St. Helens Health & Wellbeing Strategy

2013 - 2016

St. Helens Council and Clinical Commissioning Group

St. Helens Health & Wellbeing Strategy

St. Helens Council and Clinical Commissioning Group working with partners for Health & Wellbeing in St. Helens
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Welcome to the first St.Helens Health and Wellbeing Strategy. This strategy has been developed by the Health and Wellbeing Board to set out our shared priorities for improving the health and wellbeing of all people living in the Borough, and establish how we will tackle them. For the first time, this is a joint responsibility for St.Helens Council and St.Helens Clinical Commissioning Group (the local NHS).

The Health and Wellbeing Board brings together those who identify, buy and plan services across the NHS, Public Health, Adult Social Care and Children’s Services, plus elected Councillors and community representatives, to jointly consider local needs and develop the right services for St.Helens. We have worked hard to identify and agree local priorities that we believe we can make a difference to by working together in partnership as members of the Health and Wellbeing Board. We have consulted widely with members of the public, voluntary and community sector organisations and other stakeholders to check that our aspirations match those of the community. Through our joint commitment to working together to deliver our shared vision, we will be able to act more effectively, target resources and improve the health and wellbeing of the population of St.Helens.

This is a period of rapid change for all local public services and there are significant challenges on the horizon, not least of these is the current economic climate and the inevitable impact this will have on our community and local services. However, there are also opportunities to reconsider how we have delivered services in the past and make changes to secure improvements for the future. We believe that everyone in the Borough has an equal right to good health and high quality services.

It is our vision to enable all our residents to lead healthy lives by providing the support and opportunities that they need to do this. The health of people in St.Helens has improved over recent years; death rates from cancer, heart disease and stroke have fallen, there has been a decline in the number of adults who smoke, and a fall in the level of childhood obesity. However, there is still much room for improvement; too many mothers are smoking during pregnancy; breastfeeding rates remain too low, alcohol related harm has increased over recent years and too many people are admitted to hospital as an emergency. These issues are compounded by the changing demographic profile of the Borough, with the number of people living with long term conditions and dementia increasing with the ageing population. Additionally, there remains an unacceptable gap in life expectancy between St.Helens and the England average and these challenges are what we will focus on during the life of this strategy.

This strategy sets out where we will target our resources over the coming years, by putting prevention at the heart of local programmes, developing a strong communication policy, thus enabling people to take more responsibility for their own health, learning and building on our success and making improvements in areas where our outcomes are less strong.

Councillor Barrie Grunewald
Leader of St.Helens Council

Bill Guest
Chair of St.Helens Clinical Commissioning Group

1. Foreword

The overarching goals of the strategy are to improve health and wellbeing across St.Helens as a whole and to reduce inequalities that exist within the Borough. One of the most fundamental inequalities is life expectancy at birth. Recent data shows that there is a difference of 11.6 years between life expectancy of males in the Town Centre than in Rainford. Our goal is to narrow the male life expectancy gap across wards by 1 year over the lifetime of the strategy. The difference in female life expectancy is 6.3 years; this has improved significantly over the last few years, therefore we aim to reduce the gap in female life expectancy by just under 1 year over the lifetime of the strategy.

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Our Vision

“Investing in wellbeing, reducing ill health and creating a healthy St.Helens.”

Overarching Goals

The St.Helens Health and Wellbeing Board brings together health, the voluntary and community sector, Public Health and a wide range of council services. It outlines how we will work together to improve people’s health and wellbeing, by providing health, social care and other services that will meet the current and future needs of the Borough.

We have identified eight priority issues to work together on, to make our shared vision a reality. The strategy is not about tackling everything at once, but about setting priorities for joint action and making a real impact on people’s lives, particularly in relation to reducing health inequalities. Although not all of the health and wellbeing challenges facing the Borough have been identified as specific priorities, the strategy aims to improve outcomes for all residents.

The strategy has prevention of ill health and building community resilience at the heart of its approach. To improve outcomes for all residents, it will be important to influence a wide range of issues including housing, the environment, lifestyle, employment, crime, poverty and beyond. It also identifies how we intend to monitor our progress as the strategy is delivered over the next three years.

Our Vision

“Investing in wellbeing, reducing ill health and creating a healthy St.Helens.”

Overarching Goals

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Our priorities

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<th>Priority</th>
<th>Life Stage</th>
<th>Lead Agency/Partner</th>
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<td>1.</td>
<td>Give every child the best start in life</td>
<td>Public Health</td>
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<td>Early years, pre-birth to 5 years</td>
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<td>2.</td>
<td>Support for young people</td>
<td>Public Health and Children and Young People’s Services</td>
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<td>Young people</td>
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<td>3.</td>
<td>Tackling alcohol misuse</td>
<td>Public Health</td>
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<td>All age groups</td>
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<td>Obesity and excess weight</td>
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<td>All age groups</td>
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<td>5.</td>
<td>Promoting mental health and wellbeing</td>
<td>Adult Social Care, Clinical Commissioning Group and Public Health</td>
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<td>All age groups</td>
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<td>6.</td>
<td>Early detection and effective management of long term conditions</td>
<td>Clinical Commissioning Group</td>
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<td>Reduce unnecessary hospital admissions and readmissions</td>
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<td>8.</td>
<td>Support for people with dementia</td>
<td>Adult Social Care</td>
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<td>Older people</td>
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These priorities have been identified using the St.Helens Joint Strategic Needs Assessment (JSNA) - A Picture of Health and Wellbeing, which provides an overview of the current and future health needs of the Borough and forms the primary evidence base. In order to identify local priorities, each health or wellbeing topic arising from the JSNA has been assessed against the following criteria:

- What are the health and wellbeing needs (identify the impact on local people)?
- Are there health inequalities (geographical inequality or vulnerable groups)?
- What is the impact on health, social care or other services?
- Is the issue amenable to change?
- Is there a robust evidence base for change?

As highlighted within the JSNA, a wide range of social, economic and environmental factors can influence health outcomes. These are sometimes referred to as the ‘social determinants’ of health and are often described as ‘the causes of the causes’ of ill health. These social determinants include day-to-day quality of life and wider structural influences at global, national and local levels. Therefore, in the delivery of this strategy, it will be essential to influence the way in which a wide range of frontline services are planned and delivered to make sure health and wellbeing is everyone’s business.

In developing the strategy, we consulted widely with members of the public, voluntary and community groups and other stakeholders to test that the issues emerging from the data match the aspirations of the local community. It is acknowledged that it will not be possible to effectively tackle all health and social care issues immediately, therefore the Health and Wellbeing Board has selected those areas where focused partnership work is most likely to result in demonstrable improvements in health and wellbeing for residents of the Borough.

Cross Cutting Principles

The Health and Wellbeing Board has considered its role in the changing health and social care landscape and challenging economic climate. It is proposed that all commissioning plans, services and interventions should be developed in line with the following principles, in order to effectively address health inequalities and make the best possible use of resources:

- **Prevention** - Services should focus on keeping people well and preventing ill health.
- **Tackling inequality** - Provision of services should be proportional to need and targeted to those areas and groups of people that need them the most. Needs assessment and equality analysis will be used to support decision-making, and ensure reasonable mitigation where an adverse impact is identified for a particular group.
- **Good patient experience and access to services** - Services should be customer focused and accessible to all, including people with learning disabilities, the Armed Forces community, people with physical disabilities, those who do not speak English as their first language and hard to reach groups, for example Gypsy and Traveller communities.
- **Integration and joint working** - Service provision and care pathways should be integrated, where beneficial, for patients and service users with all relevant providers working together across and beyond the St.Helens health economy.
- **Effectiveness** - Services and interventions should be evidence-based and provide value for money, utilising existing assets to their greatest effect.
- **Sustainability** - Services should be developed and delivered to be socially, environmentally and financially sustainable.
- **Promote independence** – Services should support individuals to remain independent and exercise choice and control.
- **Safeguarding children and adults** – All partners must work together to safeguard children and adults from abuse or neglect in accordance with agreed St.Helens multi-agency procedures.
- **Careers** – Ensure carers of all ages are valued and recognised for the job they do, are given appropriate advice and support and are involved in care planning.
- **Community resilience** – Encourage communities and individuals to harness local assets, networks and expertise so that they can help themselves and take greater responsibility for their own health and wellbeing.
Context

The Health and Wellbeing Strategy has been developed during a period of rapid transformation, and there is recognition that the new commissioning landscape will take time to be fully established; this presents an opportunity for all partners to work together more effectively. The Health and Wellbeing Board is mindful of the impact of the current economic climate on people's health and wellbeing, and also the potential implications for the statutory and voluntary sector. The broad context of the strategy is outlined in the following section.

The New Commissioning Landscape

Following the recent Health and Social Care Act (2012), national and local health care systems are undergoing a significant period of structural reform, with further changes proposed for the delivery of social care. In introducing the Act, the Government's intention was to provide greater democratic involvement for locally driven NHS and Public Health services, to strengthen partnership working and to expand integrated commissioning between health and social care.

One of the key changes is the establishment of Health and Wellbeing Boards for each Local Authority Area. Health and Wellbeing Boards provide leadership and accountability across the health and wellbeing landscape, drive change and improvement, target resources and influence the social determinants of health.

In April 2013, Strategic Health Authorities and Primary Care Trusts were abolished and new national bodies were put in place. These include the NHS Commissioning Board and Public Health England. Clinical Commissioning Groups have taken on commissioning responsibilities for local health services and the majority of local Public Health functions have transferred to Local Authorities.

St. Helens Health and Wellbeing Board

Joint working between councils and the NHS has a long history; this reflects the close links between health care and social care and the significant impact each of these have upon the community. In St. Helens, there is a strong track record of effective partnership working with an ethos of targeting resources at those people and communities with the greatest needs, and a shared focus upon improving outcomes for local residents.

In St. Helens, the membership of the Health and Wellbeing Board includes local elected members, St. Helens Clinical Commissioning Group, Council Officers, Public Health, the Local Involvement Network and the voluntary sector.

Two of the main responsibilities of the St. Helens Health and Wellbeing Board are the production of a Joint Strategic Needs Assessment (JSNA), which identifies the current and future local health and wellbeing needs of the population, and the development of this Health and Wellbeing Strategy, which sets out the local health and wellbeing priorities and how they will be met.

Public Health

Public Health functions transferred to Local Authorities and a newly formed body, Public Health England in April 2013. Some of the functions that have become the responsibility of the Council include sexual health, drug and alcohol services, health protection and emergency preparedness, the NHS Health Check Programme, the National Child Measurement Programme and locally agreed health improvement services. Public Health England was established as the authoritative national voice for Public Health, setting the overall outcomes framework and providing support for local work.

NHS Commissioning Board

The NHS Commissioning Board was established as an independent body, at arm's length to the Government in October 2012. Initially, it carried out limited functions such as establishing and authorising CCGs. The board took on its full range of responsibilities including specialised commissioning when it was established in April 2013.

Clinical Commissioning Group

Through its member GP practices, St. Helens Clinical Commissioning Group will be responsible for commissioning planned care, emergency and urgent care for everyone within the Borough. This includes community health services, maternity services, elective hospital care, rehabilitation services, urgent and emergency care including Accident & Emergency, ambulance and out-of-hours services. The Clinical Commissioning Group will also be responsible for ensuring the continuous improvement in quality of primary care and will place an emphasis on preventing ill health and deterioration of existing conditions.

Local Healthwatch

The Health and Social Care Act aims to promote a ‘voice’ for patients and the public in the design of health services. New patient and public bodies, known as local Healthwatch, will be established to replace the current LINks. Healthwatch St. Helens will act as an independent consumer champion for health and social care and will have a seat on the Health and Wellbeing Board. Healthwatch St. Helens will be commissioned by the Council and held to account by the Local Authority’s Overview and Scrutiny Committee.

Local Authority

St. Helens Council will continue to provide and commission a wide range of services; these include Children’s Services, Adult Social Care, Environmental Protection, Urban Regeneration and Housing Strategy and Planning. In April 2013, the Council took on responsibility for local Public Health functions as set out above.

Economic and Social Context

Alongside the structural reform programme underway, local public services are also facing ongoing financial pressures. The immediate and emerging impact of spending cuts will inevitably affect health and wellbeing both in terms of individuals and future service provision. Financial constraints on all organisations and rising demand for services will put increased pressure on service delivery; therefore it is vital to ensure that services are sustainable and make the best possible use of existing assets in the Borough.

Financial pressures experienced by local residents, as a result of the current economic climate and changes to the welfare system, are also likely to have an impact on health and wellbeing and could potentially increase risk-taking behaviour. Additionally, demand for mental health services is likely to increase as a result of unemployment, personal debt, home repossession and other fallout from the economic climate.

Partnership Working in St. Helens

Partnership working in St. Helens has developed over many years; in 1999, one of the first public and private regeneration partnerships in the country was widened to include partnerships with a focus on community safety, services for children and young people and, health inequalities to become St. Helens Together, our Local Strategic Partnership (LSP).

St. Helens Together brings partners from the public sector, faith, sports, community, voluntary and business sectors to tackle the issues that matter to local people such as crime, jobs, education, health and housing. By working together to deliver against the priorities identified in the St. Helens Plan, the partnership provides strong leadership guided by community voices to achieve stronger, more inclusive and tolerant communities.

St. Helens Together oversees the 3 year St. Helens Plan which is a medium term planning document that sets out a vision for the future of the Borough. It is built on the main ambitions and concerns that local people and businesses, voluntary, community, faith, sports and other public organisations have identified, and sets out measures where shared action could make significant improvements. The plan seeks to achieve sustainable development and equal, inclusive and cohesive communities.
The work of the St. Helens Health and Wellbeing Board supports the delivery of the overarching St. Helens Plan by driving delivery and integration across health and social care services. The success of the Health and Wellbeing Strategy will also be dependent upon a much wider range of partners than those represented on the Health and Wellbeing Board therefore, the wider strategic partnership will be instrumental in supporting the implementation of the strategy.

How we have consulted with local people

Working effectively with our residents will be essential in delivering the vision of this strategy. Consultation and engagement with local residents, the voluntary and community sector and partner organisations has been an important means of developing an understanding of the priorities and aspirations of the community.

A set of proposed priorities, largely based on findings from the Joint Strategic Needs Assessment, were subject to widespread consultation and engagement. The consultation was widely promoted to encourage a broad range of stakeholders and members of the public to participate. Promotion included; a six week banner on the front page of the Council website, press releases and articles in the local press, publicity in a number of voluntary sector newsletters and bulletins, and emails and letters sent to a wide range of stakeholders.

The consultation exercise was guided by the latest Government consultation principles (2012). These principles advise that consultation should be ‘digital by default’ but using other forms where needed. The following engagement methods were used:

- An online survey (also available in hard copy), direct feedback via email and telephone.
- A public workshop, organised by St. Helens LINk, was held for members of the public to find out more about the draft strategy and to give their feedback in person.
- A workshop for young people was held at Derbyshire Hill Youth Club; the views of young carers were also put forward with support from St. Helens Young Carers.
- Engagement activity and presentations of the draft Joint Health and Wellbeing Strategy took place at a number of partnership meetings and networks across the Borough.
- Facilitated discussions supported by Halton and St. Helens Voluntary and Community Action with members of the Borough Forum.

Overall, a broad range of responses were received with feedback gathered from over 200 individuals and organisations. It has been possible to incorporate most of the suggestions put forward within this strategy. Analysis of the responses found that strong support was given for the eight proposed priorities.

The strongest support came for the following priorities:

- Promoting mental health and wellbeing
- Dementia
- Give every child the best start in life

However, a number of respondents felt that the eight priorities were too broad and needed to be more explicit about action and intervention. It was requested that the Health and Wellbeing Board should consider the inclusion of additional issues such as addressing cancer as a specific priority, getting people ready for work, support for carers (including young carers) and identifying frail elderly people as a specific target group.

There was overall support for a focus on prevention of ill health, with recognition of its long term benefits. This included recognition of the role that education, physical activity, mental wellbeing and housing has in achieving this for adults and children and young people.
1. ‘Giving every child the best start in life…’

We will focus on…

- Maternity - Continue to deliver and improve maternal smoking cessation programmes, encourage early booking of pregnant women, maintain weight loss programme for pregnant women and maximise uptake of antenatal immunisation programmes (seasonal influenza and pertussis) and screening.
- Breastfeeding - Support the St.Helens Infant Feeding Team, and development of peer support services in children’s centres, encourage a culture of breastfeeding in the local community by communicating health benefits, providing support and creating an environment where women choose to breastfeed.
- Family Nurse Partnership approach - Support the implementation of a Family Nurse Partnership approach, utilising the increased capacity within the health visitor workforce. This is an evidence based approach, working with teenage mums who are a high-risk group.
- Health visitors - Monitor, review and challenge the delivery of the Health Visitor Implementation Programme within St.Helens.
- Early intervention - Deliver the 0-5 Healthy Child Programme, with all families accessing high quality universal services.
- Targeted services - Deliver high quality, evidence based services for those families and children in greatest need. Deliver early intervention to break the cycle of poverty and help parents to maximise their skills and give their children the best start.
- Safeguarding - Ensure all partners comply with agreed multi-agency St.Helens Safeguarding procedures.
- School readiness - Support the delivery of programmes through children’s centres and other community assets to support communication, emotional, physical and social development so children start school confident and able to learn.

A child’s experience pre-birth and during the early years is critical to the child’s physical, cognitive and social development. During this development phase, the foundations are put in place for the rest of that child’s life and it is a once in a lifetime opportunity to give that child the ‘best start in life’. Both the Allen report (2011) and the Marmot review (2010) recognise the importance of giving every child the optimum conditions, and how investing in this period of a child’s life influences their school readiness, educational attainment, economic participation and long term health.

There are a number of factors that are particularly influential during this developmental phase. The health and wellbeing of the mother is very important, shaping development of the foetus and the child. Factors that can adversely affect outcomes for the child include maternal smoking, maternal obesity, alcohol consumption, drug taking and poor nutrition. Events in the mother’s life such as domestic abuse, mental illness, substance misuse and being a teenage mum can have an adverse effect on the child’s physical and mental health, and impact upon the mother-child relationship. Maternal risk factors can increase the risk of babies being born with a low-birth weight. Low birth weights are associated with poorer long term health and educational outcomes. Poverty both increases the likelihood and exacerbates the impact of these risk factors.

Early intervention at this stage of the child’s development is essential to break the cycle of poverty, enhance life chances and reduce health inequalities.
Why is this an important issue for St.Helens?

A wide range of challenges remain to improve the health of young children in St.Helens. Over a quarter of children (26.9%) within St.Helens live in poverty, and overall the health of children and young people is generally worse than the England average.

Areas where performance remains significantly below the England average include: the percentage of mothers that smoke during pregnancy (21.8% against an England average of 13.6% (2010/11)), the percentage of mothers initiating breastfeeding (48.7% compared to 74.5% average for England (2010/11)) and breastfeeding at 6-8 weeks (19.5% compared to 45.2% average for England (2010/11)), the rate of neonatal conceptions (51.2 per 1,000 females aged 15-17 compared to 38.1 for England as a whole (2008/10)) and the number of infants admitted to hospital due to injuries (205.6 per 10,000 children aged 0-5 compared with 143.2 for England (2010/11)).

However, there have been improvements in infant and child mortality rates, which are now similar to the England averages. This is as a result of a range of programmes over the past few years such as: increasing uptake of childhood immunisations, smoke free homes, campaigns to reduce the risk of sudden infant death and work to help pregnant women to quit smoking.

Both alcohol and substance misuse are major sources of harm in St.Helens and have a considerable impact upon the family as well as the individual. Alcohol and substance misuse increases the risk of domestic violence, harm to unborn babies, child abuse including neglect and early mortality, and road traffic accidents.

There are high numbers of Looked After Children (LAC) in St.Helens (91.0 per 10,000 compared to an average rate in England of 59.0 per 10,000 (2011)). Nationally, it has been shown that Looked After Children have worse health outcomes than the general population, therefore there is a need to establish the health and wellbeing outcomes for Looked After Children in St.Helens.

Evidence suggests that accidents are the main cause of death in childhood and are a major cause of ill health and disability. Recent work suggests that the most common reason for A&E attendances for children aged 0-4 years was for falls, followed by road traffic collisions. Other accidents that are common in young children include burns and scalds, choking and poisoning.

Over the medium term, the Health and Wellbeing Board will play an important role in facilitating the smooth transition of the commissioning of 0-5 Public Health services from the NHS Commissioning Board to St.Helens Council with minimum disruption to patients and services. One of the key challenges will be ensuring that the Child Health Data System is fit for purpose and generates accurate reliable data, which will enable robust performance management and the transfer of this to the NHS Commissioning Board.

Good Practice

The core programme for child development in St.Helens is the Healthy Child Programme. The programme spans the antenatal period to 19 years of age. All children, young people and their families have access to a universal service offer that is provided by multiple agencies in partnership from across St.Helens. Delivering all child development services in partnership ensures the best possible, high quality services for children, young people and their families, which will ensure the best start in life.

For the early life stages, the focus is on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews supplemented by advice around health, wellbeing and parenting. The Department of Health 'Health Visitor Implementation Programme' will deliver an increased number of health visitors in St.Helens, to support the delivery of the Healthy Child Programme.

Health visiting and the Healthy Child Programme for the under 5s is now commissioned by the NHS Commissioning Board (NCB), and in 2015, these responsibilities will transfer to St.Helens Council. It is therefore important that, regardless of who is commissioning the service, that through close multidisciplinary partnership working and the inclusion of GPs and community nursing providers, the needs of early years are met.

A programme of work to reduce child poverty and improve life chances is being delivered through the implementation of the St.Helens Child Poverty Strategy and participation in the Liverpool City Region Child Poverty Commission, including a range of work streams relevant to this area. There are also QIPP (Quality, Innovation, Productivity and Prevention) programmes of work across Merseyside underway which include:

- A social marketing approach to reducing smoking in pregnancy
- Paediatric urgent care insight work
- Preventing unintentional injuries in children
- Infant nutrition with a focus on weaning

Case Study – Gypsy and Traveller Families Health Visitor

It is vitally important that the health of all St.Helens residents is taken care of from an early age. Although the Gypsy and Traveller families in St.Helens are relatively small groups of people, St.Helens Clinical Commissioning Group have committed to support these families and have provided a dedicated health visitor to ensure the health needs of this normally hard to reach group are met.

Performance Measures

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<th>Metric</th>
<th>Baseline</th>
<th>2013/14</th>
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<tr>
<td>Percentage of women booked in under 13 weeks (12 weeks and 6 days)</td>
<td>90%</td>
<td>91%</td>
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<td>Smoking status at time of delivery %</td>
<td>23.5%</td>
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</tr>
<tr>
<td>Breastfeeding at 6-8 weeks %</td>
<td>24.37%</td>
<td>27%</td>
<td>29%</td>
<td>31%</td>
</tr>
<tr>
<td>MMR (Measles, Mumps and Rubella) vaccination coverage for one dose (2 years old)</td>
<td>93.2%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>MMR (Measles, Mumps and Rubella) vaccination coverage for two doses (5 years old)</td>
<td>87%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Number of health visitors</td>
<td>26</td>
<td>36</td>
<td>42</td>
<td>48</td>
</tr>
</tbody>
</table>

Outcomes will also link with the outcomes for the obesity work stream; of particular importance is reducing the rate of maternal obesity and the proportion of children aged 4-5 who are classified as overweight or obese. Support for young people is also relevant in relation to reducing teenage pregnancy.
2. Support for young people

We will focus on...

- **Access to services** - Commission services for young people that are specific to their needs and are accessible to them.
- **Health inequalities** - Work to reduce health inequalities by focusing resources on the communities and groups of young people most in need including young carers, Looked After Children and young people with disabilities.
- **Intervention** - Providing targeted interventions for vulnerable and at risk groups of young people to develop resilience, improve participation and reduce harm.
- **Partnership** - Services working in partnership to maximise opportunities to deliver both universal and targeted key messages and health promotion to young people.
- **Healthy behaviours** - Working alongside parents and carers to promote the development of healthy behaviours within the home and community. Encourage young people to participate in sport and other physical activity.
- **Aspirations** – Support young people to access employment and training opportunities and ensure that young people are ready to make the transition into work.
- **Assets** - Developing schools, education and youth settings as health promoting assets.
- **School Nurse Call to Action** - Ensuring the delivery of the School Nurse Call to Action contributes to the health and well-being of young people.
- **Listen** - Establishing a health and well-being profile of children and young people using their voice.
- **Impact** - Measuring the impact of interventions through the local health and wellbeing questionnaire and applying local intelligence to monitor outcomes and target resources.
- **Workforce** - Developing the frontline workforce by delivering needs led training and support.

We want all children and young people in St.Helens to grow up safe and healthy, enjoying their childhood, achieving as young people and succeeding as adults, in a community which values and respects them, and supports them as they seek to achieve their aspirations and deliver the promise of their youth.

We further acknowledge that the best possible health underpins a young person’s ability to flourish, stay safe and achieve as they grow up. As the foundations of a healthy and fulfilled adult life are laid in childhood and adolescence, services and schools have an important role to play in promoting healthy lifestyles and, in particular, providing extra support for at risk vulnerable young people.

Young people’s health and well-being is influenced by many factors, including parents and carers, family, friends, community and the wider environment in which they live. For many young people, universal health education and interventions help them to make safe and healthy choices as they move towards adulthood. However, we need to consider that for some young people, their lifestyle choices have the potential to put them at risk, and so we must offer personalised interventions which support the individual to take responsibility towards positive behaviour change.

**Why is this an important issue for St.Helens?**

The JSNA demonstrates that health and wellbeing of young people in St.Helens is generally worse than the England average. Hospital admission rates for young people due to alcohol are high at 133.6 per 100,000 young people (under 18s), compared to the England average of 61.8. Hospital admissions as a result of self harm amongst children and young people (aged 0-17) are 337.2 per 100,000, which is higher than the England average of 158.6 and the teenage conception rate of 50.5 remains above the England average of 40.2 per 1000 females aged 15-17.
In addition, the level of child poverty is worse than the England average with 26% of children aged under 16 years living in poverty, and who are more likely to experience health inequalities throughout their lives. Additionally, young people are leaving education and entering the labour market at a time when youth unemployment is continuing to rise and competition for jobs and training opportunities is high. Therefore, it is vital that as part of the Borough wide vision for health and wellbeing, a focus is given towards improving the health and wellbeing outcomes of all young people, but with a particular emphasis on the most vulnerable communities.

**Good Practice**

The Teen Action Zone (TAZ) Outreach Team has developed a risk indicator tool to identify vulnerable groups of young people to ensure a targeted six week programme can be delivered (Healthy body/Healthy mind). Partners use the tool to identify those most at risk of an unintended conception. Those most at risk include:

- Looked After Children
- People in supported housing
- Young offenders
- Young people identified as at risk using the risk indicator tool

The feedback from five programmes delivered in schools during July 2012, report that 91% felt that they had learned about TAZ and where to get help and support and 86% felt they had learnt to have healthier relationships.

Over the past few years, St.Helens’ School Nursing Service has been committed to providing high quality support and care for children and young people with severe allergies in order to ensure they are safely managed in the community, especially in schools and other educational settings. Training is also provided to a variety of extra-curricular venues e.g. Scouts, sports club staff etc. by nurses with additional qualifications and expertise in allergy. It can be tailored to individual needs and is underpinned by evidence, which is continuously updated in line with research. An allergy pathway is in place which sets out a process that once a child/young person is identified as having a severe allergy, an individual allergy care plan is completed by the school nurse, parent/carer and the child/young person which is provided to the school. The care plan is reviewed annually or sooner if necessary and ongoing support is provided to the families at their request.

To date, all schools have been offered allergy training with a 99% uptake; all sessions are evaluated (approximately 90% feedback) and audited, showing high rates of satisfaction. Questionnaires are also completed by the families which have thus far proved that the service has made very positive impacts on the lives of severely allergic children/young people and their families. This current model of allergy intervention is unique to the St.Helens area and has fulfilled its goal to create sustainable collaborative working between the acute trust, primary care and education, with the child/young person and family firmly at the centre.

**Case Study - Management of Drug and Alcohol Related Incidents in Schools and Other Settings**

A multi-agency protocol was developed for managing drug related incidents across schools and education settings in St.Helens. This was done in collaboration with St.Helens’ schools, Merseyside Police, St.Helens Healthy Schools Team and St.Helens Young People’s Drug and Alcohol Team. The local protocol ensures that any young person involved in a drug incident receives a balanced response in relation to support referral and behaviour sanctions. Equally, in the case of a young person who discloses that they are affected by either their own or somebody else’s drug or alcohol misuse, schools and settings will swiftly deploy the protocols and refer the young person into the appropriate service.

Since the protocols were introduced, we have significantly reduced the number of fixed term exclusions in schools for drug and alcohol related incidents year-on-year.

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Baseline</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce under 18 conception rate per 1000 15-17 year olds</td>
<td>51.2</td>
<td>46.2</td>
<td>45.5</td>
<td>45.0</td>
</tr>
<tr>
<td>Reduce the percentage of young people not in education, employment or training (NEET)</td>
<td>8.4</td>
<td>7.82</td>
<td>7.82</td>
<td>7.82</td>
</tr>
<tr>
<td>Hospital admissions due to unintentional and deliberate injuries to children and young people</td>
<td>162.5</td>
<td>160</td>
<td>158</td>
<td>156</td>
</tr>
<tr>
<td>Alcohol specific hospital admissions for people under 18</td>
<td>116.1</td>
<td>112.6</td>
<td>109.1</td>
<td>105.6</td>
</tr>
<tr>
<td>Percentage of pupils achieving 5 grades at A*-C including English and Maths at Key Stage 4</td>
<td>55.1</td>
<td>58</td>
<td>59</td>
<td>63</td>
</tr>
</tbody>
</table>
### 3. Tackling alcohol misuse

We will focus on…

Developing a comprehensive alcohol strategy that will:

- **Engage** - Enlisting the help and support of local families, businesses and community groups to tackle alcohol related harm and to develop innovative, practical, grass roots solutions to target both the visible and the hidden harm caused by alcohol. In order to achieve this, we will need to develop an open and honest dialogue with the community in order to best support them to bring about change.

- **Target** - Ensuring that GPs and frontline professionals are supported to talk to people about alcohol misuse, including a number of key groups which, if we were to proactively target, may assist in reducing alcohol related harm; for example, screening of people with hypertension, recurrent falls, people who are experiencing any life stresses and who may turn to alcohol to help them cope.

- **Lever disease** - Development of a liver disease pathway.

- **Partnership** - Liaison with the newly elected Police & Crime Commissioner to ensure that alcohol harm reduction remains a priority within the community safety agenda, and that there is a continued level of financial support for alcohol and drug misusing clients who have entered treatment via a criminal justice route.

- **Prevention** - Preventative work with young people.

Alcohol misuse is a major source of harm in our local communities, and the range of harm includes alcohol related violence (including domestic violence), deliberate self harm, suicide, crime and anti-social behaviour, short and long term damage to physical and mental health, harm to unborn babies, child abuse including neglect and early mortality, as well as increased risk taking in sexual behaviour. Many accidental injuries and road traffic accidents are attributable to alcohol misuse, and it is linked to alcohol related violence (including domestic violence), deliberate self harm, suicide, crime and anti-social behaviour, short and long term damage to physical and mental health, harm to unborn babies, child abuse including neglect and early mortality, as well as increased risk taking in sexual behaviour. Many accidental injuries and road traffic accidents are attributable to alcohol misuse, and it is linked to alcohol related violence (including domestic violence), deliberate self harm, suicide, crime and anti-social behaviour, short and long term damage to physical and mental health, harm to unborn babies, child abuse including neglect and early mortality, as well as increased risk taking in sexual behaviour.

### Social marketing research undertaken locally indicates that there may well be considerable challenges in convincing males in the Borough to reduce their drinking. Estimates are, that around 1 in 4 adults would benefit from reducing their alcohol intake to within DH recommended levels (this does not include dependent drinkers). Nationally, there was a 25% increase in liver disease between 2001 and 2009. Alcohol related liver disease accounts for around 37% of all liver disease deaths, and the North West of England has some of the highest rates of both liver disease and alcohol related liver disease in England. The average age of patients with liver disease is 59 and falling. There are significantly high rates of alcohol related liver disease in St.Helens than the national average.

A recent report shows that St.Helens faces a huge bill in relation to alcohol related harm, and that St.Helens is one of the eight worst affected Local Authority Areas in the North West, incurring a cost of £519 per head of population in 2010/11 compared to the national average of £387.

### Good Practice

Many positive developments have taken place in St.Helens during the previous two years in relation to alcohol misuse. These include:

- More people are being screened for drinking at levels of increased and higher risk, and receive an intervention or onward referral to specialist services where necessary.
- Local campaigns have been undertaken to raise awareness of alcohol related harm and recommended drinking limits.
- Introduction of alcohol treatment requirements and liaison with Problem Solving Courts.
- Detailed data is now collated in relation to alcohol related hospital admissions (down to ward level).
- There are now no waiting lists to access the alcohol community treatment service or waiting lists for community alcohol detoxification.
- Robust partnership and working relationship with Children and Young People’s Services is taking place, which will have the effect of reducing the impact of parental drug and alcohol misuse and improving the life chance of their children.

However, the most significant developments in terms of healthcare are the newly commissioned alcohol treatment services run by Addaction and the Knowsley and St.Helens Hospital Trust Alcohol Nursing Scheme. A modern, integrated, recovery orientated, substance misuse treatment service for adults who need support to recover fully from alcohol and substance misuse and get their lives back on track is now provided for residents of St.Helens. The Alcohol Liaison Nursing Service operates seven days a week and will ensure that high quality interventions alcohol screening and treatment interventions are carried out with people attending hospital with alcohol related harm. It also ensures that people who require long term support are linked into community services, and that people who are frequently admitted to hospital for alcohol related harm are proactively managed by both the hospital and the community.

On April 1st 2013, Public Health gained responsibility for the commissioning of alcohol misuse services for both prevention and treatment, and commissioning activity is coordinated by the multi-agency Drugs & Alcohol Strategic Commissioning Group (DASCG).

### Performance Measures

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol related hospital admissions</td>
<td>2674</td>
<td>3037</td>
<td>3238</td>
<td>3461</td>
</tr>
<tr>
<td>Alcohol specific hospital admissions (under 18s)</td>
<td>116.1</td>
<td>112.6</td>
<td>109.1</td>
<td>105.6</td>
</tr>
<tr>
<td>Under 75s’ mortality from liver disease</td>
<td>28.5</td>
<td>30</td>
<td>32</td>
<td>34</td>
</tr>
<tr>
<td>Alcohol related violent crime (per 1000 population)</td>
<td>2.91</td>
<td>2.51</td>
<td>2.11</td>
<td>1.71</td>
</tr>
</tbody>
</table>

Outcomes will also link with the outcomes for the support for young people work stream, to increase self-esteem and reduce risk-taking behaviour.
We will focus on...

- **National Child Measurement Programme** - This programme enables us to gather population level surveillance data and allows analysis of trends in growth patterns and obesity. It also increases public and professional understanding of weight issues in children and is a useful vehicle for engaging with children and families about healthy weight and lifestyle.

- **Healthy Weight Strategy** - We will refresh our Healthy Weight Strategy so that it is St.Helens specific. We will undertake an equality impact assessment of our strategy and delivery plans to ensure that the interventions we develop and services we commission are able to meet the needs of those people and communities most at risk of obesity and excess weight, and that our plans focus on reducing health inequalities.

- **Health Checks** - Obesity is a significant risk factor in some preventable diseases, therefore we remain committed to the delivery of our local Health Checks Programme. We will review the current programme to ensure as many local people as possible attend for their check, and continue to invest in services that can assist people to manage and reduce any risks identified, including working with local GPs to identify people at early risk of diabetes by measuring their blood glucose levels.

- **Involve** - We will continue to work with local people to make sure that the services we commission and the initiatives we develop are the right ones for them.

- **Workplace health** – We will encourage all local employers to promote physical activity and healthy lifestyles amongst all staff, and that these policies are fully in line with guidance from the National Institute for Health and Clinical Excellence.

Obesity and being overweight represents a widespread threat to health and wellbeing in England. Excess weight is a major risk factor for diseases such as type 2 diabetes, cancer and heart disease. However, in addition to serious ill health, there are other consequences of obesity to individuals, society and the economy. Obesity can reduce people’s prospects in life, affect an individual’s ability to secure and stay in work, and affect their self-esteem and impact on their mental health. It is estimated that excess weight costs the NHS more than £5bn each year.

Obesity is also an issue for many of our children and young people. Early diet has an impact on the health of young people and their health into adulthood. Due to an increase in the number of obese children, more young people are being diagnosed with type 2 diabetes at an early age and overweight children are more likely to grow up with problems such as heart disease.

Levels of obesity have increased consistently over the past 20-30 years. Key determinants of this increase include physiological factors, changing eating habits, changing physical activity levels, an increase in sedentary working and social lifestyles, and psychological influences which occur at the individual and societal level.

The Government set out its approach to tackling obesity through its paper, ‘Call to action on obesity’, which describes the Government’s national ambitions for a downward trend in excess weight in both children and adults by 2020 and sets out how, by working together, a wide range of partners can make these ambitions a reality. We have used this national plan along with the evidence base of what we already know works as a basis for our local plans.

**Why is this an important issue for St.Helens?**

Some of the most significant factors associated with poor health and wellbeing in St.Helens are lifestyle related. The changing shape of people in Britain is reflected in our Borough and people are becoming heavier, less fit, and much more likely to develop life-threatening illnesses and experience a poorer quality of life. In St.Helens, data from the Health Survey for England indicates that local obesity rates affect around a quarter of the adult population and this has remained static in the past 2 surveys.
Given the impact on individual health, obese and overweight individuals can place a significant burden on the NHS, with direct costs estimated to be £5.1 billion per year nationally. Across Halton and St.Helens in 2010, the estimated annual costs to the NHS of diseases related to obesity was £53.6m, by 2015 this is forecast to rise to £61.5m.

GP records obesity in people aged 16 and over as part of the Quality and Outcomes Framework (QOF). However, not all patients are weighed in the practice and sometimes a patient’s weight is self-reported. For many patients, the data is never collected. Based on the data that was collected using this method, in 2010/11, overall prevalence of obesity in St.Helens was 13.98%. This indicates that recording of obesity in general practice is lower than the expected rate. Therefore, it is possible that health promotion information and health interventions are not being offered to as many obese people in St.Helens that should be happening. Late identification of health issues such as obesity could have an impact on other health outcomes and the development of diseases linked to obesity.

Circulatory diseases (which include heart disease and strokes) and cancers are the two biggest killers in St.Helens, and as highlighted in our local Joint Strategic Needs Assessment, are within the top 10 causes of hospital admissions. Improving healthy lifestyle choices such as maintaining a healthy weight, increasing physical activity, reducing alcohol consumption and quitting smoking will help to reduce the risks of developing problems due to circulatory problems, diabetes and certain cancers. Improving access to evidence based interventions for these lifestyle factors will help improve health outcomes in St.Helens.

We have already achieved some excellent outcomes in relation to obesity. For example, data for 2011/12 shows that reception age (age 4 – 5 years) obesity in St.Helens is now only 1.5% under the national average at 6% (the national average is 9.5%). This is a reduction of 7.1% from 2007/08 when it stood at 15.1%. The Department of Health’s target for this period was a reduction by 0.5% so we have substantially exceeded this percentage reduction locally. However, there is no room for complacency. By the time young people have reached year 6 (age 10-11 years), the percentage of children who are obese in St.Helens increases to 19.7% compared with 19.2% nationally. Therefore, this is still an area for continued work, especially in the period between reception and year 6 to reduce the increase in obesity.

**Good Practice**

There are a whole range of programmes in St.Helens in relation to healthy weight that aim to support healthier lifestyles and the development of a positive health culture locally. This section describes just some of them.

We have a comprehensive Halton and St.Helens Healthy Weight Strategy (2011 – 2013), which has a range of accompanying action plans that are performance monitored via the local Obesity Commissioning Sub Group.

Obesity is a complex, multifaceted issue and requires an equally comprehensive and multi-agency response. Our strategy is based on reviewing the national evidence of what works and those interventions that are most likely to result in a reduction in obesity levels locally. They range from work with families of pre-school children on exercise, nutrition, oral health, food growing and supporting community based activities such as swimming, guided walks and cooking sessions. It also includes encouraging local businesses to support action to prevent and reduce overweight and obesity and implementing NICE guidelines for obesity treatment services locally so that we can be sure that local people are receiving high quality weight management services.

Obesity is a complex issue and it requires multiple interventions to address it, including support for people to make changes in their lives. We have a range of services that can support a healthy lifestyle. For example, our ‘Choices’ lifestyle referral service is a programme offering one to one advice and support to local people who want to become more physically active in their daily lives - whatever their age or ability. There is a particular focus on supporting clients with long term conditions (for example Chronic Obstructive Pulmonary Disease, stroke and diabetes) to engage in safe, tailored, personalised, prescriptive exercise, based on national evidence. This programme breaks away from a traditional gym based programme and focuses on a community activity model. ‘Choices’ is a 6 month programme that takes into account a person’s current activity levels and their medical history and a personal fitness plan is developed. Clients are supported and followed up to adapt and develop the programme in line with the client’s progress. Whilst not everyone who is referred to these services may be overweight or obese, participating in them can help to maintain a healthy weight which is just as important, particularly following an episode of illness.

The Early Years Healthy Food Award was launched in St.Helens in 2009, with the aim of improving nutritional standards in early years’ settings such as nurseries and childminders. Over 60 settings are now achieving the standard. The award status is reviewed during the course of the programmed food hygiene inspections undertaken by Environmental Health Officers.

**Case Study - Early Years Healthy Food Award**

In 2009, the overweight and obesity levels for children in reception year in St.Helens were one of the highest in the North West. Reducing these levels was identified as a priority for the Council and its partners. Environmental Health Officers (EHOs) are ideally placed to influence on food provision within businesses and are in a unique position to enforce, promote, advise, educate and inform. As EHOs routinely work with early years’ settings, an Early Years Healthy Food Award scheme was developed in conjunction with partners, the Council’s Healthy Living Team and Halton and St.Helens Primary Care Trust. Funding was awarded from Department of Health, Communities for Health. The work involved menu analysis using samples and software, training of 50 nursery workers in nutritional principles and the publication of a selection of early years recipes donated from each of the award winning settings. 58 settings including private day nurseries, créches, childminders and playgroups have since received the award. We have seen significant changes to menus and cooking methods, and snacks have been made to meet the pre set criteria and good practice shared. Reception age overweight and obesity levels have improved in the last few years, this work contributing to the reductions.

**Performance Measures**

<table>
<thead>
<tr>
<th>Percentage of children in reception who are overweight or obese</th>
<th>Baseline</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20.5%</td>
<td>20%</td>
<td>19.5%</td>
<td>18%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of children in year 6 who are overweight or obese</th>
<th>Baseline</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35.2%</td>
<td>35%</td>
<td>35%</td>
<td>33%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence of recorded diabetes</th>
<th>Baseline</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.86%</td>
<td>7.14%</td>
<td>7.42%</td>
<td>7.70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of diabetics with their body mass index (BMI) recorded in the past 15 months</th>
<th>Baseline</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95.9%</td>
<td>96.95%</td>
<td>98%</td>
<td>99.06%</td>
</tr>
</tbody>
</table>
5. Promoting mental health and wellbeing

We will focus on...

- **Life course** - We will use the life course approach starting with a positive childhood right through to healthy and fulfilled older years.
- **Social inclusion** - Promoting social inclusion.
- **Learning** - Afford opportunities to learn and develop skills, including life-long learning.
- **Work readiness** - Support people to access rewarding work including volunteering opportunities.
- **Challenge stigma** - We will challenge stigma and tackle inequalities.
- **Promote physical health** - Support individuals to make healthy lifestyle choices by tackling obesity, alcohol and drug misuse.
- **Physical activity** - Promote access to exercise and green spaces.
- **Community assets** - Utilise community assets and resources, such as community networks and social groups.
- **Social prescribing** - Provide non-medical support such as ‘social prescribing’ and ‘community referral’. This may include arts, books, befriending, volunteering, supported self-help as well as information and advice on debt, domestic violence, relationship breakdown and legal advice.
- **Good access to services** - All groups across the Borough will have good access to services, for example the armed forces community. We will support the St.Helens Armed Forces Community Covenant by ensuring good access to services for the armed forces community and support people making the transition from service life into civilian life.

Mental wellbeing has been defined as ‘a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.’ It has been described as having two main elements; feeling good and functioning well. Good mental health and wellbeing are associated with improved outcomes for individuals in education, employment, personal safety and social relationships and in better health, longevity and increased resilience. This in turn contributes towards improved outcomes for families, communities and society.

Positive mental health is not simply the absence of mental illness; people with mental health conditions can have a positive state of wellbeing and vice versa. Mental illness indicates a diagnosable mental disorder such as anxiety, depression or psychosis but staying mentally healthy is more than treating or preventing mental illness.

**Why is this an important issue for St.Helens?**

The ability to be resilient and flourish is fundamental to the prosperity of St.Helens, especially in this time of economic downturn. The North West Mental Wellbeing Survey 2009 identified that 16.8% of the population had low levels of mental wellbeing. Based on this percentage, potentially 24,108 people in St.Helens had low levels of mental wellbeing in 2009.

For anyone who is socially isolated, maybe because of illness, age, disability, homelessness, addiction, unemployment or prison, there is a very real chance that failure to develop the relationships, conditions and support systems that are so essential to sustain positive wellbeing will lead to further social, health and financial inequalities and widen divisions. We know it is the most disadvantaged communities that are affected most and that social and health inequalities are both a result of and a cause of poor mental health.

The demographic age-shift and projected growth in life expectancy requires that we rethink our attitudes to old age. In line with longer working lives, the proportion of older people as a proportion of the working population will increase, as will the need for these workers to continuously train and retrain.
Case Study - Citizen’s Advice Bureau

A client attended the Citizens Advice Bureau (CAB) for employment advice. She suffered from severe depression and anxiety and had been unable to work for several months because of her condition. The employer has threatened to dismiss the client, but after receiving advice from St.Helens CAB, we provided her with advice and information under the disability discrimination act. As a result of our intervention, the client eventually returned to work and we are pleased to state that her mental health state has vastly improved.

Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of people who use services who have control over their daily lives</td>
<td>76%</td>
<td>76%</td>
<td>76.5%</td>
<td>77%</td>
</tr>
<tr>
<td>Incidence of depression</td>
<td>0.92</td>
<td>0.95</td>
<td>0.98</td>
<td>1.01</td>
</tr>
<tr>
<td>Mortality as a result of suicide</td>
<td>8.3</td>
<td>8.0</td>
<td>8.0</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Although our aim is to improve the mental health and wellbeing of all people in St.Helens and not just of individuals experiencing illness, evidence shows that increasing the mental wellbeing of people with diagnosed mental illness is very important to aid recovery.

Mental health problems are both common (one in six of the adult population experiences mental ill health at any one time) and expensive, with the costs to the economy recently estimated at £105 billion and treatment costs expected to double in the next 20 years. Significantly, half of all mental illness (excluding dementia) starts by the age of 14.

Improving mental health is one of the six objectives of the cross Government national mental health strategy 2011, ‘No Health without Mental Health’, which prioritises action to increase early detection and treatment of mental health problems at all ages, as well as robust and comprehensive services for people with severe and enduring mental health problems. The objectives are:

1. More people will have good mental health.
2. More people with mental health problems will recover.
3. More people with mental health problems will have good physical health.
4. More people will have a positive experience of care and support.
5. Fewer people will suffer avoidable harm.
6. Fewer people will experience stigma and discrimination.

There is a need for targeted interventions for high-risk groups and people with diagnosed mental illnesses. A multi-agency Mental Health and Wellbeing Partnership Group will be formed to oversee the development and implementation of a local Mental Health and Wellbeing Strategy, and to ensure improvements in the collection and integration of data on wellbeing, mental health, mental illness, suicide and self harm. The data will fully inform the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy and local commissioning plans.

Positive mental health serves as a powerful protective factor against mental illness. Mental health promotion undertaken in St.Helens will also have the secondary outcome of mental disorder prevention, i.e. reducing the incidence, prevalence, and recurrence of mental illnesses, through raising awareness, facilitating early intervention and placing emphasis on robust, holistic treatment when illness is detected.

There is much that individuals can do to improve their own mental health and wellbeing. The Foresight Wellbeing and Mental Capital Report 2009 commissioned work to identify the wellbeing equivalent of ‘five fruit and vegetables a day’. The suggestions for individual action, based on an extensive review of the evidence, are connect, be active, take notice, keep learning and give. Work will be undertaken to promote these and other illness prevention messages, but we recognise that there are other factors that may be at play such as poverty, debt, personal characteristics, socially developed characteristics, attitudes and beliefs towards self and others, relationship difficulties, domestic violence, stress, childcare and carer responsibilities, worklessness, housing needs and a perceived lack of opportunities.

The Foresight Review 2009 highlighted the significant challenges to society of how to ensure that the growing number of older people maintain the best possible mental capital, and to preserve their independence and wellbeing. In addition, there is the challenge of how to reverse the continued negative stereotyping of older age, which draws parallels with the need to reduce stigma in relation to stigmatising people with mental health or substance misuse challenges.

Good Practice

At an organisational level, improving the mental health and wellbeing of the people in St.Helens should be core business for all partners as it is critical to success in the majority of strategic objectives, including social and economic success. St.Helens Health Improvement Team has produced a Live Life Well website http://www.live-lifewell.net; this started out with the initial aim of suicide prevention but has widened to offer a personalised package of support including lifestyles information and advice.
6. Early detection and effective management of long-term conditions

We will focus on...

- **Health Checks Plus** - The Health Checks Programme became a responsibility of St Helens Council from April 1st 2013. St Helens Council and St Helens Clinical Commissioning Group will continue to work together to integrate the work in the programme. They will also be considering the best way to ensure that all eligible people in St Helens have access to the programme by effective marketing and promotion.

- **Joined up management for long term conditions (LTC) using the Proactive Care Model** - The model will be developed and implemented during 2013-2014 across primary, secondary, community and social care and will support the patient in a holistic fashion. The model will include regular assessment of the risks that people have related to long term conditions and the creation of joint health and social care teams who will offer interventions to help to minimise risks. A really important part of future management of long term conditions is that patients have the information they need to self-care and take part in shared decision making with the teams. To ensure this process runs smoothly, all those patients who wish to take part in the Proactive Care Model will co-produce a care plan with the team and be given the opportunity to be involved in all decisions around their care.

A long term condition (LTC) is a condition that a person will live with for the rest of their life once they have been diagnosed and which is controlled with medication. There is no specific list of diseases in the long term condition group, but some of the most common are Chronic Obstructive Pulmonary Disorder (often called COPD), diabetes, stroke, cancer, arthritis and heart failure. Whilst long term conditions affect a person’s health, they can also impact on the quality of life a person has, for example if a person with COPD is repeatedly admitted to hospital because they are unwell, this can be extremely stressful for them and for their carers. If a long term condition is not managed well, it can prevent people from taking up hobbies, employment and being involved in day-to-day activities. Long term conditions are more common in groups of people who suffer from disadvantages; this could be that they have a low income, live in poor housing, do not have enough access to medical services or have other health problems.

Some people live their life very well despite having a long term condition but for others this is not the case. In particular, there are areas where improved outcomes can be achieved by joining up care, for example by integrating care across local health services and the Council.

### Why is this an important issue for St Helens?

In St Helens, it is estimated that approximately 22.7% of the GP registered adult population live with a long term condition, which is higher than the England average of 16.9%. Despite vigorous efforts to stem this growth, such as campaigns to raise awareness of specific issues, such as bowel and breast, by 2030 rates in the over 65s are set to double. Further analysis shows that mortality related to long term conditions is also above the England average, for example, stroke mortality locally is 43.5 per 100,000 people compared with 40.9 per 100,000 across England.

On the whole, people are living longer and this means that there will be more people living with long term conditions who need both health and social care support to live the best life possible. The increase in the numbers of people with long term conditions will mean that health and social care services will find it a challenge to provide services in the same way as we have in the past, therefore the way we view the issue of long term conditions needs to be refocused. Ideally, prevention of people developing a long term condition would be the best way of reducing need and the burden for the individual. However, we also need to proactively support people to live with their long term condition so their health and quality of life deteriorates as little as possible; this includes making sure that everyone is involved in making decisions about their own care.

### Good Practice

Across St Helens, there are a number of different initiatives related to long term conditions taking place across the NHS and also in social care. Some of the initiatives and good practice locally include intervention through early identification of those at risk of developing long term conditions and supporting people with conditions to stay well. Data shows that there are a substantial number of people with undiagnosed long term conditions and they are therefore not receiving the treatment they need to prevent deterioration.

The Department of Health introduced Health Checks for people aged 40-74; they are an opportunity to prevent heart disease and also to identify problems early and start treatment. In 2011, Halton and St Helens Primary Care Trust took the opportunity to go above and beyond the Health Checks Programme and introduced Health Checks Plus into primary care. In Health Checks Plus people were asked about many other aspects of their health so that they could be referred for any additional support or intervention they might need to keep them well, for example, people were referred to weight management programmes. Health Checks Plus also gave an opportunity for early detection of other major illnesses such as depression, hypertension and COPD. Some other issues which people were asked about were not directly about their health but about their lives and therefore could have a big impact on their health and their quality of life.

The Health Checks Plus Programme is ongoing and is a way of not only meeting the expectations of the Department of Health, but adding value to the process and showing how the health sector and the Council can work together for the benefit of patients, service users, carers and families.

### Chronic Obstructive Pulmonary Disease Rapid Response Respiratory Team

In 2010-2011, COPD was the third highest cause of deaths in St Helens and in total, 100 people died from COPD in 2010. In June 2011, to support reduction in mortality due to COPD, Halton and St Helens Primary Care Trust agreed a new service specification for a Chronic Obstructive Pulmonary Disease Rapid Response Respiratory Team.

The service specification described how the team should work and in particular, how they should support people with COPD who may become unwell at home, offering speedy clinical support so their condition did not deteriorate. The team were required to respond within two hours to referrals for people who had become unwell at home; in addition, the team work with social workers and the Local Authority, where appropriate, to ensure that the holistic needs of the service user are considered.

### Case Study - COPD Rapid Response Respiratory Team

Mr S contacted the COPD Rapid Response Respiratory Team reporting he had increased shortness of breath and his sputum was green. The team visited the gentleman at his home; he was fully assessed and a chest examination showed wheeze and crackles and Mr S's oxygen levels were low. Following national guidance, Mr S commenced his stand by antibiotics and steroids.

A visit was arranged for the following day and upon review, Mr S was finding it difficult to take his inhalers and remained wheezy. His oxygen levels were still low so the team loaned Mr S a nebuliser and medication was requested from his GP; another visit was arranged for the following day.

Upon visiting on the third consecutive day, Mr S felt much improved and was discharged from the service for this episode. The team arranged to collect the nebuliser in 7-10 days once Mr S was back on his usual inhaled therapies. An oxygen clinic appointment was arranged for 2 weeks’ time to address Mr S’s low oxygen levels and with Mr S’s consent, a referral was sent to pulmonary rehabilitation.
7. Reduce unnecessary hospital admissions and readmissions

We will focus on....

- **Emergency readmissions** - Work is ongoing across Merseyside to look for collective solutions to reduce the level of inappropriate readmissions across the area. In relation to St.Helens, the team have investigated a number of factors related to readmissions at St.Helens and Knowsley hospitals. These include the reason for readmissions, the mechanisms in place for effective planning of discharge and how this planning is monitored to ensure it is effective and efficient.

- **Integrated Discharge Team at St.Helens and Knowsley Hospitals Trust** - The jointly commissioned Integrated Discharge Team comprises both care managers and NHS health care professionals. One of the key roles is to ensure that anyone who is referred for social care on discharge from hospital will be going home to a safe environment. This includes modifications to the home and ensuring appropriate care packages are in place.

- **Assistive Technology and the Home Improvement Agency** - In 2011, a ‘Smart Flat’ was opened in St.Helens to showcase assistive technology and show how it can contribute to a safe and independent home life, in particular, reducing or delaying the need for a service user to enter 24h care. Throughout 2012-2013, the number of individuals accessing stand-alone assistive technology has continued to grow, enabling people to remain in their homes and giving peace of mind to carers. The Home Improvement Agency (HIA) provides support for vulnerable people to repair, improve, maintain or adapt their homes, to enable people to continue living independently in comfort and safety.

- **Silver Dreams Project** - Helena Partnerships, in collaboration with St.Helens Council and St.Helens and Knowsley Hospital Trust, have successfully won Lottery Funding for the Going Home Project. The project aims to provide practical support, housing support and healthy lifestyle choices to individuals who have been discharged home from hospital or intermediate care. The service works with patients who do not necessarily meet criteria for other social care support but for whom the input of additional practical help will ensure a timely discharge and enhance independence upon returning home.

- **Supporting people to remain at home during the winter by reducing emergency readmissions** - During the winter period patients, especially the elderly, are more vulnerable; winter sees a rise in the numbers of people hospitalised for a variety of conditions including falls and respiratory issues. All St.Helens GP practices are taking part in a scheme to provide follow up support to all patients discharged over the winter period. The care may be face to face or by telephone and aims to check that the patient is happy with their discharge medication and provides a chance for GPs to spot and address any other developing issues.

- **Provide support for care homes** - St.Helens Council and St.Helens CCG developed a proposal to reduce admissions of older people from care homes to hospital. The collaborative venture between St.Helens’ GPs, Bridgewater Community NHS Trust, the Council and consultants from St.Helens and Knowsley Hospital Trust will provide enhanced support to care home staff and patients. This will ensure that acute conditions such as chest infections are identified and treated before they become critical, and increase the confidence of care home staff to manage appropriate patients in the care home rather than opting to send them to hospital.

Unplanned admissions to hospital are often referred to as emergency admissions; the unexpected nature of these admissions means they are disruptive and distressing for patients and are also extremely costly for the health service. When we examine data on emergency admissions, it is found that people living in the most challenging circumstances have higher levels of emergency admissions than those from affluent areas. This includes people living in the most deprived areas and members of vulnerable groups, for example people with learning disabilities.
This inequity may have a number of causes; however a key factor is that those living in disadvantaged
areas may not access care until it becomes critical. Therefore, to reduce emergency
admissions, we need to work with and support people to take care of their health so that, where it is
avoidable, they do not reach this crisis point.

Once people are discharged from hospital, they should be healthy enough so that they can return to
and stay in their desired place of residence. For some people, this does not always work as planned
and they have to be readmitted to hospital, usually as an emergency, causing distress and upset.
Where the person's needs should have been met elsewhere and the admission is related to the original
admission, this is termed as an inappropriate readmission. To reduce the burden and level of
readmissions, we need to understand why people are readmitted and then work with the hospital, social
care, primary and community care partners to ensure they do not need to be readmitted. An additional
driving force to address this issue is that for these types of admissions, there is a financial penalty for the
hospital.

Why is this an important issue for St.Helens?

In St.Helens, the more deprived areas of the Borough have significantly higher rates of emergency
admissions than less deprived areas. For example, the Town Centre ward had more than double the rate
of emergency admissions than Rainford which is a more affluent area (15,000 per 100,000 people DSR
in the Town Centre compared with 7,500 in Rainford) and a significantly higher rate than the England
average of 8,900.

There are specific reasons why people are admitted as emergencies; in St.Helens, respiratory diseases are
the third highest cause of admission; in 2010-2011, there were 2,858 emergency admissions for
respiratory conditions for St.Helens residents.

The costs of emergency admissions are high; it was estimated that reducing the number of emergency
admissions for COPD by 10% from 2011/12 to 2012/13 would deliver a cost saving of £109,729 to the
health service.

Good Practice

There are a number of current examples of good practice to reduce unnecessary hospital admissions
in St.Helens. St.Helens Home Improvement Agency (HIA) provides support to enable residents to
remain safely in their own home. Vulnerable people who are older, have a disability or are on a low
income are assisted to repair, improve, maintain or adapt their homes. This helps people to continue
living independently in comfort and safety in their own homes and contributes to health and wellbeing.
Services include falls prevention, adaptations, home safety checks and remedial action, support for
people leaving hospital, making homes secure, improving health by ensuring homes are heated
efficiently and offering comprehensive information and advice.

The St.Helens Council Rapid Response and Reablement Service is a service which was designed
through close working of health and social care partners. As part of the service, the Rapid Response
Team will visit people at home, and work with them to keep them safe and well in their own home, where
previously, they may have been admitted to hospital.

Case Study

Mrs Z lived alone and her children lived far away. She was identified as being at risk of being admitted
to hospital by her GP. This was because over recent months, her mobility had deteriorated significantly
and she had suffered a number of heavy falls. Mrs Z had a number of medical conditions including
osteoarthritis, bowel cancer and severe depression. Mrs Z was referred to Adult Social Care and Health
for assessment; Mrs Z explained that her depression was related to her inability to complete day-to-day
tasks due to her limited mobility and this had prompted her to consider suicide. At the point of
assessment, Mrs Z’s mobility was quite poor, but the decision to admit her to a bed at the Intermediate
Care Assessment Unit was taken and Mrs Z was advised that a transfer to a nursing home might be
necessary if her level of care was too great. At this point, the potential physical and mental benefit from
a future reablement programme merited that she be given the opportunity. Mrs Z had a week of respite on
the unit and was then transferred seamlessly to a reablement programme. She returned home three
weeks later, mobilising with a delta frame and fully independent. Her depression had also lifted and she
had benefited from the company of her peers, making friends that she intended to remain in touch with in
the future.

Performance Measures

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total emergency medical admissions (adults) (per 1000)</td>
<td>24424 (127.03)</td>
<td>23610 (122.01)</td>
<td>22796 (117.80)</td>
<td>20,760 (113.60)</td>
</tr>
<tr>
<td>Total emergency medical admissions (children)</td>
<td>3933 (20.32)</td>
<td>3801.9 (19.64)</td>
<td>3670.8 (18.97)</td>
<td>3539.7 (18.29)</td>
</tr>
<tr>
<td>Emergency readmissions within 30 days of discharge (numbers and an indirectly standardised percentage)</td>
<td>3075 (12.48)</td>
<td>12.06</td>
<td>11.66</td>
<td>11.23</td>
</tr>
<tr>
<td>Unplanned admissions for chronic ambulatory care sensitive conditions (adults) (numbers and as a directly standardised rate per 100,000)</td>
<td>1145</td>
<td>1107</td>
<td>1070</td>
<td>1030</td>
</tr>
<tr>
<td>Unplanned hospitalisations for asthma, diabetes and epilepsy in under-19s (as primary diagnosis only) (as a directly standardised rate per 100,000)</td>
<td>441.9</td>
<td>427.2</td>
<td>412.5</td>
<td>397.7</td>
</tr>
<tr>
<td>Falls and injuries in people aged 65 and over (per 100,000)</td>
<td>2483</td>
<td>2400</td>
<td>2317</td>
<td>2235</td>
</tr>
</tbody>
</table>
8. Support for people with dementia

We will focus on

- ‘When memory problems have prompted me or my family or carer to approach my GP with concerns’ - Working closely with GPs to ensure there is a consistent approach to supporting people with dementia and their carers and ensuring there is good quality information available to enable people to make informed choices/decisions.

- ‘Learning that the condition is dementia’ - An Assessment, Care and Treatment (ACTs) Team has been established to provide a new diagnosis pathway for people with dementia. The team are predicted to receive around 400 new referrals each year, and it is estimated that 60% of these people will require some type of social care support. Newly diagnosed people will be directly referred into the Dementia Adviser Service so that they receive timely information and support at the start of their diagnosis. The effectiveness of this team will be evaluated.

- ‘Learning more about the disease, options for treatment, self-management and support for me and my carers/family’ - This aims to increase people’s understanding of how they can manage a diagnosis of dementia and understand where and how they can access services. Once diagnosed, the Dementia Adviser Service will empower them to have choice and control over their dementia journey to enable them to have a meaningful life ‘living well with dementia’.

- ‘Getting the right help at the right time to live well with dementia, prevent crisis and manage together’ - We will focus on preventative services that can avoid a crisis by providing timely support where required. The role of carers is pivotal to making sure the person with dementia receives the best care that is available for them, and therefore it is essential that services for carers are in place, in addition to services for those with dementia. This work will identify any gaps in current provision and work to ensure that the services in St.Helens can best meet the needs of residents with dementia.

- ‘Getting help if it is not possible to stay at home, or if hospital care is needed’ - To ensure that there is clear information on how to access 24 hour and hospital care, and to ensure that care providers will take account of the needs of people with dementia. Where necessary, training should be provided so that they are aware of the skills, knowledge and experience required to care for people with dementia.

- ‘Receiving care and compassion and support at the end of life’ - This involves reviewing the current approach to End of Life Care to ensure services support the individual and their family in receiving dignified and compassionate care. It is important that service users are informed of advanced directives as early as possible in the dementia journey to allow them to make informed decisions. During 2012, St.Helens Council has ensured they have representation on the national End of Life Care Programme.

The term dementia describes a set of symptoms that include loss of memory, confusion and problems with speech and understanding. The most common types of dementia are Alzheimer’s disease and vascular dementia. Dementia is progressive; the individual’s ability to remember, understand, communicate and reason gradually decline. Even the most basic skills such as swallowing can be lost. Dementia is most common in older people, affecting 5% over 65 and 20% over 80. Dementia has a significant impact on the whole life of the person who has it, their family, carers and friends. The condition may reduce quality of life and limit an individual’s capacity to live independently.

Why is this an issue for St.Helens?

Dementia is an increasingly common condition, and the number of people living with the condition is expected to double over the next 30 years nationally. The increase in the number of people with dementia is forecast to grow more rapidly in St.Helens than across England as a whole; this is due to a large proportion of people in the Borough aged 65 and over. The numbers of people with dementia in St.Helens are predicted to increase by almost 50% by 2025; this is estimated to be an additional 1,000 people compared to 2011. Only 43% of people with dementia have a formal diagnosis. As awareness rises, this will lead to greater numbers being diagnosed and greater pressure on health and social care services.

There is also an emerging need in St.Helens for health and social care services and support for people with learning disabilities and dementia.

Dementia has a significant impact on health, social care and other services due to the high level of support those with dementia require; pressures on services are likely to increase in the future as prevalence of dementia rises. There is a need to raise awareness and understanding of dementia so that people can receive support at an early stage before symptoms progress to requiring higher levels of care.

Services and support for people with dementia have improved over recent years and there are some excellent providers of the provision across the Borough. However, given the prevalence of dementia in the population, and the predicted increase in numbers of people with dementia, there is more to do to support people with dementia and their carers.

Good Practice

A directory of services in St.Helens, for those living with dementia, their families and carers has been produced by members of the Dementia Sub Group of the Health and Wellbeing Board. This provides information in respect of services provided by the Council, health organisations, voluntary, community and the faith sector and community support groups in St.Helens.

Specialist housing with care schemes for people with advanced dementia are located at Portland House and Carter House. Members of staff work with tenants to maintain their skills. People with dementia can also reside at the other 4 extra care schemes in the Borough (Heyeswood, Healdf Court, Reeve Court and Parr Mount Court).

There are 10 residential homes and 5 nursing homes in St.Helens that specialise in providing care for people with dementia. These homes also offer respite care for people with dementia.

There are several types of services and support in the community for people with dementia, including (but not limited to) the Dementia Advisory Service and Dementia Support Service (based at the Alzheimer’s Society), Kershaw Day Centre, and support offered by St.Helens Carers Centre, Age UK, St.Helens MIND, Disability Advice St.Helens and the Pilkington Family Trust. There is a Dementia Café located at the Marischal House, and there are others that are being developed over the next few months.

There are an emerging number of peer support groups for people with dementia and their families. These include: St.Helens Carers Centre Group, the Making Sense Group at Peasley Cross, the Alzheimer’s Society Activity Group, the Carers Support Group at Kershaw, the 5 Boroughs Later Life Forum, Broadoak Manor Carers Support Group and the Looking Forward Group, supported by Senior Voice.

Many technologies can be adapted to the needs of someone with dementia, including reminder messages, bed sensors, medication aids and locator devices. In St.Helens, individuals with dementia can access Careline, a 24/7 council run monitoring and response service that is accessed via a lifetime pendant or bracelet. Items of telecare that can be connected to the lifetime equipment (such as smoke detectors, epilepsy detectors and falls detectors) are being issued in increasing numbers, as are stand alone items of assistive technology such as falls detectors and bed sensors.

There is a range of information, advice and advocacy services in the Borough for people with dementia, delivered by the voluntary, community and faith sector and health and social care providers.

The ‘Forget Me Not’ campaign was launched at St.Helens and Knowsley Hospitals Trust in May 2011. The aim of the campaign is to raise awareness around the needs of patients who are confused. Patients and carers share information that is important to them on ‘Forget Me Not’ cards. With permission from the individual, this information is shared with everyone involved in his or her care. The card has received positive feedback from carers, the Care Quality Commission and the Royal College of Nursing.
Case Study - Dementia Advice Service

The Dementia Adviser provides quality information and signposting at the point of diagnosis, which is tailored to individual needs, and aims to empower the person with dementia and promote independence. They provide on-going emotional support, information and guidance on a one to one basis, either in a person’s home or over the phone, and support via the weekly Support/Activity Group that is held every Thursday in the United Reform Church in St.Helens.

Mrs D was referred to the Dementia Adviser Service in summer 2012 by the local memory clinic. She had been diagnosed with early dementia associated with her previous diagnosis of Parkinson’s disease. Mrs D had difficulty with communication so her husband, and main carer, assisted with much of the communication during the initial home visit. Mrs D was experiencing low moods since her recent diagnosis so the Dementia Adviser provided her with information regarding depression and anxiety and advised her to contact her GP. The family were also feeling isolated in the local community.

An information pack, which included fact sheets on the symptoms and progression of dementia, maintaining everyday living skills and financial and legal matters, was also provided. They were also advised of their entitlement to a community care assessment. The family were provided with accurate information on benefit entitlements, income and savings thresholds and financial assessments. They were surprised to learn that they may be eligible for a 25% disregard on their council tax. Information and a brief overview of the support services available to the family in St.Helens were also provided.

Mr and Mrs D received a council tax disregard of 25%. This improved the family’s financial situation. Mrs D attends a local day service and both Mr and Mrs D are now more aware of other local community based services. This helps to prevent social isolation of both service user and carer and provides a respite service for Mr D that leads to an increase in health and wellbeing for both. Having the correct information available will assist the family in making informed decisions about their future care/support. Mr D has increased awareness of his wife’s condition and the nature of her illness. This will improve his ability to care for his wife confidently and independently whilst maintaining his wife’s dignity.

Performance Measures

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of patients diagnosed with dementia whose care has been reviewed by a GP in the previous 15 months</td>
<td>82.04%</td>
<td>84.74%</td>
<td>87.54%</td>
<td>90.43%</td>
</tr>
<tr>
<td>Number of registered carers caring for somebody with dementia</td>
<td>746</td>
<td>765</td>
<td>783</td>
<td>801</td>
</tr>
<tr>
<td>Numbers of service users and carers with access to a dementia care adviser</td>
<td>1400</td>
<td>1800</td>
<td>1850</td>
<td>1900</td>
</tr>
</tbody>
</table>

Baseline figure reflects part year data. Service implemented summer 2012.

On our radar...

As part of the Joint Strategic Needs Assessment and consultation with members of the public a number of issues have emerged where the Health and Wellbeing Board intends to keep a watching brief.

The issues listed below have a significant impact on the health and wellbeing status of the Borough, and actions to address or mitigate the impacts are embedded within the delivery plans of a number of organisations. However, it is intended that these issues will be closely monitored by the board to determine whether further consolidated action is required.

These issues include:
- Cancer
- Frail elderly people
- Impact of welfare reform and the economic climate
- Tobacco
- Workplace health
- Financial pressures on services and increased demand
- Developing a better understanding of the health and wellbeing of the local armed forces community

The Health and Wellbeing Board will review the Health and Wellbeing Strategy regularly to ensure that the shared priorities are fit for purpose and reflect the needs of the Borough.

Equality and diversity

All members of the Health and Wellbeing Board will give due regard to the general duty of the Equality Act 2010 in all decisions and commissioning which arises from the implementation of this strategy. This must include relevant equality analysis being used to inform decisions, and reasonable mitigation where an adverse impact is identified for a protected group.

How will we deliver?

The Health and Social Care Act (2012) places responsibilities on members of the Health and Wellbeing Board to ensure that decisions of the board are taken seriously. Members such as St.Helens Council, St.Helens Clinical Commissioning Group and the local area team for the NHS Commissioning Board must have due regard for the priorities identified in the Health and Wellbeing Strategy and commissioner plans must reflect these priorities. Therefore there is a strong emphasis on the Health and Wellbeing Board being the review body for local commissioning plans.

This current Health and Wellbeing Strategy is the first partnership strategy focusing on the health and wellbeing of the residents of the Borough of St.Helens. The priorities identified in the strategy will be the focus of the areas the Health and Wellbeing Board will performance monitor over the next 3 years. This current document and the associated Joint Strategic Needs Assessment are the baseline for the work programme within commissioner plans and related performance management.

Each priority area will have a lead agency or council department that will work on the actions and activities that will contribute to improved outcomes and targets set out in the performance framework. Where partnership working is required to deliver outcomes, it will be up to these lead agencies/departments to coordinate this to ensure progress or action. This may be achieved by specific task and finish groups.
**Performance Management**

The joint Health and Wellbeing Strategy sets out the priorities for action and the outcomes that are expected to be delivered. In order to monitor progress in delivering these priorities, an effective performance management framework is required. It is important that any performance measures and actions identified within this framework closely link to the priorities.

A performance management framework consists of two elements: outcome based performance measures and actions for service delivery. The framework must have sufficient flexibility to enable updates on service delivery actions to be reported, as well as monitoring performance measures. It is critical that the agreed performance measures are outcome focused and measure what is important.

The performance measures should enable the Health and Wellbeing Board, on behalf of the Council and the Clinical Commissioning Group and other partners, to measure whether the actions taken to improve health and wellbeing and reduce health inequalities are making a difference.

Ultimately, the Health and Wellbeing Board will take full responsibility for holding local and national commissioners to account for commissioning and providing services. The local commissioners include: St. Helens Council Adult Social Care and Health and Children and Young People’s Services departments, Public Health and the Clinical Commissioning Group. National commissioners include: Public Health England and the NHS Commissioning Board.

There will be an agreed set of outcome measures that will be regularly monitored based upon the health and wellbeing priorities. The majority, but not all, will be taken from the three published national outcomes frameworks – NHS, Public Health and Adult Social Care. For some areas of our work however, these will not be appropriate measures and local measures will be used. In addition, it is important to capture the contribution of the wider determinants of health on health and wellbeing outcomes. There will be regular reporting on progress against actions and performance targets to the Health and Wellbeing Board.

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**How will we manage performance?**

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Priority</th>
<th>Delivery Forum</th>
<th>Lead agency/partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early years, pre-birth–5</td>
<td>Give every child the best start in life</td>
<td>Healthy Child Programme Steering Group</td>
<td>Public Health</td>
</tr>
<tr>
<td>Young people</td>
<td>Support for young people</td>
<td>Healthy Child Programme Steering Group</td>
<td>Public Health and Children and Young People’s Services</td>
</tr>
<tr>
<td>All age groups</td>
<td>Alcohol</td>
<td>Drug and Alcohol Strategic Commissioning Group</td>
<td>Public Health</td>
</tr>
<tr>
<td>All age groups</td>
<td>Obesity</td>
<td>Healthy Lifestyles and Mental Wellbeing Partnership Group</td>
<td>Public Health</td>
</tr>
<tr>
<td>All age groups</td>
<td>Promote good mental health and wellbeing</td>
<td>Healthy Lifestyles and Mental Wellbeing Partnership Group</td>
<td>Adult Social Care, Clinical Commissioning Group and Public Health</td>
</tr>
<tr>
<td>All age groups</td>
<td>Early detection and effective management of long term conditions</td>
<td>Long Term Conditions Steering Group</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>All age groups</td>
<td>Reduce unnecessary hospital admissions</td>
<td>Urgent Care Steering Group</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>All age groups</td>
<td>Support for people with dementia</td>
<td>Dementia Task Group</td>
<td>Adult Social Care</td>
</tr>
</tbody>
</table>

Over the next few months, the lead agencies will be expected to work with partners, service users and carers to develop plans that will deliver upon improvements in the priority areas for 2013/14 and beyond. These action plans will be made available as part of the performance framework. It would be expected that these plans be embedded within commissioning plans for partner organisations.

The Health and Wellbeing Strategy has been developed largely from information from the Joint Strategic Needs Assessment. This information will be updated and refreshed annually and a summary will be provided to the Health and Wellbeing Board. Any new and emerging issues will be assessed and considered in relation to existing priorities. As resources are limited, new priorities will need to be assessed against the relative importance of the current priorities.

The Health and Wellbeing Board is a membership board and therefore minutes and reports will be fed into the appropriate groups within member organisations to ensure priorities and decisions of the board are discussed.
Please contact us to request a translation of Council information into Braille, audio tape or a foreign language.
St.Helens Health and Wellbeing Board

Members:
St.Helens Council
St.Helens Clinical Commissioning Group
Halton and St.Helens Voluntary and Community Action
Healthwatch St.Helens
NHS England
Helena Partnerships
Bridgewater Community Healthcare NHS Trust
5 Boroughs Partnership NHS Trust
St.Helens and Knowsley Teaching Hospitals NHS Trust

5 Boroughs Partnership NHS Trust

St.Helens and Knowsley Teaching Hospitals NHS Trust

Bridgewater Community Healthcare NHS Trust

Clinical Commissioning Group

St.Helens Council
Public Health
Atlas House
ST.Helens WA9 1LD
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publichealth@sthelens.gov.uk
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