilient and where needs arise, support would swiftly be deployed to avoid (where applicable) escalation to higher tier services. It has been recognised that support does not necessarily have to be a public sector service, it includes digital responses (e.g. self-help tools) and communities as well as families. In addition, businesses have a 'social value' role to play in supporting local communities.

3.10. Families that need help tell us they don't want to be in 'systems' or 'services'. Families want to be supported by their friends, families and in their communities to deal with the day-to-day challenges they face. The PBA supports this aspiration whilst also ensuring there is a clear pathway to access safeguarding services should any safeguarding concerns arise.

3.11. Following the July 2016 workshop, representatives from Staffordshire County Council, Staffordshire Office of the Police and Crime Commissioner, Staffordshire Police, Newcastle Borough Council and Tamworth Borough Council came together to scope what the PBA approach would look like across Staffordshire. Appendix 3 details the outcomes of these conversations and the Health and Wellbeing Board are asked to endorse this approach.

3.12. The FSPB commissioned Keele University to lead a Knowledge Exchange Group (KEG) to provide further understanding on how best to take forward the PBA approach. At a Staffordshire-wide level, partners detailed in paragraph 3.11 attended the Staffordshire KEG as well as representatives from the Clinical Commissioning Group (CCG) and the Voluntary and Community Sector (VCS). Keele University also attended partnership workshops in Newcastle-under-Lyme and Tamworth to inform its findings detailed in the diagram below.

3.13. Diagram 2: Place Based Approach – Steps to Operationalising the Concept

3.14. Following conversations detailed above, there was a recognition that a wider stakeholder conversation was required. Further conversations have now taken place at the FSPB as well as within the District/Borough PBA pilot workshops. Stakeholders engagement has been extended to include a wide range of partners, including Early Years providers, Schools and Housing providers.

4. Overview of Placed Based Approach Pilots

4.1. Following conversations with a range of stakeholders, it was acknowledged that a high level definition, principles and approach is required to ensure consistency across Staffordshire, however, it was also recognised that the delivery model will vary between Districts and Boroughs based on local needs, resources, etc., Partners have agreed the following working definition for PBA "A collaborative approach using the right resources (multi-skilled teams, universal services, voluntary sector, communities, etc.) at the right time to improve outcomes for children, young people, families, vulnerable people and communities in an identified locality."

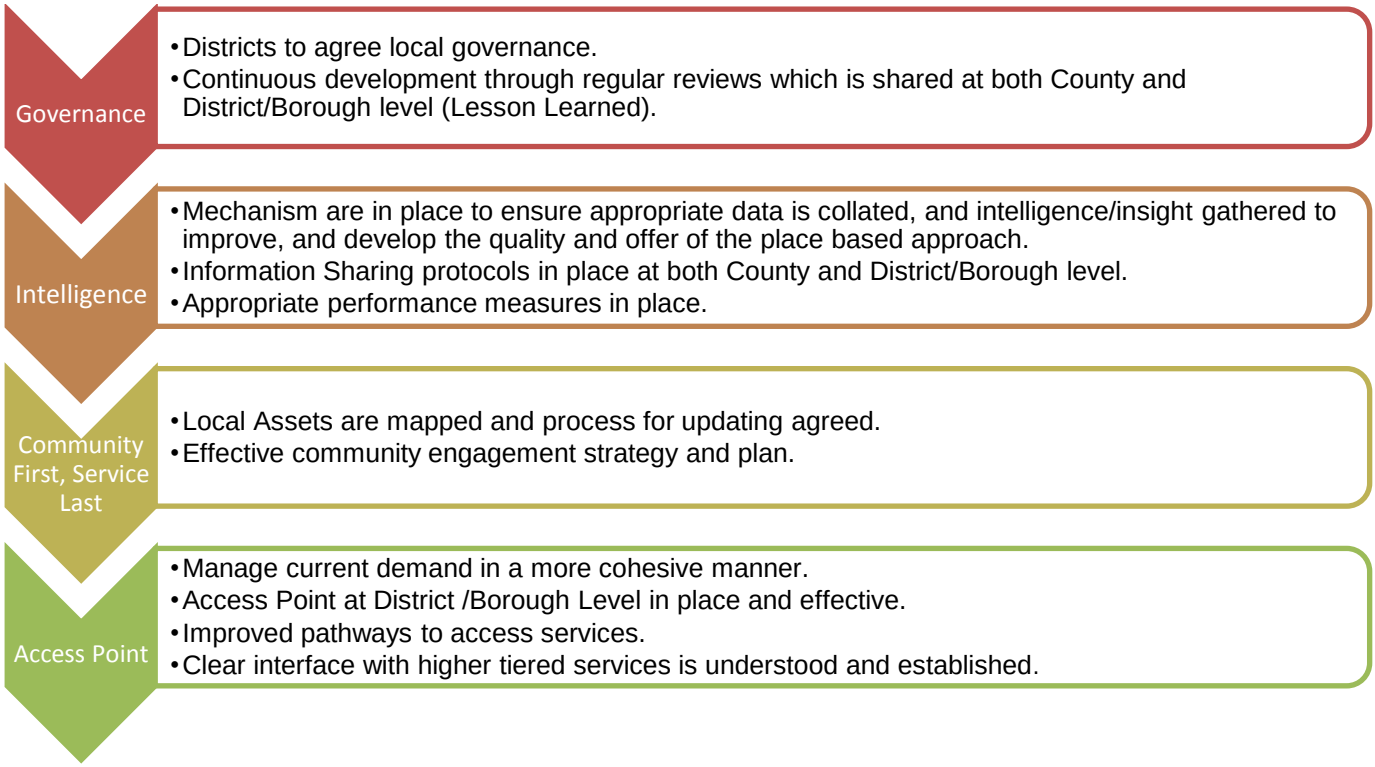
4.2. The focus of the two pilots will initially be upon children, young people and families with an ambition that this be extended to include vulnerable adults within communities. This ambition is shared with a range of partners at both District/Borough and County level.

4.3. Appendix 4 provides an overview of activity which has taken place to date in Newcastle-under-Lyme and Tamworth. Discussions are currently in the initial stages and plans being developed. Current county-wide platforms have not enabled effective engagement with schools so the PBA provides an effective platform to enable robust discussions with schools with the aim to improve outcomes for children, young people and families. These discussions have taken place at both Newcastle-under-Lyme and Tamworth as well as the other six Districts/Boroughs across Staffordshire.

4.4. Appendix 3 provides the key elements of PBA across Staffordshire and locally partners are working together to shape a model that involves (based on feedback from the pilot areas):

- Sharing information at the earliest point to ensure the right help is given at the earliest opportunity.
- Embracing a 'community first' philosophy when working with children, young people and families and maximising the use of community resources to provide support. Services will provide appropriate support if the needs can not be met within the community. Where there are safeguarding concerns, there will be clear referral pathways to signpost cases to specialist safeguarding services.
- Building on existing successful initiatives, for example: Building Resilient Families and Communities (BRFC).
- Commissioning and reshaping support for families to meet local needs, identify and deal with root causes and enables demand to be managed effectively.
- Making best use of local resources and assets, such as, schools, GPs, community centres, voluntary groups and community leaders.

4.5. In order to deliver PBA within District/Boroughs, the following components have been identified as key to the success of its implementation:



4.6. High level draft plans to deliver the PBA in Newcastle and Tamworth are detailed in Appendix 5.

4.7. South Staffordshire are currently engaging in discussions to test the PBA concept, as discussions progress, these will be shared with the appropriate partnership boards.

4.8. The PBA approach will be evaluated to monitor the progress of the pilots and share learning with other Districts and Boroughs. Discussions are taking place with Centre for Health and Development (CHAD) on how PBA can be qualitatively evaluated and the Districts/Boroughs will identify success measures locally.

5. Other Locality Based Activity

5.1. Discussions are taking place with a range of key stakeholders involved in locality working to explore collaborative opportunities, for example, the Sustainability Transformation Plan (STP) prevention workstream and Public Health Social Model focuses on adult services and is seeking opportunities to work collaboratively with stakeholders at a locality level. The PBA should attempt to align with the Public Health Social Model and STP 'New Models of Care' work where 23 localities have been identified across Staffordshire and Stoke-on-Trent.

5.2. Multi-Agency Risk Assessment Conference (MARAC) is the forum that discusses high risk domestic abuse cases within a partnership forum. A MARAC review is underway as partners have recognised that an increase in domestic abuse cases has placed pressures on all organisations and that the MARAC process has not changed to keep pace with new ways of working.

5.3. The aim of the MARAC review is to develop a blueprint for an integrated end to end domestic abuse process. Much of the work is carried out locally and supported by the central Multi-Agency Safeguarding Hub (MASH). The development of a MARAC process is complimentary to the development of local ways of working and could form a method of working that supports partners working together in a locality. As a result, it is recommended that where possible the development of this new domestic abuse process will be piloted alongside the PBA pilots before being rolled out across Staffordshire.

6. Links to Wider Children and Families System

6.1. PBA is a key component of the whole system as it will bring together public and community assets to:

- reduce demand to higher tier services,
- improve outcomes for children, young people, families by providing support as early as possible,
- build resilience and encourage independence within communities, and
- provide high quality statutory services when required.

6.2. The PBA pilots are part of a whole system transformation and their aim is to ensure that support and interventions occur at the earliest point therefore preventing escalation into higher tier statutory services. The PBA approach does need to be seen as a part of the whole system change and further work is being undertaken to provide strong support for those children and families who are on the 'edge of care', for example:

- The new Intensive Prevention Service has been established to help families in crisis. This has kept children from needing higher level specialist services and has avoided the costs associated with this. Over the year, a total of 151 young people ceased to receive a service from Intensive Prevention. Of these, 85% remained living with their parents or other and 23 young people entered care. Comparing the living arrangement at the point of referral to the arrangement at the case conclusion, shows a similar pattern – low numbers of children have entered and remained in care.
- The Breathing Space project is targeting support to families who have had a child removed from their care to reduce the likelihood that any subsequent children will need to be taken into care too. 12 babies were born between April 2016 – March 2017, of these:
    - 11 of these babies returned home to parents following the birth subject to Children In Need (CIN), Child Protection (CP) or Interim Care Order (ICO) at home.
    - 1 came into care subject to ICO however was later placed in the care of father.
    - All 12 of the mothers engaged in both Mellow Bumps and Practical Parenting programs delivered by the project workers one to one.
    - 10 of the babies fathers were also engaged within the parenting programs.
    - A program of Dads work was trailed with one father assessed as the main carer successfully.
    - 6 of the babies mothers engaged in the Freedom Program one to one with the project worker
- The Intensive Family Support Service has been developed to target support to parents who misuse drugs and alcohol, as this is a common cause of wider problems in the family. So far 91 families with 194 children have completed the programme; of which 165 (85%) have remained united with their families.
- The BRFC Family Intervention Projects (FIPs) are District/Borough multi-agency teams that work intensively with identified BRFC families on the cusp of care, adopting a whole-family approach to their support. The FIP teams consist of key workers from a range of organisations including: Families First, Police Community Support Officers (PCSOs), Housing Providers and Voluntary/Community Sector partners. The FIPs are showing evidence of preventing families entering higher tier services.

6.3. As discussed earlier in the report, whilst the focus of the model is on children and families, the model could be adapted at a locality level to address increased needs of adults, particularly those without a family.

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Appendix 1: Description of Family System model

Resilient and self-supported families and communities

What is the Vision? An environment (resilient community) where families, children and young people are well informed and able to help themselves

How will it work?

- Relevant, accessible and up to date information available through a range of formal and informal channels to families and communities
- Targeted information and advice / awareness raising campaigns based on community issues
- Community 'touch points' in places that make sense
- Better use of technology to promote information and behavioral campaigns (phone apps)
- Intergeneration projects that tackle the cycle of entrenched behaviors
- Joining up people in communities, increasing positive community role models
- Place and market shaping
- Solution focused district and parish councilors who support community behaviour change
- Promotes personal and community responsibility

Who is it for? Communities

How will we know it is successful?

- Improving opportunities / behaviors and outcomes

How is it different?

- Targeted IAG into communities (based on issues identified in that community)
- Local businesses, the universal services and the community themselves plays an active role in IAG
- Active behavioral change approaches to address long standing and inter generational problems
- Recognizes talents and assets rather than needs and issues, stimulating a culture of 'we can do it ourselves'

What will need to change?

- Culture – pro-active and focused on root cause, using data and evidence base
- Working with local business, communities and universal services to have an active role in IAG and connecting people
- Staffordshire Cares includes children and families and supports localized information portals
- More work with the CVS improved outcomes
- Support CVS to apply for funding
- Pro-active approach to market shaping
- All council and partner services in the area play an active role in IAG
- New training for parish and district counsellors

Skilled & Supportive Communities

What is the Vision? An environment where communities (people, universal services and businesses) around children, young people and their families are skilled and confident to positively help open another

How will it work?

- Trained community navigators, mentors, ambassadors and champions
- Growth of community interest companies, charities, social enterprises set up by local people to help and support local people
- Growth of new community funding methods (e.g. crowd funding, donations)
- Stimulate greater use of community assets (e.g. time-banks and swap shops where people can exchange skills)
- Universal provisions, the community and local business have the skills to help families and take a solution focused empowering approach
- Stimulate the growth of charities and voluntary organization based on what will help the most
- Social impact bonds and payment by results methods

Who is it for? All children, young people and families and the people they interact with in their community

How will we know it is successful?

- Improving opportunities / behaviors and outcomes

How is it different?

- Active market shaping – working with universal providers and CVS to stimulate the right environment
- Empowering responses to peoples problems – educating them to help themselves and connecting them to the community
- Local businesses, the community and universal services have a more active role
- New models of delivery and funding
- Asset focused

What will need to change?

- System Culture – pro-active and focused on root cause, using data and evidence base
- Front line culture change - empower people to do it rather than 'refer' or do it for people
- Greater work (and more partnerships) with the CVS to stimulate the growth of the sector and attract new funding
- Closer links between all tiers of services
- Support services in closer proximity to universal services, to up skill and give people confidence (co-location around school cluster for example), giving a better understanding between the two about their roles in supporting families and communities
- Online and local methods to help communities connect
- Improved intelligence from the top end of the system (root cause) to market shape in this part of the system
- Training for the community and investment on community instigators/champions/navigators

Community & Services Working Together

What is the Vision? Developing an environment that enables the community, voluntary, local businesses universal services and statutory services to work together to jointly find solutions that support children and their families

How will it work?

- Statutory services are co-located around universal services
- There are strong local partnerships between community members, services and local business who work together to develop local solutions, accessing or developing the community to respond in the first instance
- Targeted Brief interventions run by the community members and services together – upskilling the community and universal services over time
- Greater investment in upskilling the community and CVS
- Local alliances/co-operatives between communities, services and business who jointly apply for funding and share resources and skills
- Community commissioning funding pooled / local commissioning
- Stimulating growth of social investment
- Skills sharing across services (e.g. peer auditing)
- Increased amount of proactive, targeted interventions in an area based on local needs (partnership responses)
- Sharing local intelligence
- Trained community navigators, mentors, ambassadors and champions

Who is it for?

- Children and Families who are identified as needing additional help
- Children and Families where issues have occurred
- Children and Families de-escalated from targeted support
- Local communities identified as having multiple risk factors

How will we know it is successful?

- Improving opportunities / behaviors and outcomes

How is it different?

- Partnership and community responses rather than just services responses – joint ownership of an area
- Proactive, targeted approach based on risk factors
- A move away from referral
- Community commissioning pots with innovative funding solutions
- Locally driven and owned
- Clear performance targets
- Developing the role of the 3rd sector and other key partners and people in localities
- Effective working practices across the board regarding information sharing

What will need to change?

- Building confidence, capability and capacity in the community
- Culture – internally and amongst partners / communities; pro-active and focused on root cause, using data and evidence base
- Attitudes to risk and attitudes to how support is provided
- KPIs and measures to focus on outcomes for children and families
- Raising awareness of when / how things can go wrong so that appropriate support can be accessed at the appropriate time
- Infrastructure support to help glue partnerships and maintain and develop localised intelligence
- Joint community and service workforce development

Multi-agency services responses

What is the Vision? Developing an environment that identifies and engages promptly with family units in need of support to enable them to regain and maintain an independent family life

How will it work?

- Local services work in partnership to create local team, pool resources, funding and skills e.g. build on the good practice of LSTs
- Resources are allocated to areas based on need
- Multi-agency local support is clustered around local universal services (schools, early years providers, health centres – so all services can work together more effectively)
- Resources are available / targeted based on need
- Partnerships receive joint training on brief interventions/ evidenced based interventions that will make a big difference to the community they work in
- Families are allocated a key worker / lead professional who engages with the family and other professionals to arrange support
- Local teams take a proactive approach and work with people in the local area before referrals are made
- There is a clear triage system across the partnership and a help and advice method
- Targeted brief interventions are offered where it is necessary to do so
- Support is provided to the whole family not just the child, so resilience is improved and root cause addressed
- Teams are incentivised against performance targets

Who is it for?

- Children and Families who are identified as having multiple / complex needs
- Children and Families where multiple issues have occurred
- Children and Families de-escalated from statutory services
- Local communities that have long term, ingrained challenges

How will we know it is successful?

- Improving opportunities / behaviors and outcomes

How is it different?

- There are local teams which are truly multi-agency and resources across teams are pooled and shared
- Workforce development is joined up and relevant to the skills required for supporting that community
- All partners have a role to play in Early Help
- The threshold for help from a team are 'higher'
- There is a key worker response who works with the whole family

What will need to change?

- Culture - working together to deliver a response and running a key worker approach; working as a multi-agency team; pro-active and focused on root cause, using data and evidence base
- Developing a working relationship with the community and approaches to grow community resources first to solve problems
- Targets to increase community capacity and reduce service responses
- Attitudes to risk
- KPIs and measures to focus on outcomes for children and families
- Policy, process and ways of working to enable teams to work together

Statutory Services Responses

What is the Vision? Developing an environment where vulnerable families, children and young people are supported at and for the right time by the right services, in order to return to independent family life as quickly and safely as possible

How will it work?

- Multi-agency approach across statutory services (Safeguarding, Police, Mental Health, SEND, Youth Offending)
- Co-located statutory response hubs across agencies
- Intensive prevention approaches (proactive approaches to identifying most vulnerable and taking action before they come into the system)
- Rehabilitation approaches and active step-down working with multi-agency teams
- Personalised / Managed budgets (by service users)
- Local commission /spot purchasing relevant to families need
- Enhanced regional approaches
- Active family and community approaches to build resilience of the most vulnerable
- Commissioning is integrated and commissioners work to design and commission integrated service responses
- Locality delivery in areas of greatest demand
- Families will know how and when interventions will cease
- Addresses root cause to prevent re-referral
- Shares intelligence to inform root cause and Early Intervention Indicators for learning up stream

Who is it for?

Covers children, young people and families in the statutory parts of the social care (Children in Need – S17 Children Act definition; LAC; safeguarding; adoption), mental health, SEND (a proportion of) and YOS systems and partners statutory responses for vulnerable people (e.g. Police, Housing, DWP)

How will we know it is successful?

- Improving opportunities / behaviors and outcomes

How is it different?

- Integrated commissioning and delivery across all key partners
- Family and community focus
- Multi-agency co-located teams across statutory services
- Proactive prevention and rehabilitation
- Funding and payment methods
- Demand led

What will need to change?

- Culture – working together; pro-active and focused on root cause, using data and evidence base; locality working
- Power and control of individual agencies
- Attitudes to risk internally and across partners
- Proactive funding teams
- Skills and capabilities – to work in new ways across family and community
- System and process

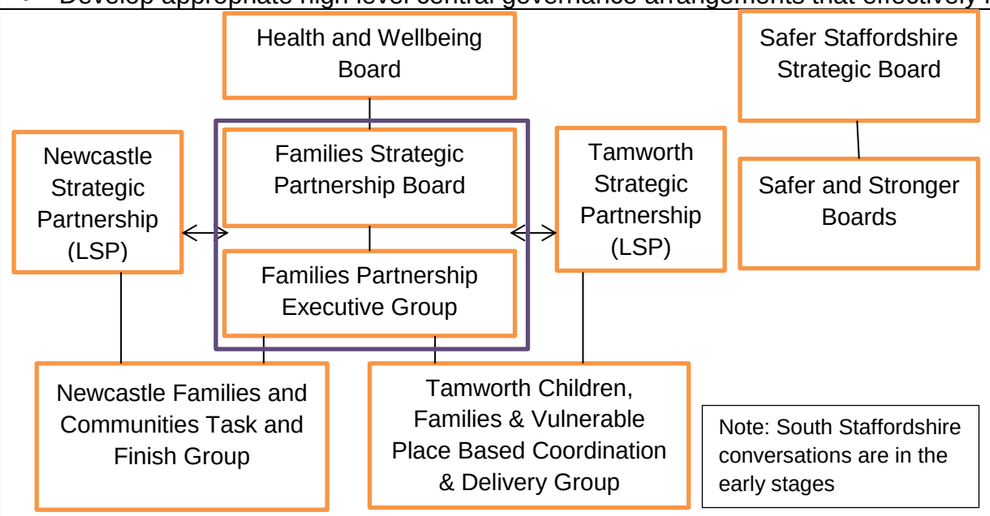
Appendix 2: Overview of District/Borough Pilots

District	Summary	Key Outcomes	Headline KPIs
Cannock: Chadsmoor & Western Springs Community Family Intervention Service	A coordinated community led universal and Tier 2 family intervention. Referrals are received from partners and other agreed referral/vulnerability identification processes. This Pilot supports: • children and families to utilise universal services and build resilience; when issues arise the aim is to prevent escalation to Tier 3 services; • an exit strategy for those families de-escalating from Tier 3. The commissioned service aims to support 150 families over 12 months across the two providers Key workers were fully trained and working with families from October 2016.	• Demand on statutory services is reduced • Improved family wellbeing with emotional needs met or supported • Improved community safety • Children are kept safe • Education and learning improved • Boundaries/behaviour in place and improving • Improved social networks • Personal responsibility is increased	• WCFC to work with 75 families not supported by any other agency, within 12 months • CESS to work with 50 families not supported by any other agency, within 12 months • Increase the number of families accessing community led early intervention • % of families reporting improved outcomes by analysis of outcome star e.g. - 30 families all increased with regards to effective parenting. • Reduce the number of referrals to LST in the two areas
East Staffs: Shobnall Community Hub	This pilot is working to strengthen community assets in Shobnall Ward, bringing together VCS and statutory services with the community to provide a tailored local offer which addresses root cause. A structured community engagement programme has enabled local residents to articulate their needs. There is a focus on early identification of families in need; developing new ways of working with communities to promote engagement and building capacity e.g. peer support models and volunteer programmes. The pilot mobilised in November 2016, following three successful engagement events. This pilot is being informed and developed by community engagement and VCSE support.	• Partners commissioning resources are more aligned & address root cause • Demand on statutory services is reduced • Community capacity exists to support families in need • Families are more resilient • More local people engaged in volunteering • Partners more involved in Early Help	• Information, advice and guidance – ensuring people who live in the Shobnall know what service are available to them • An increase in the uptake of Think2 places and Children Centre attendance • An increase in the number of people in paid or voluntary work, focussing on twelve families identified through BRFC in this ward • A reduction in Anti-Social Behaviour in the local park within Shobnall.
Lichfield: Community managed family centres in Burntwood	This pilot focuses upon the development of community-based solutions to support families with babies / pre-school-age children, where there are known lower level risk factors & potential for earlier and less formalised intervention to have a significant longer term impact. The pilot is being managed and delivered in partnership with Spark CIC and Burntwood Childcare Hub (virtual). This includes the development of a single virtual front door, partnership integration, community delivered activities, data capture of participation and outcomes, & technology development, VCS funding bid capacity development and development of a “how to” guide for others interested in establishing community managed family centres.	• More children school ready, achieve educational milestones and potential • Demand on statutory services is reduced • Families are empowered to access support earlier from within their community • Reduced numbers of CiN/CP/LAC • CYP&F are in good physical/emotional/ mental health and are protected from harm • Communities are supported to support themselves	• Increase Early Years reach (by Wards) quarterly • Maintain Early Years reach (0-30% wards) • Increase Children’s Centre registrations (by Ward) quarterly • Increase Early Help Assessments held by community groups • Increase Free Pass attendance at community groups in Burntwood • Increase free pass issues in Burntwood

District	Summary	Key Outcomes	Headline KPIs
Moorlands : Children and Family Approach	The Staffordshire Moorlands District Pilot is focused on the Leek North ward and is seeking to compliment and develop existing and planned activity in the District which is being coordinated and governed through the Moorlands Together Partnership. Visyon was commissioned earlier this year to deliver the Early Intervention element of the District Pilot. Visyon supports the emotional health and well-being of children, young people and their families through the provision of a range of services, including one-to-one therapy, group work, mentoring, therapeutic play and family support work. The District Pilot is open to all Schools in the town and is part of a wider programme of activities to improve outcomes for children, young people and families in Leek North.	• Reduction in the referrals to agencies locally • Families are supported at an earlier stage and are less likely to need future interventions	• Increase the number of children and young people accessing the service provided by Visyon. • Increase the number of children and young people, seen within 10 days of a referral. • Increase the number of children and young people who engaged in the service and achieved the desired outcomes. • Reduce children and young people requiring support from the Local Support Teams. • Increase the number of children, young people and families who are involved in other initiatives to support communities such as the Food Cooperative.
Newcastle : Information Sharing and Girls Empower-ment	Two pilots will be delivered in Newcastle, providing preventative, Early Help and targeted support to young people at risk of/ or victims of CSE ('Girls Empowerment Project') and exploring the potential for a local intelligence hub. The Girls Empowerment pilot will build on an existing project by promoting positive, preventative activities, 1:1 and group work. The information sharing pilot will assess the viability of a local intelligence hub, exploring the development of a pathway for partners in dealing with early concerns and will also support the shared information requirements of the Girls Empowerment Project. Innovative methods for information sharing to support early help and prevention will be explored through a Tenshi Challenge. The Tenshi Challenge will develop a solution that will assist agencies and communities to provide low level support to families which should reduce the need for more formal or statutory interventions. We would envisage the solution would provide multi-platform secure access to information about our families. We are also asking for proposals that would support a Social Action/People Helping People element potentially through a Social Network offer to participating/identified families.	• Improved confidence and self-esteem for vulnerable young women • Satisfaction with the service received from participants • Young women reporting an improvement in their safety and wellbeing • Increased availability of support for young women • Reduction in demand for statutory services. • Improved educational attendance • Improved behaviour in school/training • Improved emotional wellbeing for vulnerable young women	• Improved educational attendance of participants • Reduction in fixed term exclusions of participants • Percentage of participants reporting improvement in their emotional wellbeing • Percentage of participants reporting improvement in their confidence and self-esteem • Percentage of participants reporting an improvement in their safety and wellbeing • Percentage satisfaction reported by participants • Percentage satisfaction reported by participating schools • Reduction in the referrals into the LSTs • Provider reporting progress towards self-sustaining model for support for young women
Stafford: Multi Agency Centre +	The pilot has been designed to reduce high end demand through providing early (Tier 2) multi-agency support mechanisms within schools linked with community resources, capacity building and development which supports children and families at the earliest stages and helps to identify early support requirements. This pilot builds on BRFC, and Safer Schools Initiatives, leading to skilled and supported communities. Five schools have been identified in the first phase covering primary schools, secondary schools and one Pupil Referral Unit.	• Families are more resilient & supported in & by their local community which has capacity • Fewer (repeat) referrals to Tier 3/4 services • Fewer CiN/CP/LAC • Effective information sharing • Reduction in persistent absence rate • Commissioning resources	• Reduction in the referrals into the LST • Referrals into LST - reduction of CIN and CP • Reduce the rate of re-referrals into the LST • Improve the level of pupil premium attendance • Improve the level of FSM attendance • Reduce Pupil premium behaviour incidents • Reduce the number of behaviour incidents of students on Free School Meals • Reduce the number of fixed term exclusions

District	Summary	Key Outcomes	Headline KPIs
	To date, two have been selected, one is mobilised and a resource base within the second school has now been identified and work will now begin to identify and work with appropriate families.	effective/aligned • Partners play a greater role in Early Help	• Reduction in the number of young people's ASB outside school • Reduction of referrals to CAMHS • Number of agencies working within the MAC • Number of voluntary sector organisations engaging with families from the school.
South Staffs	This pilot focuses on a school cluster approach to family support addressing the root causes of presenting issues. Embracing principles of BRFC, Early Help and social action, the work focusses on identifying existing resources available within the schools and the local community and how these can best be engaged , coordinated and shared across the cluster to address root causes with a strong emphasis on empowering families to become resilient and bridge the gap between school and community resources through a multi-agency approach and commissioned tier 2 service	• Improved parenting skills • Improved emotional wellbeing of the whole family • Community safety is improved • CYP have a home environment conducive to learning and achieving	• Reduction of referrals into LST • Reduction of persistence absence • Reduction in exclusion rates • Reduction in behaviour incidents in school • Reduction in the rate of re-referrals into LST • Increase the number of families supported through community organisations • Reduction in the level of YP ASB • Number of YP signposted to positive activities
Tamworth: MAC Family & School Partnership Programme	This pilot has a three-phased approach: (i) Multi Agency Centre (MAC) development; MAC provision in academy setting, includes pastoral staff support to coordinate the MAC and attending agencies. (ii) Emotional health support; Enhancing the skills and capabilities of professionals to support children and young people experiencing Tier 2 (mild/moderate) difficulties with their emotional health and wellbeing. (iii) Targeted family support (BRFC principles); commissioning a Tier 2 family support service for identified families. Malachi (tier 2 family support provider) was commissioned in September and began work with families in October 2016 after developing the relevant process and pathways with the local support team and schools.	• Underlying family issues identified/addressed • Children kept safe and emotional needs met • Families achieve their goals • CYPF have good physical/emotional health • Children are supported in their learning • Parental employment/skills development • Families have improved household finances • CYP have a stable/secure home environment	• How many referrals per family have been received into the LST - Reduction in referrals to LST • How many re-referrals (family) have been received into the LST -Reduction in re-referrals to LST • How many families were allocated and received LST intervention - Reduction in LST intervention • How many referrals (family) have been received into Children's Social Care - Reduction in referrals to Statutory Children's Social Care • How many re- referrals (family) have been received into Children's Social Care -Reduction in re-referrals to Statutory Children's Social Care • How many families were allocated and received Children's Social Care S17 & S47 intervention -Reduction in Statutory Children's Social Care Intervention S17 & S47 • How many referrals (family) have been received into CAMHS - Reduction in referrals to CAMHS • How many families have received CAMHS intervention Reduction in Higher Tier Intervention • What was the attendance rate for RAWLETT & TEC -Increase in Attendance Rates • What was the educational attainment rates for RAWLETT & TEC - Increase in Educational attainment rates • What are the permanent exclusion rates for RAWLETT & TEC - Reduction in Permanent Exclusion rates • What are the fixed exclusion rates for RAWLETT & TEC - Reduction in Fixed Exclusion rates. • What are the rates of NEETS for young people that used to attend RAWLETT & TEC - Reduction in NEETs

Appendix 3: Children and Families Place Based Approach Concept in Staffordshire

Definition of a Place Based Approach for Children and Families	A collaborative approach using the right resources (multi-skilled teams, universal services, voluntary sector, communities, etc.) at the right time to improve outcomes for children, young people, families, vulnerable people and communities in an identified locality.
Aims	• Communities will become safer and healthier • Inappropriate, repeat and future demand for public services will be reduced by identifying and tackling problems earlier. • A more effective collaborative approach to the planning and delivery of support will be adopted, helping people to better help themselves and others • A resilient and sustainable system that is 'fit for the future' focusing on prevention and early help will be designed. • All stakeholders will benefit from the operating model.
Shared Principles	• Build on good practice of existing initiatives whilst removing duplication and streamlining / redesigning services. • Make better, collective use of our assets, resources and knowledge. • Ensure our decisions are evidence-based. • Use intelligence to effectively target resources to meet the local needs. • Address the presenting issue and the root cause factors. • Engage appropriate stakeholders in planning and delivery. • Be flexible in our approach and learn from emerging ideas and practice. • Address and resolve barriers and issues that arise.
Approach	• Joint understanding and ownership of an area and the associated issues. • Shared aspiration and approach which reflects local needs. • Ensure we have the right resource capability, competences and behaviours in the right places. • Focus on prevention and early help as an approach rather than a process. • Identify and proactively intervene within potential geographical hot-spot areas, vulnerable communities or seasonal issues. • Recognise and encourage community capability and capacity to grow to achieve maximum impact and sustainability. • Use intelligence to inform wider commissioning intentions to better meet local needs. • Build an evidence base to demonstrate success and to share learning. • Develop a shared risk appetite. • Develop appropriate high level central governance arrangements that effectively interfaces with existing local structures.
Existing decision-making forums	
Strategic Direction of Travel	Partner have agreed that the Place Based Approach not to be limited to addressing issues from increasing demand and fiscal challenges for children and families but to take a more ambitious approach. However, it is also acknowledged that by starting with children and families, in two geographical locations, a platform will be generated on which to build a county wide, consistent, evidenced based approach to dealing with the demand partners share across Staffordshire.

	The above describes the high level Place Based Approach concept which would be the same across Staffordshire but the models designed at District/Borough level by partners will be tailored to meet the needs of local communities. Pilots are currently underway to test the 'proof of concept' at a locality level and there is a two-way dialogue between the Local Strategic Partnerships and the Families Strategic Partnership as this progresses.

Appendix 4: Overview of Place Based Approach Pilots

Pilot	Overview of workshop discussions	Key Findings / Themes	Next Steps, including high level timescales

Newcastle-under-Lyme	Newcastle has held two workshops in April aimed at operational staff and managers. Organisations that attended represented those that work with children, families and vulnerable people.	Key findings included:
		• Some participants felt we 'have been here before'
		• Some frustration at lack of pace of change
		• Recognition that whole sector engagement is key along with change in culture towards resilience and away from services.
		• Information sharing at the earliest point is important to give the right earliest help.
		• We have to avoid 'demand shunting'.
		• Schools are key in delivering the change required
		• All agencies and partners are committed to making change happen and understand why it has to be made
		• A significant amount of valuable data and feedback received.
			• Consider and analyse feedback and data received
			• Integrate current Pilot work into PBA
			• Focus on 3 key areas:
			  ○ Community Resilience, Prevention and Earliest Help
			  ○ Demand Management
			  ○ Commissioning and reshaping of support to families
			• Develop an engagement and communications plan.
			• Follow-up workshop late Summer.
			• Understand our long-term aims and short/medium term deliverables and develop a project plan
			• Build the relationship between the Place Based Approach Task and Finish Group and the Secondary Head Teachers Partnership Group.
			• Understand the underlying culture change necessary to implement our agreed requirements.
			• Build on the successes of BRFC and broaden the principles to wider areas of work

Tamworth	Tamworth held two workshops in March aimed at operational staff and managers. Organisations that attended represented those that work with children, families and vulnerable people. The workshops informed partners of the background to the Place Based approach and looked at case studies and focussed on:
	1. What could have been done differently?
	2. How might we achieve necessary change?
		Key themes identified in the workshop include:
		• Earliest Help is in the community
		• Identify and deal with root causes
		• Knowledge sharing across the organisational and communities
		• Improving here and now (Development of a local multi agency model)
			• Staffordshire County Council, Tamworth Borough Council and Staffordshire Police met on 24th April to progress beyond the 2 workshops.
			• Local ownership via the Tamworth Strategic Partnership.
			• Coordination & Delivery Group with appropriate senior representation to lead. 1st meeting set for 12th June.
			• Task & Finish Group approach to progress the 4 identified theme areas
			• Focus on the 4 key themes identified in the workshop and:
			  ○ Collate and use shared knowledge and insight
			  ○ Agree approaches and priorities for change and identify success factors
			  ○ Deliver targeted, realistic initiatives and monitor outcomes
			• Virtual Communication with Tamworth Partners
			• Repeat multi agency workshop to be held in October 2017.

Appendix 5: High Level Draft PBA Implementation Plans

Tamworth Place Based – Action plan

Theme/Work-stream	Aims (deliverable by October 2017) & Outcomes	Lead	Considerations/Actions	Progress
Here and Now (collaborative working)	Establish an action focused multi agency hub approach to dealing with children, families and vulnerable people by October 2017 Hub is operational and roles are clear Systems in place to utilise intelligence Objectives for further development defined and plan for development in place **Outcomes:** Improved joint working, communication and coordination between agencies. Reduction in demand in service areas	Jason Nadin	scope the current hub approach Consider; • Needs and requirements of participating agencies • Process • Relationship to other groups • Name • Terminology • Membership? • How do we utilise the hub as an intelligence gathering tool • Establish performance measures?	JN to establish T&F Group to progress hub development Police, TBC & SCC in agreement that we should avoid creating additional front doors or increasing/shunting demand to partners. CH – Families First supportive re assisting development. KJ – TSU to scope the hub
Earliest Help in the community	To embed and implement the Early & Earliest Help approach To understand local organisational offers such as SCC Children's Services new structures and other organisations service offers. **Outcome** Supporting communities to help themselves. Supporting communities to offer the earliest help to children, families and vulnerable people	Tim Leese, Rob Barnes, Cheryl Rice	To identify and understand what early & earliest help is available across Tamworth To understand and join up organisational approaches to early & earliest help to communities. To align the SCC People Helping People approach. with the TBC Community approach and other organisational approaches, To communicate the new SCC children's services structures and local impact of changes. To understand and link in; • BRFC Accreditation Scheme & PBR, • Schools Grants, • 0-19 Contracts.	Agreement for TSU to assist in scoping out what is available across Tamworth.
Intelligence (using knowledge and creating insight)	Establish system to utilise the Tamworth hub/place based intelligence to inform; Root cause theme Service design, Local commissioning, Development of local initiatives Exploration of root causes	Rob Barnes	To be developed following further development of the hub. Scoping linked and aligned to the TSP exercise regarding intelligence and data insight.	Dependent upon learning, knowledge and experience from the development of the hub approach

Theme/Work-stream	Aims (deliverable by October 2017) & Outcomes	Lead	Considerations/Actions	Progress
Root Causes	To identify and understand root causes in target areas To target and tackle root causes to ultimately reduce demand in children's, families & vulnerable service systems **Outcome** Reduction in demand in service areas	TBC	To be developed following further development of the hub Understand what is root cause and its impact	Dependent upon learning, knowledge and experience from the development of the hub approach
General	Coordination and Delivery Group established	All	Needs recognition and empowerment Part of TSP- model for work on other issues	Meetings set for 12th June.
General	Follow up Multi Agency Workshop to be held in October	All	Date and venue to be confirmed	

Newcastle Place Based – Action plan

Theme/Work-stream	Aims (deliverable by October 2017) & Outcomes	Lead	Considerations/Actions	Progress
Local Strategy	**Outputs:** • Local Strategy Statement • Outcome Measures • Insight and Intelligence required	Mark Hewitt	First draft of Newcastle PBA strategy - By end of June	
Access & Triage	**Outputs:** • Develop Access and Triage design. • Develop community access routes. • Take full advantage of opportunities offered through public sector hub.	Sarah Moore	Paper going to PSH steering group, covering proposals for the Hub - End June Informal agreements on proposals to be signed off with service leads prior to PSH steering group meeting - End June Move to Castle House - Mid September Agree format/regularity of MA Triage - End July	

IAG & Engagement	**Outputs:**
	• Complete Asset mapping
	• Design strategy for accessing information for assets. Engagement Plan
	• Mapping and Engagement of wider stakeholders.
	  • Adults
	  • Communities and Voluntary
	  • LEP
		TBC	Confirm group Membership and Deliverables - Mid July	

Funding and Commissioning	**Outputs:** • Investigate funding approach and opportunities • Develop Commissioning Framework/Aspirational Model • Performance Measures	Craig Chorlton	Confirm group Membership and Deliverables - Mid July	

Staffordshire Health and Wellbeing Board	
Title	Prevention through Wellness – our People and Place based approach
Date	07 September
Board Sponsor	Richard Harling
Author	Karen Bryson
Report type	For Debate

Recommendations

1. The Board is asked to:
   a) Note the overlap between the Health and Well-being Strategy and the Sustainability and Transformation Partnership (STP) Prevention Workstream, and agree that the Strategy be adopted as the strategic framework for the (STP) Prevention Workstream.
   b) Agree that the development and implementation of the Delivery Plan should be overseen by a Prevention Steering Group established as a sub-group of the HWB, with membership drawn from key partners, and reporting to the HWB and the STP Board.
   c) Consider the proposed key themes for the Strategy to focus on.
   d) Consider the proposed approach to prevention.

Context

2. Staffordshire has a growing and ageing population - with all of the growth among people over 65. The number of people aged 65-84 will increase by 36,000 and the number 85 plus by 19,000 over the next 10-15 years. At the same time the number of people of working age will fall so that by 2030 there will be just 2 working age adults for each person aged 65 plus, compared to 5 in 1985.

3. Life expectancy at birth currently in is 80 years for men and 83 years for women, similar to the national average. Healthy life expectancy in Staffordshire is 64 years for both men and women. So people typically spend 15-20 years towards the end of their lives in progressively poorer health. There are significant health inequalities across the county, with a six year difference in life expectancy and a 12 year difference in healthy life expectancy between people living in the most and least deprived communities. People with a severe mental illness are three times more likely to die early than the general population.

4. 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. A growing number of people have one or more long-term conditions, many of which a lifestyle related: over half of people aged over 65 have a limiting long-term illness; by 2025 the number of people with dementia is projected to increase to 14,800, an increase of 34%.

5. The ageing population will have huge implications for health and care services. Demand already outstrips supply to the tune of £150m. This is predicted rise to £500m over the next few years if no action is taken. However the growing demand is not just a consequence of demographic changes and individual lifestyle choices. It is in large part driven by public and professional perceptions of accountability for well-being, the wider determinants of health, and a model of care that favours intervention.

Background

6. On 06 July 2017 the HWB considered an early draft of the Health and Well-being Strategy 2018-23. The HWB provisionally agreed a revised vision:

> *"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."*

with the role of the HWB:

> *"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."*

7. The HWB also discussed that the Strategy should:
   - Be simple and succinct so that it can be understood by the public;
   - Encourage and help people to take responsibility for their own health and well-being and reduce dependence on health and care services;
   - Include a renewed **focus on prevention** and early intervention;
   - Promote dialogue between partners to enable a more **integrated approach;**
   - Make sure people can **navigate** our systems and services;
   - Focus on a small number of key themes;
   - Include action across the **life course**; and
   - Include a **Place based approach** to identify what can be done at a local level.

8. The Sustainability and Transformation Partnership (STP) in the meantime has been continuing work on its five priority Workstreams:
   - Prevention;
   - Enhanced Primary and Community Care;
   - Effective and Efficient Planned Care;
   - Mental Health; and
   - Urgent and Emergency Care.

9. The emerging Health and Well-being Strategy has much in common with the STP Prevention Workstream. **Recommendation a)** therefore is that the Strategy be adopted as the strategic framework for the Prevention Workstream and that they should have a single Delivery Plan. **Recommendation b)** is that

the development and implementation of the Delivery Plan should be overseen by a Prevention Steering Group established as a sub-group of the HWB, with membership drawn from key partners, and reporting to the HWB and the STP Board.

Key themes for the Strategy to focus on

10. If the HWB is going to focus on a small number of key themes, these ought to be issues that are major causes of poor health and well-being health. The initial suggestion is to focus on three key themes as below. Full details about the impact of these can be found in the Joint Strategic Needs Assessment. **Recommendation c)** is that the HWB consider these:
    - **Lifestyle factors** – obesity, physical activity, smoking, drugs and alcohol.
    - **Mental well-being** – social isolation, dementia, suicide prevention.
    - **Long term conditions** - diabetes, heart disease and stroke, respiratory disease, end of life.

Our approach to prevention

11. Our approach to improving health and well-being will need to continue a fundamental shift from an approach based on providing services for people to an approach based on creating a social movement whereby people aspire to good health as the norm a culture and environment which promotes personal "wellness". This is about encouraging and enabling people to own and manage their well-being as part of everyday life and creating a.

12. During the next five years we will need an ongoing **dialogue with the public** about how they can take responsibility for staying well and independent and planning for their later years. In return the local public and private sectors will need to commit to developing local areas that favour positive choices. For example, people need to eat better and exercise more: to help them take responsibility organisations will need to think about the availability of healthy food choices and opportunities for physical activity. We will also need to think about how individuals and families can build emotional resilience and what schools and workplaces can contribute to improving their mental health. We will need to secure multiagency commitment to improving well-being and our **Health in All Policies project** will help organisations consider the health impact of their decisions. This will include the traditional public sector organisations and we will also look to develop new relationships with businesses and industry to understand opportunities for them to get involved in improving health.

13. We already offer access online to **information and advice** for people about how to maintain well-being and independence. We need to expand the content to include advice about planning for long term care and for death. We also need to continually improve the profile and presentation of resources so that they are promoted consistently as a first point of contact and are really easy to find and understand.

14. Staffordshire is rich in **community assets**: we have lots of individuals and organisations who give their time to helping others. Over the next few years we need to build on this and increase the range and volume of support available. The County Council has a contract with the voluntary sector to develop community capacity. We will also need to continue to encourage and celebrate communities that support one another. And we will need to better understand what's out there so that we can enable more people to be able to take advantage. The intention is to have a full and up to date list of community assets available on the website to facilitate **social prescribing** by health and care professionals.

15. We will continue to invest in support for higher risk individuals in order to avoid the need for more expensive treatment and care - for example drug and alcohol services, reablement and falls prevention. We will also look to develop a proactive approach to identifying and supporting those at highest risk of needing care through the use of **risk stratification tools**, investment in evidence based interventions and redesign of **redesign of pathways** to address their underlying problems – for example falls, social isolation, diabetes and dementia.

16. We will also continue to encourage and enable **self-service and** expand the ability for people to self-assess their own health and care. We want to link this to a range of community assets, services and products to help them. We will particularly focus on **assistive technologies** that people can buy simply and cheaply to improve their lives.

17. Whilst the issues are different for adults and children, this fundamental approach should be the same across the **life course**.

18. Throughout this we will adopt a **Place based approach**. We will look to local leaders to join the conversation with the public about their health and care. We will support local organisations to understand what they can do in their area to make it a Place conducive to good health and well-being. We will aim to map community assets to the 23 localities that are being developed by the STP. We will also use these localities as the footprint for identification and development of pathways for management of high risk individuals.

19. **Recommendation d)** is that HWB consider and comment on this approach. The Delivery Plan will then reflect the key themes and this approach in a 'matrix'.

Staffordshire Health and Wellbeing Board	
Title	Better Care Fund Update
Date	07 September 2017
Board Sponsor	Dr Richard Harling
Author	Rebecca Wilkinson
Report type	For noting

1.0 Summary

1.1 The planning guidance and templates have now been released and the County Council and Staffordshire CCGs (CCG's) are working towards the 11th September for the final submission

1.2 The iBCF has been signed off by the County Council and CCG's and was submitted 21st July 2017.

1.3 As part of the iBCF the Delayed Transfer of Care (DTOC) trajectory was submitted and we are awaiting feedback from the BCF National Team

2.0 Recommendations to the Board:

2.1 HWB note the contents of the report

2.2 HWB note that the DTOC trajectory has been submitted to the BCF regional team does not meet the target set (agreed at July 2017 HWB),

2.3 HWB note that since the submission of the DTOC trajectory, West Midlands Local Authorities have been notified that there was an error in the DTOC calculations, the DTOC trajectory will have to be resubmitted, the date for the new submission has not been released

2.4 HWB Board note that the key HWB sign off required is for the detailed 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 the £431m Disabled Facilities Grant (DFG) and £1.115bn new grant allocation to local authorities to fund adult social care, as announced in the 2015 Spending Review and Spring Budget 2017. Both grants are paid directly from the Government to local authorities

3.3 The value of the new grant allocation to Staffordshire (iBCF) is £15.5m, the new iBCF grant is in addition to the BCF and will be paid directly to local authorities via a Section 31 grant with conditions set by Government to ensure it is included in the BCF at local level and will be spent on adult social care.

3.4 The NHS contribution to the BCF (The BCF for 2017-8 is awaiting confirmation but expected to be 16/17 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

3.5 The iBCF must be used for 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;
- 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;
- 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 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.

4.0 Progress

4.1 The iBCF is complete and has been submitted

4.2 SCC and the CCGs are working together to ensure all the national conditions and KLOE's are met prior to submission on 11th September 2017.

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

Staffordshire Health and Wellbeing Board	
Topic:	JSNA outcomes report – August 2017
Date:	7 September 2017
Board Member:	Richard Harling
Author:	Kate Waterhouse
Report Type	For information

1 Purpose of the report

1.1 The health and wellbeing 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 data updated this quarter include: rates of childhood immunisation rates have fallen slightly but remain higher than the national average; pupil absence rates remain lower than the national average; the number of people being offered and taking up their offer of a NHS health check has improved.

2.2 Some of the challenges in Staffordshire based on data from this quarter include: higher than average women smoking throughout pregnancy; lower than average breastfeeding rates; diagnosis rates of chlamydia below the recommended average, the number of delayed transfers of care from hospital continues to be higher than the national average; fuel poverty rates are higher than average; the number of older people taking their offer of a pneumococcal vaccine remains below average and end of life care measured by the proportion of people dying at home, or their usual place of residence, is below the England average.

working together for better health

Health and Wellbeing outcomes Summary report for Staffordshire August 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 attainment rates. Unplanned admissions to hospital for lower respiratory infections and self-harm for children and 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)	▪ 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	▪ **Pupil absence** ▪ 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 ▪ **Adult smoking prevalence** ▪ 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
Age well	Fewer Staffordshire residents over 65 take up their flu vaccination or their offer of a pneumococcal vaccine; in addition fuel poverty rates are high, these two factors 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.	▪ **Fuel poverty** ▪ **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**	▪ 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 some 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	No	Inequalities in life expectancy - males (slope index of inequality) (years)	2013-2015	7.1	9.2	Stable
1.2b	No	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	12.6%	10.5%	Stable
2.4a	No	Breastfeeding initiation rates	2016/17 Q3	66.9%	73.0%	Stable
2.4b	Yes	Breastfeeding prevalence rates at six to eight weeks	2016/17	21.4%	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	96.6%	93.1%	Stable
2.6b	Yes	Measles, mumps and rubella at 24 months	2016/17	93.7%	91.3%	Worsening
2.6c	Yes	Measles, mumps and rubella (first and second doses) at five years	2016/17	91.1%	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
2.1	Yes	Pupil absence	2015/16	4.3%	4.6%	Stable
2.2	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	No	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	2016 Q1	22.6	20.4	Stable
3.8b	No	Under-16 conception rates per 1,000 girls aged 13-15	2013-2015	4.9	4.3	Stable
3.9	Yes	Chlamydia diagnosis (15-24 years) (rate per 100,000)	2016	1,614	1,882	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	No	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (ASR per 100,000)	2015/16	334	312	Stable
3.12	No	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	No	Child admissions for mental health for under 18s (ASR per 100,000)	2015/16	84	86	Stable
3.14	No	Hospital admissions as a result of self-harm (10-24 years) (ASR per 100,000)	2015/16	490	431	Stable
4.1	No	Satisfied with area as a place to live	Mar-17	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	Yes	Sickness absence - employees who had at least one day off in the previous week	2013-2015	2.0%	2.2%	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	No	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	No	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	Yes	Smoking prevalence (18+)	2016	15.4%	15.5%	Stable
4.13b	Yes	Smoking prevalence in manual workers (18+)	2016	29.8%	26.5%	Stable
4.14	No	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	72.2%	74.1%	Improving
4.20b	Yes	NHS health checks received (as a proportion of those offered)	2013/14 - 2016/17	42.9%	48.9%	Stable
4.20c	Yes	NHS health checks received (as a proportion of those eligible)	2013/14 - 2016/17	31.0%	36.2%	Improving
4.21	No	Hospital admissions as a result of self-harm (ASR per 100,000)	2015/16	205	197	Stable
4.22a	No	Successful completion of drug treatment - opiate users	Oct 2015 to Sept 2016	6.2%	6.6%	Stable
4.22b	No	Successful drug treatment exits - opiate users	Mar-17	7.3%	7.1%	Stable
5.1	Yes	Fuel poverty	2014	12.0%	11.0%	Worsening

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	Yes	Pneumococcal vaccine in people aged 65 and over	2016/17	65.6%	69.8%	Worsening
5.4	No	Seasonal flu in people aged 65 and over	2016/17	69.3%	70.5%	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	No	Acute ambulatory care sensitive (ACS) conditions (ASR per 100,000)	2015/16	1,418	1,319	Worsening
5.9b	No	Chronic ambulatory care sensitive (ACS) conditions (ASR per 100,000)	2015/16	800	812	Worsening
5.10	Yes	Delayed transfers of care (average delayed days per month per 100,000 population aged 18 and over)	Jun-17	534	406	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	2015/16	87.8%	82.7%	Stable
5.12b	No	Older people aged 65 and over who received reablement services after hospital discharge	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	Jun-17	68.0%	67.9%	Stable
5.15	No	Falls admissions in people aged 65 and over (ASR per 100,000)	2015/16	2,239	2,169	Stable
5.16	No	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 Q3	41.6%	45.8%	Stable
6.12	No	Mortality attributable to particulate air pollution, persons aged 30 and over	2015	4.5%	4.7%	Stable

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 6 July meeting	
	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)	
		Public Conversation		
		Commissioning Intentions		
		Ofsted report of Children's Services		
	Items for Information	**HWBB Strategy**	Final draft	
		Staffs & Stoke Adult Safeguarding Partnership Board Chairman: John Wood	Annual report	
8 March 2018 PUBLIC BOARD	**Items for Decision**	HWBB Strategy	Final approval	

Date of meeting	Item		Details	Outcome
MEETING	**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 Mark Sutton – Cabinet Member for Children and Young People Philip White – Cabinet Support Member for Learning and Employability	Mike Sutherland – Cabinet Support Member for Adult Safeguarding
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 Commissioning Group	Mo Huda – Chair of Cannock Chase CCG Paddy Hannigan– Chair of Stafford and Surrounds CCG John James – Chair of South East Staffs and Seisdon Peninsula CCG **CO CHAIR - Charles Pidsley** – Chair of East Staffs CCG Alison Bradley - Chair of North Staffs CCG	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	Gareth Morgan – 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