HALTON JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

PURPOSE:
This document is an annual summary - a supplementary document to support the updating of the JSNA. It reflects work undertaken during 2012 and developments that are taking place during 2013-14.

Updating the JSNA:
This document is the second to use the '*Life course'* approach to summarise data and priorities from the suite of JSNA documents.

Since the commissioning priorities across the JSNA were last reviewed, the Health & Wellbeing Board has agreed its first Health & Wellbeing Strategy, 2013-2016. Based on the JSNA and wide ranging consultation, 5 priorities have been chosen. The board used a prioritisation process and the reasons for choosing the 5 priorities are summarised in this document. Halton Clinical Commissioning Group (CCG) has produced its first overarching commissioning strategy and Halton Borough Council has also updated several of its commissioning plans and strategies.

Each of the health issues and social determinants identified in the 2011 JSNA continue to present challenges locally, although there has been much progress.

The full 2011 JSNA, together with the annual data updates spread sheet, can be found on Halton Borough Council's website at
http://www3.halton.gov.uk/councilanddemocracy/statisticsandcensusinformation/318888/

In depth needs assessments and other reports are also available at
http://www3.halton.gov.uk/healthandsocialcare/318895/318899/

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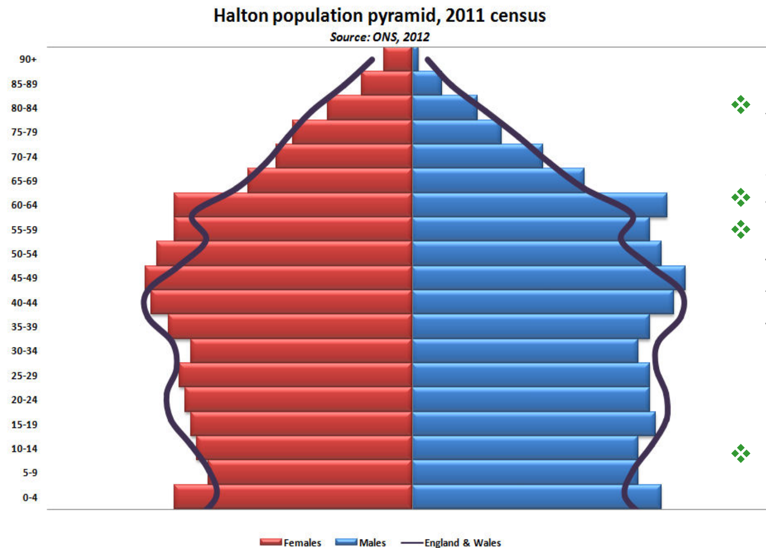
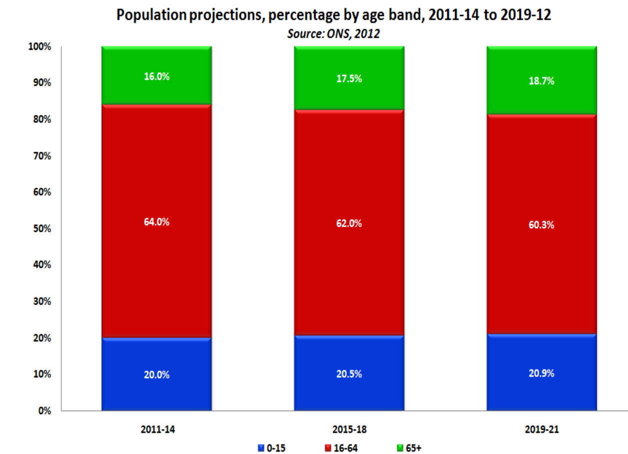
Produced by Sharon McAteer, Public Health Development Manager, Halton Borough Council, August 2013



- As at the 2011 Census, Halton's population was 125,700 *rounded to nearest 100)*
- 48.8% male to 51.2% female
- Population projections based on the 2011 census suggest the younger age band will remain fairly static, with the working age population to shrink and older age band will increase as a proportion of total population
- Population registered with Halton GPs is 128,446 (July 2012).



Index of Multiple Deprivation (IMD) 2010

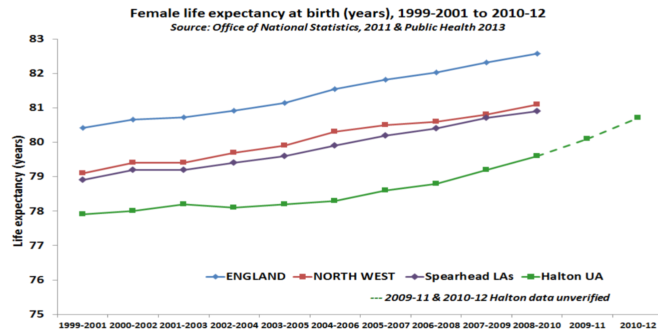
- Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities). This is the 3rd worst out of the six local authorities which make up the Liverpool City Region, behind Liverpool and Knowsley.
- The ward with the highest average IMD score in 2010 and therefore the most deprived ward in Halton is Windmill Hill. The least deprived ward in Halton is Birchfield.
- The overall IMD is made up of seven domain measures. Daresbury ward does well across all of these whilst Windmill Hill has some of the highest scores.
- Deprivation scores at small area geography (known as Lower Super Output Areas) shows that the area with the highest deprivation is located in Kingsway ward.
- There are 21 LSOAs in Halton that fall in the top 10% most deprived nationally. Of these 10 fall in the top 3% most deprived nationally and 2 fall in the top 1%.

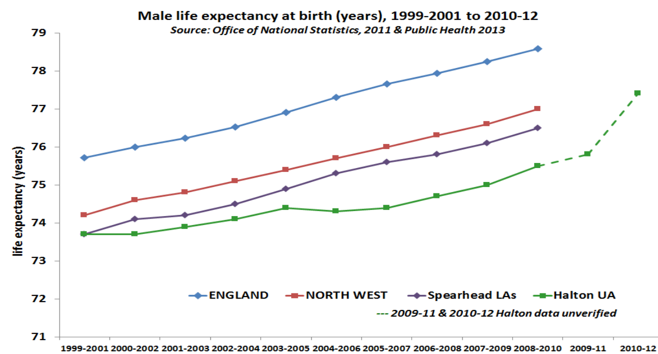
Just a few success stories from across the borough

- Halton has been successful in attracting new jobs in to the borough.
- Employment rates as at February 2013 were slightly lower than those seen in February 2012.
- The number of young people not engaged in education and training (NEET) has decreased from 10.3% in 2011 to 8.9% in 2012.
- Attainment of 5 or more A*-C including English and Maths again improved in 2012 and was the Halton's best ever result. Overall, 87% achieved 5 A*-C's, with 59% achieving 5 A*-C's including English and Maths.
- The level of excess winter deaths is lower than England average
- The Infant mortality rate has fallen and is now similar to the national average.
- The rate of statutory homelessness is lower than England average.
- Immunisation rates are similar to the England average.
- There were 125 children in care at 31 March 2012 which gives a lower rate when compared to the England average. A higher percentage of children in care are up-to-date with their immunisations compared to the England average.
- The ASB (Anti Social Behaviour) Victim and Witness Service Impact Report showed a positive impact, providing accessible supportive service to vulnerable hard to reach groups and individuals in Halton. The service has also shown caseload and cost benefits for the police. The service has had positive feedback from users.

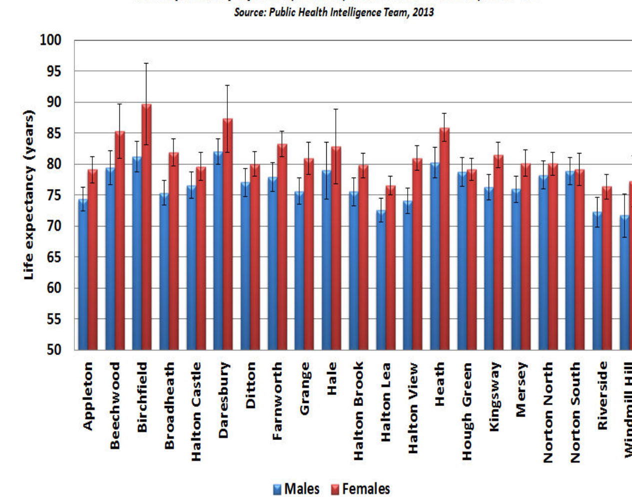
…… and lots of others.

Life expectancy

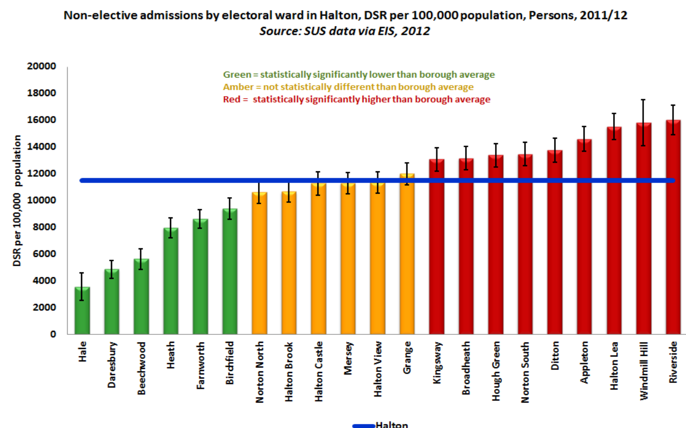




- Life expectancy has risen steadily over time. In 2010-12 average life expectancy in the borough was 77.4 years for men and 80.7 years for women. However, the borough is consistently lower than its comparators (about 3 years lower than the England figures).
- Internal differences in life expectancy range from 71.1 years for males in Windmill Hill to 82.1 years in Daresbury. For females the differences range from 76.4 years in Riverside to 89.7 years in Birchfield ward: a difference of 10.4 years for males and 13.3 years for females
- This is a slight narrowing of internal inequalities for men from 11.4 years and widening for women from 9.4 years during the previous reporting period 2008-10.

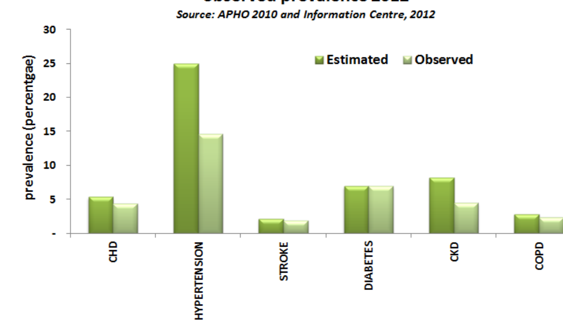


Hospital admissions



- There were 15,035 15,779 emergency admissions, a slight decrease on the previous years figure of 15,779. Injuries accounting for 14.6%, respiratory for 12.1%, digestive 10.3% and circulatory 9.3%. Riverside ward remains the ward with the highest admissions rate (compared to 2010/11) and Hale is now the lowest (in 2010/11 Daresbury was lowest).
- There have been year on year improvements in the number of people identified with long term conditions (CHD slight decrease in number in 2011/12 compared to 2010/11, prevalence rate remained the same). This has further closed the gap between the numbers identified and the estimated levels.

Disease prevalence: expected against observed rates



LONG TERM CONDITION	MODELLED		OBSERVED	
	Number	Prevalence (%)	Number	Prevalence (%)
CHD	6933	5.41	5,651	4.41
HYPERTENSION	32141	25.00	18,760	14.64
STROKE	2868	2.20	2,405	1.9
DIABETES	7072	6.94	7,108	6.97
CKD	7,474	8.2	4,544	4.5
COPD	3635	2.84	3,106	2.42

Pregnancy & 1st year of life

1661 live births (1% pop)

- Smoking at time of delivery *21.1%,* higher than comparators
- Low birth weight *8.5% (2011),* higher than England rate
- Breastfeeding initiation 51.1% and breastfeeding at 6-8 weeks 22% (2011-12). An improvement on the previous year but remaining lower than comparators
- Access to antenatal care within 12 weeks of pregnancy *85.5% (Q1-Q3 2010-11)*
- Infant mortality *4.8 per 1,000 live births* (2009-11) which is slightly higher than comparators

Childhood (1-15)

23,200 children (19% pop)

- Child Poverty **27.3%**
- Hospital admissions due to asthma (0-18 years), crude rate *367.9 per 100,000 population (crude rate)*
- Hospital admissions due to accidental injury, 2011-12, *3010.9 per 100,000 population. An increase from 2010-11*
- Children in Need *959* (as at 31 March 2012)(higher rate than NW and England)
- Looked After Children *125* (as at 31 March 2012)
- Obesity : *Reception 9.6%*, a reduction on previous year.
- Obesity: *Year 6 19.5%,* a reduction on previous year
- Immunisation : MMR 1st & 2nd dose by 5years **85.2%** (2011-12), an increase on the 2010-11 figure
- Children achieving a good level of development at age 5*, 55.2%.* This is an improvement on the previous year but remains lower than comparators and one of the lowest in the country.

Young adulthood (16-24)

14,500 people (12% pop)

- NEETs 2012 **400** people aged 16-18 (8.93%, higher than comparators). An decrease on the 2011 figures.
- Teenage pregnancy: ***41.5 per 1,000 females aged 15-17*** (2011), a reduction on the 2010 rate.
- Hospital admissions due to alcohol: ***122.9 per 100,000 population*** (2008-11), a reduction on previous period.
- Sexually Transmitted infections 2008-10: ***Chlamydia 1851 cases; genital warts 1483 cases***
- Chlamydia screening (2010-11) ***34.4%*** 15-24 year population tested
- Hospital admissions due to self harm, aged under 18, ***204.2 per 100,000*** (crude rate), a reduction on the previous year.

Healthy adulthood (25-64)

67,800 people (54% pop)

Lifestyle choices:
- Smoking prevalence *23.1%*; prevalence for manual workers *30.7%*
- Binge drinking *23.9%*
- Obese *25.9%*

Number of people with long term conditions (All ages) (QOF 2011-12):
- Hypertension *18,760*
- CHD *5,651*
- Diabetes *7,108*
- COPD *3,106*
- Stroke *2,405*
- Depression *12,471* (12.4% GP pop aged 18+)

Coverage/uptake of cancer screening (average for CCG, range across GP practices):
- Breast: average *73.5%*, range *60.8% to 78.4%*
- Cervical average: *76.2%*, range *73.4% to 85.64%*
- Bowel: average *51.22%*, range *34.29% to 68.87%*

Hospital admissions (all ages, rate per 100,000 population, 2011-12):
- Emergency admissions *11,490*
- Alcohol specific *1017.7*
- Alcohol related *3,027*
- Cancers *1,349.55*
- Heart Disease *514.57*
- Stroke *163.39*
- Digestive *1,300.5*

Older people (65+)

18,500 people (15% pop)

Life expectancy (2009-11)
- Males *76.5 (England 78.91)*
- Females *80.7 (England 82.89)*

Life expectancy at 65 (2009-11)
- Males *16.7* (England 18.40)
- Females *19.5* (England 21.05)

Inequalities in life expectancy (by ward 2008-12)
- Males *10.4 years* (71.7 in Windmill Hill, Daresbury 82.1) (a decrease in inequality)
- Females *13.3 years* (Riverside 76.4, Daresbury 89.7) (an increase in inequality)

All age all cause mortality:
- Males *843.14 per 100,000* population (2008-10)
- Females *610.85 per 100,000* population (2008-10)

- Hospital admissions (2011-12) due to falls *, aged 50+, 2768.7 per 100,000 population*
- Dementia: estimated ***1,143 people aged 65+: QOF register (2011-12) 690*** people diagnosed (better diagnosed to expected ratio that NW & England)

- Flu vaccination uptake 65+ CCG average *73.6%* (2012-13), range *56.9%-83.1%.* 9 out of 17 achieved 75% target.

Populations all based on 2011 census rounded to nearest 100 (ONS 2012) except live births which is actual numbers for 2012.
Population percentages rounded to nearest whole number (based on population of 125,700)

Economic

- Unemployment (Job Seekers Allowance) rate *4.8% = 3927* adults (May 2013)
- *11.4%* working age adults in Windmill Hill unemployed (Job Seekers Allowance)
- Working age adults claiming out of work benefits *13,650* (February 2013) or *16.6%.*
- Windmill Hill *37.6%* working age adults claiming out of work benefits (February 2013) is the highest in the borough. (range 4.7% to 37.6%)
- Youth unemployment rate (18-24years) *10.5% = 1,170* people (May 2013)
- Business survival rate (after 1 year) similar to England average at *90.8%* (Eng 90.9%).
- Average weekly earnings for full-time workers lower than England and North West averages, *£452.2* in 2012 (NW £472.5, GB £508)
- Gap between Halton adult qualifications & GCSEs compared to England has narrowed since 2010 across all levels.
- Proportion of working-aged adults with no qualifications slightly higher than England average, *11.5%* (Jan 2011-Dec 2011).
- *75.9%* working aged adults economically active (Oct 2011-Sept 2012) (NW 75.2%, GB 76.7%)

Community Safety

- Anti-social behaviour incidents ***83.5, per 1,000*** residents
- Hate crimes ***0.4, per 1,000*** residents
- Domestic incidents ***116, per 1,000*** residents
- Domestic violence ***46, per 1,000*** residents
- Levels of crime were seen as important indicators for making an area a good place to live (2011 Residents survey)
- Overall crime rate ***42.8 per 1,000*** residents

(all data is for 2011)

Housing

- At 31st March 2013 there were ***54,833*** dwellings in Halton.
- ***25%*** housing in Halton is social rented accommodation (higher than the England level of 10%)
- There were ***86*** Statutory Homeless Households and ***15*** households in temporary accommodation (2012/13). This means rates per 1,000 households are much lower in Halton than in England.
- Homelessness was prevented for a further 431 households during the year.
- In 2011 ***14.9%*** of households were in fuel poverty. This is a fall on the previous 2 years (18.1% for 2010 and 19.3% for 2009). Previous to this rates had been rising.
- During the first three quarters of 2012/13 ***165*** mortgage possession claims were issued, of which ***120*** resulted in a repossession order being made.
- Over the same period ***275*** Landlord Possession claims were issued, resulting in ***185*** orders being made.

Transport

- The number of cars licensed in Halton between 2002 and 2009 increased by ***22%***
- Since 2001, Halton has experienced an ***increase in traffic growth***. This increase is greater than the increase experienced by Great Britain as a whole.
- ***27%*** of households are without private transport (no car/van), compared to 25.8% across England (Census 2011)
- ***40.4%*** use their car/van to get to work, ***5.6%*** travel on foot, ***1.3%*** use a bicycle, ***4.1%*** bus, ***4.3%*** car passenger (Census 2011).
- The rate of all persons and children killed or seriously injured on the roads is higher than comparators. Steady reductions since 2000, but static for last 4 years. Number children seriously injured has more than doubled over the same four. There were ***40*** people killed or seriously injured 2012 with ***337*** slightly injured (a reduction on the previous year)
- The number of people working from home increased from 3.6% (2001 census) to ***4.2%*** (England 6.9%) (Census 2011).

Social care & vulnerable people

- Proportion older people discharged from hospital to intermediate care/ rehabilitation/ re-ablement who are still living 'at home' 91 days after discharge: ***74.1%. This is an increase on previous figures*** but lower than NW and England. Higher for females (72.5%) than males (61.5%) and for those aged 65-74 (82.4%) than total 65+ population
- Clients and carers receiving self directed support as percentage of all receiving community based support ***49.5% = 2785*** out of total of 5620, a significant rise on previous reported figure of 27.5%.
- Adults with learning disabilities in settled accommodation ***77.2%,*** higher than NW & England (2011-12)
- Proportion of adults on CPA receiving secondary mental health services in settled accommodation ***80%*** (2011-12).
- Rate of Disability Living Allowance claimants ***8.53%*** (England 5%) (August 2012)

In developing our first joint Health & Wellbeing Strategy the wide social influences on health and the need to work on prevention & early intervention across the life course have been at the centre of priority setting

Using the JSNA to understand need

Early discussions about the Health and Wellbeing Board produced a consensus on the need to focus on prevention and early detection and the value of using the Marmot Review life course approach.
The February 2012 JSNA summary document pulled data and commissioning priorities from all the JSNA chapters in to 5 broad life stages.
This enabled Health & Wellbeing Board members to see what the issues were overall but also to clearly identify health and wellbeing needs for particular sections of the population. This helped identify key priority groups to target, for example, for hospital admissions due to injuries, young children and older adults were the groups most at risk of accidental injury.
The summary document also looked at the wider determinants of health, detailing the levels of need and commissioning priorities.

Information on these life stages and wider determinates are updated in this summary.

Prioritisation process

The Health Strategy sub-group sifted the issues and identified a list of potential priorities across all life stages and wider determinants where performance was poorer than comparators and/or where it had worsened or had been resistant to change over recent years.

A further sifting produced a shorter list of issues, all of who merited further investigation and discussion. This list was used for a wide ranging community consultation and also with the Health & Wellbeing Board.

A prioritisation framework was developed and agreed with the Health & Wellbeing Board. Information on all the 'shortlisted' issues was provided across the prioritisation framework categories.

Chosen Priorities

The Health & Wellbeing Board considered the feedback from the community consultation events and information provided from the JSNA to agree a small number of priorities were they felt significant action needed to be taken.

The priorities chosen were:

- **Prevention and early detection of cancer**
- **Improved child development**
- **Reduction in the number of falls in adults**
- **Reduction in the harm from alcohol**
- **Prevention and early detection of mental health conditions**

Making it happen.
The Health & Wellbeing Strategy:

- Does not replace existing strategies, commissioning plans and programmes, but influences them.
- Agreed that integration is a key strategic approach with all partners working together to deliver joint commissioning, bring about a culture change and joint advocacy and policy work.
- Has a set of Action Plans to meet the key priorities.
- The Wellbeing Areas will be utilised, based on the existing Area Forum boundaries, to deliver the Board's vision at a community level.
- The Well Being Practice model commissioned jointly by the council and Halton Clinical Commissioning Group underlines their commissioning intentions to focus provision around local communities.

Ultimate responsibility for the monitoring of the implementation of the Strategy and Action Plans against set outcomes and key performance indicators lies with the Health and Wellbeing Board who are accountable to the public.

Early Child Development

- **Strategic Fit:** relevant to public health outcomes framework and identified as key action in Marmot Review on health inequalities
- **Health Inequalities:** significant impact on outcomes in later life
- **Strength of Evidence:** some
- **Value for Money:** likely to be cost saving
- **Magnitude of benefit:** significant
- **Number of people benefiting:** whole population
- **Public acceptability:** highly desirable
- **Risk of not investing:** high impact

Cancer

- **Strategic Fit:** relevant to public health outcomes framework and identified as high priority in the JSNA due to high death rates .
- **Health Inequalities:** major cause of continuing health inequalities. Highest death rates in England for women and one of highest for men.
- **Strength of Evidence:** strong
- **Value for Money:** clear cost benefit, especially screening and behaviour change
- **Magnitude of benefit:** significant benefit on life expectancy and quality of life
- **Number of people benefiting:** over 5,000 people screened each year; over 3,000 accessing health improvement services
- **Public acceptability:** very high
- **Risk of not investing:** significant as major cause of death and disability

Mental Health

- **Strategic Fit:** relevant to all three national outcomes frameworks. Government strategy. High level of mental ill health, self harm and unemployment identified in JSNA.
- **Health Inequalities**: largest single cause of healthy life years lost
- **Strength of Evidence:** some interventions have sound evidence e.g. NICE guidance; Foresight report
- **Value for Money:** cost benefit analysis of NICE guidance; other areas less clear although likely to be cost saving; Foresight Report and national strategy provide for evidence.
- **Magnitude of benefit:** substantial impact on levels of ill health and costs to health and care budgets as well as wider economy.
- **Number of people benefiting:** over 5000 e.g. 1 in 4 attendances as GP mental health related
- **Public acceptability:** highest priority from public consultations
- **Risk of not investing:** high impact

Alcohol

- **Strategic Fit:** relevant to public health outcomes framework; new national strategy. High levels of alcohol related harm - hospital admissions and community safety
- **Health Inequalities:** current limited capacity for Tier 1 (prevention) and Tier 4 (treatment for highly dependent drinkers); rates of admissions higher than national average. High rates of undewr-18 admissions
- **Strength of Evidence**: NICE guidance for schools-based prevention and treatment; national strategy
- **Value for Money:** sound cost benefit analysis – NICE and cost saving - National Audit Office £1 investment saves £4.
- **Magnitude of benefit:** minimum pricing can bring about large improvements, including life expectancy and reduce social burden
- **Number of people benefiting:** large numbers drinking above recommended levels, 5000+
- **Public acceptability:** public priority
- **Risk of not investing:** high impact

Falls amongst older people

- **Strategic Fit:** relevant to public health outcomes framework; high levels of falls identified in JSNA. Impact on other outcomes frameworks re independent living
- **Health Inequalities:** significant impact on outcomes for older people; one of highest rates of hospital admissions due to falls in England.
- **Strength of Evidence:** NICE guidance on falls prevention.
- **Value for Money:** cost benefit analysis within NICE guidance **Magnitude of benefit:** impact on disability, mobility, social isolation and loss in independence
- **Number of people benefiting:** over 4000 falls amongst 65+ per year and predicted to rise due to aging population
- **Public acceptability:** likely to have high level of acceptability
- **Risk of not investing:** to date lack of strategic approach

HALTON JSNA: AREA FORUM (AF) HEALTH & WELLBEING PRIORITIES

AF1
Broadheath
Ditton
Hale
Hough Green

Similar to the Halton averages across all academic, environmental and crime indicators.

Similar to the Halton figures for unemployment – however this is still worse than the England figures.

Overall, Broadheath, Ditton and Hough Green similar to the Halton average for the majority of the health indicators.

However, Hale tends than the Halton and England average.

Alcohol-specific hospital admissions for males are significantly higher than the Halton average for Broadheath and Hough Green.

Smoking quitter rates are significantly higher for Broadheath and Hough Green, but are significantly lower for Hale.

AF2
Appleton
Kingsway
Riverside

Higher than average levels of 16-18's Not in Education, Employment or Training (NEET) and higher than average levels of children claiming free school meals.

High levels of anti-social behaviour, burglary, criminal damage to dwellings and deliberate fires.

Higher rates of unemployment, people on out-of-work benefits and youth unemployment than the Halton average. The area also has low average house prices.

Generally worse than the Halton average for the majority of the health indicators, particularly in terms of alcohol hospital admissions and life expectancy.

Smoking quitter rates significantly better for all wards in the Area Forum compared to the borough average.

AF3
Birchfield
Farnworth
Halton View

Lower than average levels of children claiming free school meals.

Crime is comparatively low.

Relatively low levels of unemployment, worklessness, youth unemployment and 16-18's Not in Education, Employment or Training (NEET). High levels of GCSE attainment (5+ A*-C inc. English and Maths).

Health generally better than the borough average.

Levels of overweight and obese children are around the same or lower than the Halton and England averages.

Admissions to hospital due to alcohol-related and alcohol-specific conditions are lower than the borough average.

Smoking quitters rate significantly worse than the borough average.

AF4
Grange
Halton Brook
Heath
Mersey

Has the largest population out of the 7 area forums in Halton.

Quite poorly performing economy (when compared with Halton's average) and quite poor crime rates.

However, Heath ward is an exception, as this area generally performs better than the Halton average across most indicators.

Grange, Halton Brook and Mersey generally perform similar to or below the borough average for the health indicators. However, Heath tends to perform better.

The percentage of overweight or obese children in Reception and Year 6 is higher than the Halton average, (except for Year 6 in Halton Brook).

Percentage of low birth weight babies is higher than the borough average.

AF5
Halton Castle
Norton North
Norton South
Windmill Hill

Higher than average levels of NEET and lower GCSE pass rates than borough average.

Contains some of the most deprived areas in Halton. Norton North is an exception to this.

Very high levels of unemployment, youth unemployment and worklessness. Very low average house prices.

Deaths under 75 years of age due to cancer higher than the Halton and England averages (except Norton North).

Alcohol-attributable and specific hospital admissions are higher than the Halton and England averages (except Norton North).

The percentage of overweight or obese children in Reception is higher than the borough average.

Smoking quitter rate is higher than the borough average, except for Halton Castle which is slightly lower

AF6
Beechwood
Halton Lea

Consists of two differing areas, the ward of Beechwood is one of the most affluent in Halton, with low levels of unemployment and crime.

Halton Lea is quite deprived, with high levels of unemployment and worklessness and low house prices.

Crime also remains an issue in Halton Lea But is lower than Halton average in Beechwood.

Beechwood better than the borough average for all but two of the health indicators (cancer incidence is slightly higher and the smoking quitter rate is lower).

Halton Lea worse than the Halton and England averages for the majority of health indicators.

AF7
Daresbury

Has the smallest population out of the 7 area forums in Halton .

NEETs: lower than borough average.

All crime indicators are better than borough average.

Area one of the most affluent in Halton, with low levels of unemployment, and higher than average house prices.

Better than the borough average for the majority of health indicators.

Highest male life expectancy in Halton.

The percentage of overweight and obese children in Reception and Year 6 is slightly higher than the England and Halton averages.

Assessing the Impact of the Economic Downturn on Health and Wellbeing (February 2012)

Key Findings

This recession is different than others:

- ❖ Diminished safety net for the unemployed
- ❖ New unemployment along side structural worklessness
- ❖ Changing nature of work environment – less secure employment
- ❖ Areas hard hit already have low resilience
- ❖ Reduced welfare support plus public sector cuts in services

Some groups are especially vulnerable

- ❖ Those already disadvantaged
- ❖ Ethnic minorities and women – disproportionately employed in public sector
- ❖ Disabled and older people – heavier reliance on public sector services
- ❖ Children living in poverty – low income and workless families

Health impacts: adults

- ❖ Mental health & wellbeing of adults –job insecurity and unemployment leading to increased use of mental health services and welfare advice
- ❖ Food poverty – increased reliance in cheap high fat, energy dense 'junk food' and use of food banks
- ❖ Increases in alcohol consumption (young men especially)
- ❖ Cuts in legal aid and welfare may leave women and children more at risk of domestic violence (economic dependence)
- ❖ Possible affect on mortality rates
- ❖ Fuel poverty has increased by 31% to 50% across Merseyside between 2006 to 2009

Health impacts: children & young people

- ❖ Mental health & wellbeing of children
- ❖ School staffing reductions could affect educational development
- ❖ Increasing child poverty can affect child development in to adulthood
- ❖ High youth unemployment – attempted suicides up to 25 times more likely for unemployed young men than those in employment

Child emotional health and wellbeing (October 2012)

Key Findings

❖Across Merseyside, there are likely to be between 1,804 to 2,706 new mothers with a mental health problem

❖Good level of development at age 5:

❖Having GCSEs reduces the risk of depression at the age of 42 by five percentage points : GCSE attainment has been improving

❖Analysis at small area level shows many areas across Merseyside where school absence rates are between 11.3% to 22.5%.

❖Research suggests that almost 1 in 4 children (24%) who are in receipt of disability benefit have an emotional disorder (ONS, 2005).

❖In Merseyside, for under 18's admitted to hospital with alcohol specific conditions, levels are more than twice as high as the national rate

❖Being in education, employment and training between the ages of 16-18 increases a young person's resilience. In 2011 across Merseyside, levels of young people who were 'NEET' were higher than the average

❖Conception rates amongst those aged under 18 are higher than the national average in each Merseyside area except Sefton

❖In Merseyside in 2010, each local authority (with the exception of Sefton) had levels of child poverty significantly worse than the national average

❖Looked after Children across Merseyside all had lower levels of emotional wellbeing than the national average (2011), apart from in Sefton which was higher.

❖Across Merseyside, estimated to be significant numbers of children living with a parent with mental health problems, included those who live with a problem drinker and/or drug user who also has mental health problems.

❖For those children and young people with mental health conditions severe enough to be admitted to hospital, rates of admission were higher than national and North West averages in each local authority in Merseyside.

❖Children and young people from more deprived areas are significantly more likely to be admitted to hospital for self-harm. In Merseyside rates were worse than the national average.

Both reports included a set of recommendations for local commissioners and policy makers

Full needs assessments detailed on pages 9 and 10 can be found at http://www.liv.ac.uk/PublicHealth/obs/publications/report/obs_report.htm

Adult offenders (June 2012)

Prisons

❖Offenders and staff were generally satisfied with prison health care.
❖Areas for improvement included the need to submit 'applications' for health care at most prisons, which could deter prisoners with low literacy levels from seeking help.
❖Offering the option of health care on prison wings would increase uptake.
❖Prisoners reported that questions about accommodation, employment, benefits etc, were sometimes only raised shortly before discharge, which did not give sufficient time to plan.
❖Prisoners and health care staff also mentioned that it was easy to access drugs in prison. However, being sent to prison provided an opportunity for offenders to withdraw from drugs, with excellent support services.
❖ Other areas of concern for prisoners and prison health care staff included security procedures delaying transfer to hospital.
❖Female prisoners reported losing residency of their children whilst in prison. Women lost accommodation whilst in prison, and because they served relatively short sentences, it was difficult to get appropriate accommodation in place prior to discharge: the same was true of issues such as employment, benefits etc.

Probation/other

❖Wider health needs such as accommodation, employment and benefits advice were key concerns. Accommodation immediately following discharge was not always conducive to preventing re-offending. Female offenders did not always feel safe using accommodation/services that were used by male offenders.
❖Employment and training needs were of priority health concern. Although provision for some groups of offenders was excellent, more comprehensive 'signposting' for offenders was necessary.
❖Services that were specifically targeted at female offenders, were highly valued by both offenders, and staff. This included being able to access a range of services under one roof. Women were also able to get basic needs met, e.g. food, and access to a washing machine.
❖Offenders and health care staff expressed the view that services were in place, should offenders be willing/able to use them. Offenders were more likely to use services where they could access several services under 'one roof', or drop-in services that they were able to access immediately.

Young Offenders (March 2013)

Interviews were conducted, with young offenders at HMOI Hindley, and Red Bank Community Home, and with young offenders being managed in the community by Merseyside YOSs. Interviews were also conducted with members of staff.

Accessibility was key in terms of ensuring that young people engaged with services in the community, and staff were very flexible about where and when they saw young people. Key areas for improvement identified include gaps in services for those aged 16-18, and in provision for wider health needs, such as accommodation and education, training and employment needs. Earlier identification of health problems, and increasing the confidence of front-line staff to identify these problems, particularly ADHD and mental health problems, was a further recommendation.

Health needs assessment for ex-Armed Forces personnel (March 2013)

❖Estimated 42,659 ex-Service personnel in Merseyside, aged under 65.
❖ A high proportion of UK recruits come from more deprived
❖Service in the armed Forces may have a positive impact on the health of individuals who might otherwise have had a poorer diet, limited exercise, and been at risk of unemployment and criminality.
❖However, a study conducted by the Royal College of GPs found that the risk of death for those in the Army was 1 in 1000, 150 times higher than for the population as a whole (rate is lower for those in the Navy and the RAF).
❖Conflicts in Iraq and Afghanistan have increased the risk of injury that results in amputation.
❖Some evidence, that ex-Armed Forces personnel aged under 65 were more likely to report long term health problems than their peers in the general population.
❖Some evidence that alcohol misuse is a problem.
❖Stress and common mental health problems may also be a feature, although many personal do not ask for help.
❖younger members of the armed Forces returning from duty were more likely to commit violent offences than the rest of the population. 20% of males aged under 30 had been convicted with violence, compared with 6.7% of civilians. King's College London has recently begun a large scale study, looking at the impact of military Service upon families.

Full needs assessments detailed on pages 9 and 10 can be found at http://www.liv.ac.uk/PublicHealth/obs/publications/report/obs_report.htm

National Institute of Health & Clinical Evidence (NICE) guidance

NICE are global leaders in the production of gold-standard guidance, based on bespoke evidence reviews into the cost effective and efficient interventions across clinical and public health priorities. These are supplemented by commissioning guides and care pathways within and across individual pieces of guidance to support commissioners and providers in ensuring robust care management. NICE is also involved in the development of the Quality Outcomes Frameworks for GPs and will soon be tasked with producing guidance on key areas of social care. Currently housed on the NICE website are:

- **41** Quality standards
- **46** Public health guidance
- **176** Clinical guidelines – primary and community care
- **294** Technology appraisals e.g. drugs
- **395** Interventional procedures – secondary care

NHS Evidence

It is not possible to find ready-made systematic reviews of evidence on every subject. It is sometimes necessary to supplement evidence from NICE guidance and/or national policy with bespoke reviews of evidence. NHS Evidence provides a portal through which to search multiple databases of primary research papers, policy documents, NICE guidance, Social Care Institute of Excellence (SCIE) guidance and so on.

Local Insight work

Intelligence reports and data tell us what is happening but often stop short of telling us why. For example we know that cancer deaths in Halton are amongst the highest in the country. We know some of the risk factors that lead to this such as smoking rates, screening uptake and to some extent deprivation. Once we know what is happening we need to understand why in order to put in place appropriate services and advice that connect people people's attitudes, motivations, barriers, aspirations and so on. Locally, a range of research techniques are used to discover these insights, such as.

- Lifestyle Survey amongst residents aged 18+
- Social marketing, for example, on Impaired Glucose Regulation (IRG)
- Schools survey

Needs assessments, equity audits, health impact assessments

The Public Health Evidence & Intelligence team carry out are range of topic based health needs assessments and health equity audits. These use a wide range of local and national data, policy, evidence reviews and details about local services and local consultations (where available) to describe the current and future health needs of our local communities. They also assess where gaps in service provision and/or improvements in service delivery mechanisms or performance are needed to reduce inequities. Needs assessments are also carried out by other teams/staff, of major policy areas such as Housing, Child Poverty and Substance Misuse. Recently, some of the larger scale polices and developments in the area have been subject to health impact assessments to determine likely impacts of the developments at various stages and remedial action to ensure potential negative impacts are not realised.

In-depth needs assessments:

Diabetes	Cancer	Alcohol	Older People
Maternity	Cardiovascular Disease	Chronic Obstructive Pulmonary Disease	Young People's Sexual Health
Pharmaceutical Needs Assessment	Adult Mental Health	Children & Young People's emotional health & wellbeing	
Children in Care	Housing	Child Poverty	Sexual Violence
Adult Drug Misuse	Young People's Drug Misuse	Adult Offenders	Young Offenders
Military Veterans	Learning Disability & Autism	Child & Adolescent Mental Health	

In development

Child Speech, Language and Communication Needs Assessment

Homelessness (due April 2014)

Research: Health & Wellbeing Impacts of Fixed Odds Betting Terminals (due April 2014)

Health Impact Assessments:

Core Strategy   Local Transport Plan   Castlefields Health Centre development

Assessing Impact of the economic downturn(February 2012)   HBC Field development

Profiles:

National : general health profile; child health profile; CVD; Diabetes; GP practice

Local: Area Forum profiles; dementia; COPD; set of cancer profiles

It is not the intension of JSNA to update every element on an annual basis. The full refresh will fall in line with the Health & Wellbeing Strategy timeline i.e. it will be a three-year rolling programme of work. In addition to in-depth needs assessments, research and analysis, the core dataset for the overall JSNA and the Area Forum profiles will be updated on an annual basis.

The following information details key developments and issues for 2013.

Focus on: children

Children's Trust Executive Group requested a review of the children's element of the JSNA. Using the lifecourse approach, a template has been agreed by public health intelligence and key stakeholders through the Children's Trust Commissioning Partnership. A task & finish group has been established to oversee the review and rewriting of this work. Focus on:

- Early years
- School age
- Transition to adult services
- Vulnerable groups e.g. children in care, children with complex needs
- Wider social and economic issues as they affect families and children

It is envisaged this review and rewrite will take the whole of 2013/14.

Focus on: Disabilities

The current JSNA includes a chapter on physical, sensory and learning disabilities. However, this generic consideration of disabilities has not given scope to explore issues about specific types of disability in any detail. A piece of work has been commissioned across Merseyside, Halton and Warrington to assess the needs of people with learning disabilities and autism. ***Completion is due August 2013.***

The RNIB has recently published a toolkit for assessing need to people with eye health problems. The need to a work on sensory disabilities and physical disabilities will be explored towards the end of 2013/14.

Focus on: Environmental Health

The JSNA currently does not include any reference to environmental health issues. Given the history of and continuing concern about such issues it has been agreed to write a new chapter detailing the level of environmental health issues, best practice and current provision. This can then be used for onward planning of preventative and remedial activity needed.

It will link closely to the Local Development Plan which details spatial usage and developments over the next 15 years.

The *scope* and datasets needed will be agreed in the autumn of *2013, with the **chapter being completed during 2014** (schedule to be agreed)*.

Outcomes Frameworks: Role of JSNA in base lining and target setting

Data contained in the JSNA will be used to establish the baseline position and looking at trends will assist in setting targets that are realistic yet challenging.

Staff leading on each priority have been working with public health intelligence staff. Additional work by the public health intelligence staff looking at each of the national outcomes is ongoing. Close links are being made across the local authority intelligence and performance teams as well as CCG. Information sharing agreements with Commissioning Support Unit and data from NHS Commissioning Board, Local Area Teams and Public Health England are also needed.

Collaborative working to assess need

It is important to continue to work on a bigger footprint where with delivers economies of scale and enables scarce skills to be utilised locally.

- Cheshire & Merseyside Public Health Intelligence are currently reviewing their collaboratively commissioned research & intelligence.
- Needs assessments continue to be generated for Liverpool Pubic Health Observatory
- Explore possibility of undertaking Secondary Care Demand modelling .
- ChaMPs (public health network) collaborative service work plan is being developed
- Working within the new NHS commissioning arrangements, for example, on the Pharmaceutical Needs Assessment