Staffordshire Health and Wellbeing Strategy: A review of the available evidence

Staffordshire Health and Wellbeing Strategy Development Report

Contents

1.0 Executive summary p.3

2.0 Introduction and Background p.5

3.0 Starting well p.6

4.0 Growing well p.9

5.0 Living well p.11

6.0 Ageing well p.14

7.0 Ending well p.17

8.0 New potential action points p.18

9.0 New potential areas for action p.22

10.0 Recommendations p.24

1.0 Executive summary

1.1 This report reviews the current areas for action identified in "Living Well in Staffordshire". It considers evidence available from the latest JSNA data, the engagement exercise, and the agenda and discussion of minutes from the Health and Wellbeing Board meetings.

1.2 The data has been reviewed in the following ways:

1.2.1 The JSNA data has been reviewed by considering whether key performance indicators for each of the areas for action are statistically worse, better or similar to England.

1.2.2 The engagement exercise data has been reviewed by considering whether the areas for action were highlighted as issues by the public. This identified areas that were highlighted clearly as an issue and areas that were not raised.

1.2.3 The agenda and minutes for the Health and Wellbeing Board meetings were reviewed by considering whether relevant papers to the areas for action have been received and discussed.

1.3 It is worth noting that this is based on a limited data set. It is important the Health and Wellbeing Board consider the wider context in reviewing the inclusion of these areas. This would include the e-JSNAs developed by the district partnerships. Specific questions include:

1.3.1 Is being similar or better than England is good enough?

1.3.2 Does the potential cost of the negative outcome that makes the area a priority?

1.3.3 Is the area a root cause for other areas?

1.3.4 Are there are inequalities between areas that makes the area a priority?

1.3.5 Should the priorities focus on areas that are within the direct control of the Health and Wellbeing Board or go beyond?

1.4 There is strong evidence to maintain focus on the following areas for action:

1.4.1 In care

1.4.2 Alcohol

1.4.3 Drugs

1.4.4 Lifestyles (split from lifestyles and mental wellbeing)

1.4.5 Falls prevention

1.4.6 Dementia

1.5 There is strong evidence to maintain focus on the following areas for action, these areas may benefit from a more focussed definition:

1.5.1 Parenting

1.5.2 Mental Wellbeing (split from lifestyles and mental wellbeing)

1.5.3 Frail elderly

1.6 The following relevant could be considered in reviewing the focus

1.6.1 Health in pregnancy and breastfeeding

1.6.2 Domestic abuse

1.6.3 Mental health and learning difficulties

1.6.4 Housing

1.6.5 Reducing social isolation

1.7 There is less evidence to maintain focus on the following areas for action:

1.7.1 School readiness

1.7.2 Education

1.7.3 NEETs

1.7.4 End of Life

1.8 There is evidence that the following areas require some focus but are not currently areas for action in 'Living Well in Staffordshire':

1.8.1 Support for carers

1.8.2 Support the mental wellbeing of vulnerable groups

2.0 Introduction and Background

2.1 “Living Well in Staffordshire: Keeping you well, Making life better” identified 12 areas for action. These action points are divided into the categories of *‘Start well’, ‘Grow well’, ‘Live well’, ‘Age well’* and *‘End well’* in order to reflect the differing stages of life of all Staffordshire residents. They are:

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

2.2 Each of these action points will be reviewed in terms of priority for the Board according to the evidence available from:

2.2.1 The latest JSNA data (sourced from Public Health Outcomes Framework, Adult Social Care Outcomes Framework, NHS Outcomes Framework, Children’s Outcome Framework, Feeling the Difference Survey)

2.2.2 The results of the Health and Wellbeing Engagement strategy

2.2.3 The discussion and agenda of Board meetings

2.3 This report aims to link together the evidence base to inform the Health and Wellbeing Strategy. The impact of changes in JSNA data, engagement feedback and the content of HWB agendas will be considered together in reference to each action point of the strategy. The report will then consider what the evidence suggests should be the focus points of the yearly strategy and whether any new potential action points can be identified based on the available evidence.

2.4 Where there is a lack of relevant evidence for a particular action point, or where the action point requires greater clarification, this will be noted.

3.0 Starting well

3.1 Parenting

3.1.1 Parenting is a very broad action point within the Health and Wellbeing strategy. It could be argued that the majority of outcomes in the strategy can be related back to parenting.

3.1.2 Directly relevant indicators included in the JSNA where Staffordshire performs better than England include:

3.1.2.1 Tooth decay (2011/12) in children aged 5 years is better in Staffordshire than England as a whole.

3.1.2.2 Children in low income families (2011) has decreased in comparison to the previous year (2010) and is lower than England as a whole (this is relevant in that there may be additional challenges to parenting in low income families)

3.1.3 Directly relevant indicators included in the JSNA where Staffordshire performs worse than England include:

3.1.3.1 Unhealthy weight in 4-5 year olds (2012/13) has increased compared to the previous year (2011/12) and is now significantly worse than England.

3.1.3.2 Hospital admissions caused by unintentional injuries aged 0-14 years (2012/13) has improved compared to the previous year (2011/12) but is still significantly worse than England.

3.1.4 Members of the public and professionals were specifically asked *'what do you think would make the most impact on helping children in Staffordshire to get the best start in life'* as part of the Health and Wellbeing Engagement exercise. 'Parenting' was a popular theme. There was a broad range of suggestions about how 'parenting' could be supported including: more affordable child care, flexible working opportunities, greater availability of clubs and activities for children (both to support children's development and to allow parents to return to work), parenting classes and extended health visits. Many professional respondents argued that support for parenting should be focussed upon the most disadvantaged and *'at risk'* families.

'*More direct intervention is needed during early pregnancy with vulnerable, or potentially vulnerable, families and parents'* (Lichfield District Strategic Partnership)

3.1.5 The Health and Wellbeing agenda has included a presentation from the Staffordshire Safeguarding Children Board which stressed their aim to work more closely with the Staffordshire Health and Wellbeing Board to support the most vulnerable children, particularly those at risk of domestic abuse or sexual exploitation.

3.1.6 The evidence to support the ongoing inclusion of parenting as a Health and Wellbeing Board area for action is strong. However, the action area of ‘parenting’ could benefit from a more focussed definition identifying specific outcomes improving parenting needs to achieve and therefore which aspects are important and whether it should be universal or targeted.

3.2 School readiness

3.2.1 School readiness (2012/13) is statistically higher in Staffordshire than England as a whole. 53.6% in Staffordshire compared to 52.0% for England. The way in which school readiness is measured has changed since the previous year (2011/12) and therefore it is difficult to assess the trend.

3.2.2 Despite the positive position compared to England, the data shows us that nearly half of children in Staffordshire are not achieve the benchmark for school readiness.

3.2.3 There was no discussion about *‘school readiness’* in the Health and Wellbeing Strategy Engagement.

3.2.4 There has been no focus on *‘school readiness’* on the Health and Wellbeing Board agenda. A Children and Young People’s Partnership Group has formed which addressed Health and Wellbeing issues affecting children. It is not currently a formal sub-group of the Health and Wellbeing Board although there is common membership. The Children’s Partnership Strategy has been requested as an agenda item for the Health and Wellbeing Board

3.2.5 Purely in terms of how Staffordshire benchmarks compared to England, feedback from the engagement exercise and content of the Health and Wellbeing Board agenda, school readiness is not a priority. However, action around parenting should impact positively on ‘school readiness as an outcome’.

4.0 **Growing well**

4.1 Education

4.1.1 There is limited evidence that education should be a particular focus of the Health and Wellbeing strategy based on the latest JSNA data. However, there are other data sources which are also worth investigating e.g. progress learners make.

4.1.1.1 Pupil absence in Staffordshire (2011/12) is statistically lower than England as a whole. 4.9% in Staffordshire compared to 5.11% for England. This has improved from 5.58% in the previous year (2010/11).

4.1.1.2 The proportion of young people in Staffordshire who have 5 A-C GCSEs including English and Maths (2013) is similar to the national average (59.9% for Staffordshire compared to 59.2%) for England and has increased from 58.7% since the previous year (2012).

4.1.2 The Health and Wellbeing Engagement did not raise issues about academic achievement. However, there was feedback about the importance of health, sexual health and lifestyle education for children and young people. In addition there was feedback as education as a way to encourage proper use of health and social care services.

'Is there a way of having something set up to educate people (including children) to use the correct facility (i.e. 999, 111, chemist etc).

"It may take a generation to work through the system but the younger the child introduced to healthy living as a way of life, the better.'

4.1.3 There was also feedback about the importance of education in addressing other areas for action in particular to tackle the misuse of alcohol.

'There should be more education around the effects of alcohol and drug abuse, for example some people don't understand what a unit of alcohol is' (South Staffordshire Health Master class).

4.1.4 As an additional source of data, recent focus groups informing the redesign of sexual health services were carried out by Engaging Communities Staffordshire and commissioned by the County Council. In these focus groups a number of young people and professionals shared the view that the sexual health education offered to young people was *'sometimes very poor'* in Staffordshire. Some respondents felt that teachers were often ill equipped to carry out sexual health education and that it should be carried out by other professionals.

4.1.5 Purely in terms of how Staffordshire benchmarks compared to England, feedback from the engagement exercise and content of the Health and Wellbeing Board agenda, academic attainment is not a priority. However, health and social education could be.

4.2 Not in Education Employment or Training (NEET)

4.2.1 The proportion of 16-18 year old NEETs in Staffordshire has increased from 5.3% in 2011 to 5.4% in 2012. This is significantly lower than England at 5.8% (2012)

4.2.2 The proportion of first time entrants into the criminal justice system has decreased from 440 per 100,000 in 2011 to 332 per 100,000 in 2012. This is significantly lower than England at 537 per 100,000 (2012)

4.2.3 Despite the positive comparison to England for both these indicators, the cost of poor outcomes in this area is high and children and young people who face these challenges are at higher risk of other priority outcomes across the lifecourse.

4.2.4 NEETs as a focus area was not particularly discussed by public or professional respondents within the engagement exercise.

4.2.5 NEETs have not been included on the Health and Wellbeing agenda.

4.2.6 Therefore, purely in terms of how Staffordshire benchmarks compared to England, feedback from the engagement exercise and content of the Health and Wellbeing Board agenda, NEETs is not a priority.

4.3 In care

4.3.1 The emotional wellbeing of looked after children has deteriorated from 15.2 in 2010/11 to 15.3 in 2011/12. This compares unfavourably to England at 13.8 (2011/12). A high score is a worse score.

4.3.2 However, investigating this further identifies that data was only collected for 47% of looked after children in Staffordshire compared to 70% for England which makes comparison difficult. Improving data collection would be beneficial.

4.3.3 Looked after children was not discussed by public or professional respondents within the engagement exercise. Qualitative data in this area would be beneficial.

4.3.4 Looked after children has not specifically been included on the Health and Wellbeing agenda. However, it is relevant to the agenda item around safeguarding.

4.3.5 Given the poor comparison with England for emotional wellbeing of looked after children in Staffordshire, and the relevance to safeguarding the evidence would support the ongoing inclusion of ‘in-care’ as a priority.

5.0 Living well

5.1 Alcohol

5.1.1 Alcohol related admissions to hospital amongst under 18s are worse in Staffordshire than England (2010-2013). 53.5 per 100,000 in Staffordshire compared with 42.7 per 100,000 for England).

5.1.2 All age alcohol-related hospital admissions within Staffordshire they are lower than the national average (2012/13). 1795 per 100,000 in Staffordshire compared with 1950 per 100,000 for England. Although they have increased from 1717 per 100,000 in the previous year (2011/12).

5.1.3 Members of the public and professionals were specifically asked *''what do you think will have the biggest impact on reducing harm caused by alcohol and drugs'* as part of the Health and Wellbeing Engagement exercise. There were many different responses including support for the minimum pricing of alcohol and early intervention in people who have, or are at risk of, addiction problems.

'All drug and alcohol services need to have capacity to accept referrals at the point an individual chooses to take part as the service users have to be ready to accept control of their substance misuse and this can quickly change if they have to wait months to get any support.'

5.1.4 The issue of drug and alcohol misuse also overlaps with numerous other issues, such as support for carers and education.

'More education in school - perhaps take people who have had an addiction in to schools to talk to the children.

''As we cannot force those who need help to take help, ensure wellbeing of the carer' (Lichfield & District CVS Forum).

5.1.5 Alcohol has been discussed at the Board. Minutes included:

'New types of indicators need to be used, data needs to be collected (although behavioural data is difficult to collect). Data on A&E attendance and other hospital admissions would be useful. It may be difficult to measure as long term conditions originate from alcohol and drug abuse.' (Board Meeting, 13th June, 2013)

5.1.6 Given the quantitative data and the inclusion in engagement feedback and on the Health and Wellbeing Board agenda, the evidence would support the ongoing inclusion of 'alcohol' as a priority.

5.2 Drugs

5.2.1 Successful completion of drug (opiate) treatment (2012) is similar to national levels. 8.4% in Staffordshire compared to 8.2% for England. This has deteriorated from 9.7% in the previous year (2011)

5.2.2 Successful completion of drug (non-opiate) treatment (2012) is similar to national levels. 41.9% in Staffordshire compared to 40.2% for England. This has improved from 34.2% in the previous year (2011)

5.2.3 The quantitative evidence in the Living Well outcomes is narrow. Only successful completion of drug treatment is identified. There theoretically may be a high number of drug abusers who are not identified or offered treatment.

5.3 Lifestyle and mental wellbeing

5.3.1 Lifestyle and mental wellbeing is a very broad category. Therefore they have been considered separately.

5.3.2 The available JSNA data shows that lifestyle trends within Staffordshire vary in comparison to the national average.

5.3.2.1 Adult smoking prevalence (2012). 17% in Staffordshire compared to 19.5% for England. Staffordshire is significantly lower than England

5.3.2.2 Proportion of physically inactive adults (2012). 30% in Staffordshire compared to 28.5% for England. Staffordshire is significantly higher than England.

5.3.2.3 Excess weight in adults (2012). 67.9% in Staffordshire compared to 63.8% for England. Staffordshire is significantly higher than England.

5.3.3 Lifestyle choices are a risk factor for other areas for action.

5.3.4 Within the engagement exercise there was some support for *'healthy lifestyles'* initiatives but only if these took practical forms (e.g. free exercise classes, cookery classes, early health checks) as opposed to general marketing campaigns.

'Stop spending or contributing money on short-term health drives. The majority of adults know that overeating, smoking and drinking will harm their health.

'Offer FREE full health screening (including lifestyle assessments).'

5.3.5 Given the quantitative evidence around lifestyle, the potential impact on other areas for action and the inclusion in the

engagement exercise, the evidence supports the ongoing inclusion of lifestyles as a priority.

5.3.6 In general terms there are many positive indicators of the overall mental wellbeing of the Staffordshire population. Data are better for Staffordshire than for England as a whole and have improved in comparison with the previous year (where available) for: People who feel satisfied with their lives; People who feel happy; People who don't feel anxious; People who feel that the things they do in their life are worthwhile; hospital admissions for self-harm; Percentage of the population affected by noise; Unemployment; Statutory homelessness; Utilisation of outside space for health reasons

5.3.7 Data for Staffordshire are similar to national levels in terms of: Suicide and Self-reported wellbeing

5.3.8 However, for outcomes that are indicators of wellbeing in specific groups data tend to be less favourable. Domestic abuse has increased. Adults with mental illness in stable and appropriate accommodation has decreased (although still higher than national average) Adults with learning difficulties in stable and appropriate accommodation has decreased and is lower than the national average. Adults with learning difficulties in employment is lower than the national average.

5.3.9 'Mental Wellbeing' was raised in the Health and Wellbeing Engagement exercise in relation to issues such as support for carers, preventing social isolation and tackling the underlying causes of drug and alcohol misuse.

'Alcohol consumption is a symptom, not a cause, of social problems.'

[We need] *''Better/improved use of volunteers befriending'* (Lichfield & District CVS)

5.3.10 Given the quantitative evidence around mental wellbeing, the potential impact on other areas for action and the inclusion in the engagement exercise, the ongoing inclusion of mental wellbeing as a priority should be reviewed. It relevance for particularly vulnerable groups and as a contributory factor to other areas for action could suggest are more focussed approach.

6.0 Ageing well

6.1 Dementia

6.1.1 The estimated diagnosis rate for people with dementia is significantly lower in Staffordshire than nationally (2012/13). 42% in Staffordshire compared with 48% for England.

6.1.2 Dementia is an illness which has a particularly high impact upon carers. Carers receiving a needs assessment, review specific carers service or advice and information is lower than average in Staffordshire

6.1.3 The Health and Wellbeing engagement feedback did not centre around dementia specifically. However, there was considerable feedback around support for the frail and elderly and support for carers.

6.1.4 Additional qualitative surveys carried out by Healthwatch Staffordshire found that the majority of people with dementia, or their carers, felt that there was a lack of coordination and communication surrounding dementia care. They also stressed the importance of early diagnosis and intervention for people with dementia and their carers.

6.1.5 The Health and Wellbeing Board agenda has not specifically addressed dementia, but it has been raised during discussions about frail elderly.

6.1.6 Given the quantitative data and the inclusion in engagement feedback and on the Health and Wellbeing Board agenda, the evidence would support the ongoing inclusion of 'dementia' as a priority.

6.2 Falls prevention

6.2.1 Injuries due to falls are significantly lower in Staffordshire compared to England (2011/12). 1574 per 100,000 in Staffordshire compared to 1665 per 100,000 in England. This has increased from 1544 per 100,000 in the previous year (2010/11)

6.2.2 Hip fractures in those aged 65 and higher are significantly higher than national levels (2011/12). 491.8 per 100,000 in Staffordshire compared to 457.2 per 100,000 in England. This has increased from 448.8 per 100,000 in the previous year (2010/11)

6.2.3 Falls was not specifically mentioned in the Health and Wellbeing Engagement. However, there was much discussion around the importance of appropriate housing for the frail and elderly and support for sheltered housing, extra care housing and retirement communities.

'Ageing population demographically but sheltered housing complexes do not seem to be getting built at the rate their needed. A person who is vulnerable can remain independent then with their own very important front door.'

6.2.4 The issue of falls prevention is strongly related to housing, for example through the provision of Disabled Facilities Grants within the homes of those most likely to experience a fall. A recent study carried out in partnership between Healthwatch Staffordshire and Public Health Intelligence estimated that between 45% and 190% of cost of an average Disabled Facilities Grant in Staffordshire can be saved through the prevention of falls alone.

6.2.5 The Health and Wellbeing Board has received presentations about housing which included content about the link between housing and long term health, the minutes of the presentation noting that:*'Good work is being done to improve housing and reduce related poor health but it is not consistent and there is no coordination.'*

6.2.6 Given the quantitative data and the inclusion in engagement feedback and on the Health and Wellbeing Board agenda, the evidence would support the ongoing inclusion of 'falls prevention' as a priority.

6.3 Frail elderly

6.3.1 Frail elderly is a very broad action point within the Health and Wellbeing strategy

6.3.2 Relevant indicators included in the JSNA where Staffordshire performs better than England include:

6.3.2.1 The proportion of older people still at home 91 days after discharge from hospital into reablement/ rehabilitation services (2012/13) is higher in Staffordshire. 85.9% in Staffordshire compared to 81.4% for England

6.3.2.2 Permanent admissions to care homes in adults aged 65 years and over are lower in Staffordshire than nationally (2012/13). 661.1 per 100,000 in Staffordshire compared to 697.2 per 100,000 for England.

6.3.2.3 Health related quality of life for carers (2012/13). 8.5/12 in Staffordshire compared to 8.1/12 for England

6.3.3 Relevant indicators included in the JSNA where Staffordshire performs worse than England include:

6.3.3.1 Population vaccinations amongst those aged 65+ (2012/13) are lower than national levels and have decreased. 70% in Staffordshire compared with 73% for England.

6.3.3.2 Health related quality of life for older people is lower than national levels (2012/13). 18.5/24 for Staffordshire compared to 18.8/24 for England.

6.3.3.3 Proportion of adult social care service users who have as much social contact as they would like is significantly lower than national levels (2012/13). 35.3% in Staffordshire compared to 43.2% for England. This is a deterioration from 46.3% in the previous year (2011/12).

6.3.3.4 Only 13.4% of carers had received a needs assessment or a review and specific carers service or advice and information.

6.3.4 Members of the public and professionals were specifically asked '*what do you think would make the biggest difference to help people live independently and well for as long as possible?'* as part of the Health and Wellbeing Engagement exercise. Responses tended to centre around reducing social isolation, provision of appropriate housing, better transport systems and high quality domiciliary care. As support for the frail elderly is such a broad category, many of these issues are discussed through other action points.

6.3.5 Given the quantitative data and the inclusion in engagement feedback and on the Health and Wellbeing Board agenda, the evidence would support the ongoing inclusion of 'frail elderly' as a priority. There may be benefit in terms of greater clarification as to what the action point of the 'frail and elderly' entails and how it overlaps with other action points.

7.0 Ending well

7.1 End of life

7.1.1 Life expectancy at birth for males and females is similar in Staffordshire to England (2010-12). For males, life expectancy is 79.4 years in Staffordshire compared 79.2 year in England. For females, life expectancy is 83.0 years in Staffordshire compared to 83.0 years for England.

7.1.2 Premature mortality from all the major causes of death (CVD, cancer, respiratory, liver) are all better or similar to England

7.1.3 Premature mortality in vulnerable groups (Adults with mental illness) is also better than England. Despite the positive position compared to England, there is still a considerable gap between this group and the general population.

7.1.4 Deaths at home from all causes (2012) is similar in Staffordshire compared to nationally. 21.3% for Staffordshire compared to 21.6% for England.

7.1.5 This data does not provide any insight into quality of end of life care. National insight shows that most people don't want to die in acute care. There may be a need for greater data collection in this area, as end of life experiences tend to be complex, sensitive and subjective qualitative data may be of particular benefit to evidence and measure this action point.

7.1.6 Purely in terms of how Staffordshire benchmarks compared to England, feedback from the engagement exercise and content of the Health and Wellbeing Board agenda, 'end of life' is not a priority.

8.0 New potential action points

8.1 A number of action points can be identified that are not currently specifically included on the Health and Wellbeing Strategy, but which the latest available evidence suggests may be areas of concern and could be incorporated into current areas.

8.2 **Reducing social isolation -** There is evidence from the latest JSNA data and from the Health and Wellbeing Strategy Engagement that reducing social isolation should be a focus.

8.2.1 35.3% of adult social care services users have as much social contact as they would like. (2012/13). This has decreased from 46.3% in the previous year (2011/12). This is significantly lower than England at 43.2%.

8.2.2 48.1% of adult carers users have as much social contact as they would like. (2012/13). This is significantly higher than England at 41.3%.

8.2.3 As part of the public engagement in the development of the health and wellbeing strategy the public were asked how the frail and elderly could best be supported. *'Reducing social isolation'* was the most frequent theme of the responses.

'More befriending / home visits, often old people are just lonely and crave company but are often not able to get out to socialise.'

Numerous professional stakeholders also stressed the importance of reducing social isolation.

'Ensure continuity of care for those who cannot leave their homes but who need our services so that a relationship develops and the impact of loneliness and isolation diminishes in that person'. (Lichfield District Strategic Partnership)

8.2.4 *'Reducing social isolation'* also fits well with the overriding focus of the Health and Wellbeing Board upon prevention. National research from the Campaign to End Loneliness cites that:

'Research has demonstrated that the effect of loneliness on mortality exceeds the impact of well-known risk factors such as physical inactivity and obesity, and has a similar influence as cigarette smoking.'

When influential factors including physical and mental health are taken into account, loneliness was still associated with a 64% increased risk of the disease [of Alzheimer's].'

'Lonely individuals are more likely to undergo early entry into residential and nursing care.'

8.3 <u>Domestic abuse</u> - There is evidence from the latest JSNA data, public and professional engagement study and Board discussion that domestic abuse should be an action point of the health and wellbeing board.

8.3.1 Rates of domestic violence is higher in Staffordshire than for England (2011/12). 19.0 per 1000 in Staffordshire compared to 18.2 per 1000 in England. This is an increase from 18.8 per 1000 in the previous year (2010/11)

8.3.2 Domestic abuse could be seen as an action point for *'living well'*, and/or for *'starting well'*. The Health and Wellbeing Engagement identified concerns that growing up within vulnerable families (which would include families at risk of domestic violence) can have a major impact upon the life outcomes of the children of those families.

Provide targeted support to vulnerable families—providers and District Councils are well placed to deliver/shape this' (Tamworth Health and Wellbeing Board)

8.3.3 In Board discussions (13th Feb) it was stressed that recent guidance has encouraged linkage between Health and Wellbeing Boards and the Safeguarding Children Boards. The Health and Wellbeing Board received a presentation from the Staffordshire Safeguarding Children Board at which they discussed their priorities which included:

'A particular focus on work with children at risk of harm from child sexual exploitation and domestic violence.'

8.3.4 This action point could be included more specific action within the broad action point of '*parenting'*.

8.4 <u>Health in pregnancy and breastfeeding</u>

8.4.1 These two issues have been grouped together as they are both issues of health in infancy and depend upon engagement with mothers who are pregnant or have recently given birth. There is evidence from the latest JSNA data that health in pregnancy and breast feeding should be considered as an action point.

8.4.1.1 The proportion of babies that are initiated into breastfeeding in Staffordshire has improved in comparison with the previous year but is lower than the level for England

8.4.1.2 The proportion of babies who are still breastfed at 6-8 weeks has decreased in comparison with the previous year and is lower than England as a whole

8.4.1.3 Mothers who smoke at the time of pregnancy has increased and is worse than the level for England

8.4.1.4 On a positive note, population vaccines in pregnant women have increased considerably (from 29% to 42%) and are now higher than for England

8.4.2 This action point could be included more specific action within the broad action point of '*parenting'*.

8.5 <u>Housing</u>

8.5.1 The link between housing and health has been high on the Board's agenda. A presentation from housing representatives entitled *'the wider determinants of health and wellbeing'* was presented to the Board on 10th of October 2013 and the minutes note that:

'The link between poor housing and poor health is compelling… Good work is being done to improve housing and reduce related poor health but it is not consistent and there is no coordination.'

8.5.2 In terms of data, there are some positive indications:

8.5.2.1 New housing, new affordable housing and number of rights to buy have all improved in comparison to the previous year.

8.5.2.2 Statutory homelessness has decreased and is lower than national levels

8.5.3 However, there are also a number of negative indicators:

8.5.3.1 The level of fuel poverty in Staffordshire is worse than for England

8.5.3.2 Adults in contact with secondary mental health services in stable and appropriate accommodation has decreased (although Staffordshire is still better than England as a whole)

8.5.3.3 Adults with learning difficulties in stable and appropriate accommodation has decreased considerably (from 75% to 61%) and is worse than the level for England

8.5.3.4 The level of hip fractures in people aged 65+ in Staffordshire is worse than England as a whole

8.5.4 In the engagement exercise many respondents stressed the importance of appropriate housing for the elderly showing support for sheltered housing, extra care housing and retirement villages.

8.5.5 [You should] *'Provide more sheltered accommodation.'*

8.5.6 This action point could be included more specific action within the broad action points targeting specific groups including 'frail elderly*'* and 'mental health and learning difficulties' if this is included.

8.6 Supporting the mental wellbeing of vulnerable groups

8.6.1 General indicators of mental wellbeing across Staffordshire tend to be similar or better than national levels.

8.6.2 There are a number of indicators that identify concerns in the mental wellbeing of the most vulnerable groups, such as victims of domestic abuse, the frail and elderly, people with mental health problems, people with learning disabilities and looked after children.

8.6.3 Within the Engagement exercise with the public and professional stakeholders a number of arguments were offered as to why it is important to tackle the mental health, or the risk of poor mental health, of vulnerable groups in a number of areas including:

8.6.3.1 Poor mental wellbeing of parents can have adverse effects upon the wellbeing, lifestyle, physical and mental health of their children.

8.6.3.2 Poor mental wellbeing in vulnerable people is often an underlying cause of alcohol and drug abuse.

8.6.3.3 Poor mental wellbeing, particularly social isolation, is particularly prevalent amongst the frail and elderly and can cause worsened physical health outcomes and risk of mental health crisis

8.6.3.4 Poor mental wellbeing within vulnerable groups can escalate putting some at risk of mental health crisis. When crisis occurs this can put unmanageable pressure upon other services not equipped to best deal with these issues, such as the police or A&E departments.

8.6.4 As a focus, the mental wellbeing of vulnerable groups fits well with the agenda and discussion of the board, which often focusses on wider determinants of health such as inappropriate housing, the safeguarding of vulnerable children and the impact of the reconfiguration of Mid Staffordshire NHS Foundation Trust on the most disadvantaged sections of society.

8.6.5 A focus upon the mental wellbeing of vulnerable groups fits well with the Board's overriding strategy upon prevention, as national evidence shows that mental wellbeing can have a significant impacts on health and social outcomes. For instance, national research indicates that social isolation poses a greater health risk than obesity and approximately the same level of risk as smoking.

8.6.6 This action point could be included more specific action within the broad action points targeting specific groups including 'mental wellbeing'.

9.0 Areas that could be considered for inclusion as areas for action

9.1 Support for Carers

9.1.1 Only 13% of carers within Staffordshire receive a carer's specific service, information or advice. This is less than half the national level of 28%.

9.1.2 This level is even lower when we consider specific client groups, the levels of carers receiving a service, information or advice are:

9.1.2.1 10.1% of those caring for an adult (18-64) with a physical disability

9.1.2.2 9.5% of those caring for an adult (18-64) with a mental health problem

9.1.2.3 8.3% of those caring for an adult with a learning difficulty

9.1.3 As a focus group, the focus on 'carers' also supports many other priority areas such as dementia, alcohol, drugs, mental wellbeing, falls prevention and end of life

9.1.4 Support for carers was also strongly supported amongst the public and professional stakeholders that took part in the Health and Wellbeing Strategy Engagement exercise

9.1.5 A focus on carers fits well with the overriding strategy of **prevention** and a shift in resources from acute to community care, as carers are crucial in supporting people to manage long term conditions in the community to avoid crisis interventions in acute care

9.1.6 Support for carers also fits well with the local and national agenda, with the Department of Health, Staffordshire County Council and Healthwatch Staffordshire all identifying support for carers as a key priority. This could support partnership working across organisations

9.1.7 Support for carers could be considered as an additional area for action under "aging well"

9.2 Mental health and learning difficulties

9.3 Mental health and learning difficulties are arguably loosely covered under the action point of *'lifestyle and mental wellbeing'*. However, there is evidence from the latest JSNA data, public and stakeholder engagement, and the Board agenda that mental health should be considered a specific action point.

9.4 According to the latest JSNA data adults in Staffordshire that are in contact with secondary mental health services in stable and appropriate

accommodation have decreased from 76.2% in to 76.0%, although they are still higher than the national average at 58.5%.

9.5 Adults with learning difficulties in stable and appropriate accommodation has decreased from 75.3% in (2011/12) to 60.7% (2012/13) and is worse than England at 73.5%.

9.6 The level of adults on contact with secondary mental health services in employment is significantly higher than for England at 20.4% compared to 8.8%.

9.7 The level of adults with learning difficulties in Staffordshire in employment is also significantly lower than for England at 4.2% compared with 7.0%

9.8 The Health and Wellbeing Engagement study both members of the public and stakeholders from relevant professional organisations stressed the importance of support for people with mental health or learning difficulties.

We think that mental health/ mental wellbeing should also be considered as a priority within the first year.' (Feedback from Lichfield District Board, Lichfield District Health and Wellbeing Group)

'I work for the police - there is simply not enough money for mental health units or nurses (CPNs) to support people in the community, because they come to us a last resort, very often when they are suicidal, because the system can't help them.'

Appropriate mental health care for parents was also seen as being essential to improve outcomes for their children.

'Treatment for mental health for parents—stop the cycle' (Lichfield & District CVS)'

9.9 The Health and Wellbeing Board has also had detailed discussions about mental health. It was stressed that improvements in mental health require effective partnership working across numerous organisations and that failure to intervene early in mental health crisis situations can lead to wider negative consequences throughout the public sector.*'Board Members highlighted the importance of addressing the issues identified around crisis interventions, particularly as failures in this area could lead to wider consequences. It was noted that the ambulance service also experienced similar issues to the police, principally around taking some individuals to identified provision.'* [Minutes Health and Wellbeing Board meeting, Thursday 13 February]

9.10 Mental Health and Learning Difficulties could be considered as an additional area for action under "Living Well".

10.0 Recommendations

10.1 It is worth noting that this report is based on a limited data set. It is important the Health and Wellbeing Board consider the wider context in reviewing the inclusion of these areas. This would include the e-JSNAs developed by the district partnerships. Specific questions include:

10.1.1 Is being similar or better than England is good enough?

10.1.2 Does the potential cost of the negative outcome that makes the area a priority?

10.1.3 Is the area a root cause for other areas?

10.1.4 Are there are inequalities between areas that makes the area a priority?

10.1.5 Should the priorities focus on areas that are within the direct control of the Health and Wellbeing Board or go beyond?

10.2 The Health and Wellbeing Board should maintain the focus on the following areas where there is strong evidence:

10.2.1 In care

10.2.2 Alcohol

10.2.3 Drugs

10.2.4 Lifestyles (split from lifestyles and mental wellbeing)

10.2.5 Falls prevention

10.2.6 Dementia

10.3 The Health and Wellbeing Board should maintain the focus on the following areas where there is strong evidence, however the definition should be reviewed to consider greater focus:

10.3.1 Parenting

10.3.2 Mental Wellbeing (split from lifestyles and mental wellbeing)

10.3.3 Frail elderly

10.4 This could include focus in the following areas:

10.4.1 Reducing social isolation in 'frail elderly'

10.4.2 Health in pregnancy and breastfeeding in 'parenting'

10.4.3 Domestic abuse in 'parenting' and/or 'mental wellbeing'

10.4.4 Housing in 'frail elderly' and/ or 'Mental Health and Learning Disability'

10.4.5 Supporting mental wellbeing in vulnerable group in 'mental wellbeing'

10.5 The Health and Wellbeing Board should review the following areas for action where there is less evidence to support:

10.5.1 School readiness

10.5.2 Education

10.5.3 NEETs

10.5.4 End of Life

10.6 The Health and Wellbeing Board should consider the following areas as additional areas for action given the available evidence:

10.6.1 Support for carers

10.6.2 Mental Health and Learning Disability