Draft Worcestershire Joint Health and Well-being Strategy 2016 to 2020

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Contents

Forward

Placeholder: Forward by Cllr Marcus Hart, Chair of Health and Well-being Board.

Introduction

1. This will be Worcestershire's second Joint Health and Well-being Strategy It is a statement of the Health and Well-being Board's vision and priorities for 2016-20, based on the findings of the Joint Strategic Needs Assessment and public consultation. Preparation of the Strategy is a statutory duty for the County Council and the Clinical Commissioning Groups under the Health and Social Care Act 2012. The Strategy is a basis for the public to hold local organisations to account for achieving the stated outcomes.

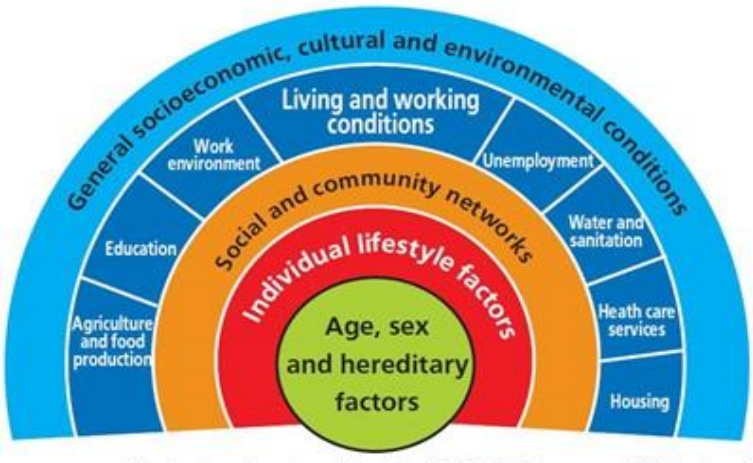
2. The Strategy sets the context for other health and well-being plans and for commissioning of NHS, public health, social care and related children's services. We will work with all partners to help align policies, services, resources and activities with the Strategy. This will enable joined-up action to tackle issues that will benefit from multi-agency working.

3. The Board expects that the commissioning plans of the County Council and the local NHS are consistent with the Strategy, as required by the Health and Social Act 2012. The Strategy will provide a basis for commissioners of NHS, public health, social care and related services to integrate commissioning plans and pool budgets wherever possible, using the powers under Section 75 of the NHS Act 2006 where appropriate.

Context

National Policy

4. Health and well-being is influenced by a range of factors over the course of people's lives. These factors are related to people's surroundings and communities as well as their own behaviours. Collectively they have a much greater impact on health and well-being than health and social care services. To improve health and well-being it is these factors that we need to influence.



The Determinants of Health (1992) Dahlgren and Whitehead

5. Subsequent national policy has emphasised the importance of prevention. Two Government White Papers on public health in the last decade have focussed on the need to develop a wide-ranging and effective approach to prevention. These have made recommendations from changing individual behaviour through education and empowerment, to changing what choices are available by regulating the availability and sales of tobacco, unhealthy food and alcohol.

6. These have not yet proved sufficient to reduce the burden of avoidable disease. In response to this, the NHS has recently produced a **Five Year Forward View**, which argues that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. It particularly calls for all parts of the system to work together on prevention right through life.

7.

8. Prevention duties are increasingly being articulated within legislation and statutory guidance including the Health and Social Care Act 2012 and the Care Act 2014. The Childcare Act 2006 requires the Council to improve the well-being of young children and reduce inequalities; the Education and Inspections Act 2006, requires the Council to secure equality of access for all young people to the positive, preventive and early help they need to improve their well-being.

9. The Care Act 2014 set out three levels of prevention and noted that these were a shared responsibility across the health and care system:
   - Primary prevention. To **prevent** ill health and the need for care before it occurs. Includes these services for people who currently have no particular health and

care needs, and they help people to avoid developing needs. They focus on promoting well-being, good health, and independence;

- Secondary prevention. To **reduce** the impact of health problems by detecting them as soon as possible and intervening early. Includes services are designed for people who have an increased risk of developing needs, where provision of services or resources may slow down or reduce the development of that need;
- Tertiary prevention. Getting the right help to people who already have needs and giving support to prevent those needs escalating and **delay** the need for more intensive care. Includes services for people with established health conditions who need support to regain skills or to delay deterioration.

Health and Well-being in Worcestershire

10. There are around 575,400 people living in Worcestershire. The county has a greater proportion of older people resident than the nation in general. The population of Worcestershire is projected to increase by 21,579 to around 597,000 in the next 10 years with the biggest increase projected to be in the older age groups. This is especially apparent in the 75-79 age range, although proportionally the projected rise in the 90-plus age range is higher. The forecast increase in numbers of older people is due to increased life expectancy resulting in greater numbers of older people, surviving to very old age[1].

11. Overall health in Worcestershire is better than the England average. The average number of years a person born today in Worcestershire would expect to live in good health is 66.4 years for women and 66 years for men compared to 63.9 and 63.3 nationally[2]. Death rates from causes that could potentially be avoided by public health interventions in the broadest sense are below national rates and have been declining[3].

12. There are also some serious ongoing challenges to health and well-being:
    - A growing number of elderly people who are also frail and people with complex health needs;
    - An ongoing burden of avoidable ill-health related to lifestyles - about two thirds of adults are overweight or obese, a third of men and half of women don't get enough exercise, about a third of people drink too much alcohol, and one in six adults smoke.
    - An increasing cost of providing health care due to the introduction of expensive new drugs and technologies;
    - The growing need for savings due to pressures on public sector finances;
    - Persistent inequalities between the most disadvantaged and the most affluent communities - the average number of years a person born today in

Worcestershire would expect to live in good health is 15.4 years lower for men and 14.3 years lower for women in the most disadvantaged 10% of communities compared to the 10% most affluent.

Vision

13. The vision of the Board is that:

> Worcestershire residents are healthier, live longer and have a better quality of life especially those communities and groups with the poorest health outcomes.

Principles

14. The Board works to **six key principles** and these underpin the Strategy:

i.  **Working in partnership.** We will facilitate partnership and ensure that organisations work together across the public, voluntary and private sectors to maximise their contribution to health and well-being.

ii.  **Empowering individuals and families.** We will encourage and enable individuals and families to take responsibility and improve their own health and well-being. We will also ensure that targeted support is available where necessary to increase individual, family and community resilience and self-reliance.

iii.  **Taking Local action.** We will recognise local assets and strengthen the ability of communities to develop local solutions to local issues.

iv.  **Taking actions that we know will work.** We will draw on the evidence of what works when develop ping strategies and plans for action.

v.  **Involving people.** We will respect the views of the public, patients, service users and carers and ensure that they have an opportunity to shape how services are organised and provided.

vi. 

Being open and accountable. We will be clear about the impact we expect from investment and action to improve health and well-being, and open about the progress we are making.

Prevention

15. Meeting the challenges described above will require renewed emphasis on prevention with action in the long term to address the wider influences on health and well-being, as well as more immediate action to continue to improve the quality and value for money of health and social care and to make sure that prevention is embedded in care pathways.

16. The Board will ensure that actions to implement this Strategy align with our **five approaches to prevention**:

✓  1. Working together to promote healthy lifestyles

✓  2. Helping people to take charge of their health and wellbeing

- ✓  3. Giving good clear information to people
- ✓ 

4. Planning and buying services that work to prevent people becoming ill.
- ✓  5. Making sure our help goes to those that need it most.

Priorities

17. **Our priorities for 2016-20 will be:**

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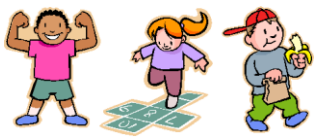
1. Mental health and well-being throughout life 
-  2. Being active all through your life 
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3. Helping all people to drink less alcohol 

Mental health and well-being throughout life

18. We will focus on **building resilience to improve mental well-being,** and **dementia**.

19. People who are more resilient do better in life, being happier, more able to cope with adversity and less at risk of developing mental health conditions such as anxiety and depression. There is growing evidence about how to improve resilience throughout life, and we will base out work on this.

20. The numbers of people with dementia are expected to rise by almost one third between 2012 and 2020. There are things that can be done to reduce the risk of getting dementia. There are also things that can be done to help people live with dementia so early diagnosis is important - only 40% of cases are diagnosed currently.

- Mental ill health costs the economy £105 billion per year
- Mental health has an impact on people's physical health: for young people, mental ill health is strongly associated with behaviours that pose a risk to their health, such as alcohol and drug use and smoking
- In Worcestershire 70,000 adults and 7,000 children are living with mental ill- health at any time
- A higher proportion of adults (7.8%) are diagnosed with dementia than the national average (5.8%)
- 50 people take their own life each year

21. We will also focus on four groups:

    Under 5s and their parents. Because building resilience from an early age will have life-long benefits: resilient children do better at school and grow up to be resilient adults; resilient parents will support their children well through childhood and adolescence.

    Young people. Front-line professionals across the health, education, and social care system are expressing concern about a deterioration in the mental health and well-being of young people. There has been an increase in Emergency Department attendances for self-harm related reasons in this age group.

    Older people. Dementia is more common in older people. Worcestershire has a higher proportion of people aged 65 or over than the national average and the number of people in this age group is going to grow by over a third between 2014 and 2029. There are large numbers of people who care for people with dementia, and this can put a significant strain on mental health and well-being.

    Populations with poorer health outcomes. Building resilience can help people to succeed, improving health and social outcomes. This will help to reduce the gap in in health outcomes across the county, between different social groups and between different geographical areas.

Being active at every age

22. We will focus on **increasing everyday physical activity** because this is a low or no cost option, and because long-lasting behaviour change is most likely to be achieved by making changes to daily routines.

- Being inactive is a major cause of ill health throughout life - including heart disease, diabetes and some cancers.
- The negative health impact of being inactive is both avoidable and in some cases reversible
- In Worcestershire at least a third of people do not meet the recommended guidelines for being physical active

23. We will also focus on three groups:

Under 5's and their parents. One in four children in Worcestershire are overweight or obese by 5 years old and one in three children by 11 years old. Being physically active can easily become a life-long behaviour if it is started in early childhood. Physical inactivity can reduce the chances of doing well at school for children, and is associated with poorer mental health in childhood.

Older people. Physical activity reduces the risk of depression in adults and older adults as well as the risk of cognitive decline and dementia, including Alzheimer's disease. Physical activity builds and maintains muscle mass, which will increase older people's ability to live independently and reduce the risk of falls.

Populations with poorer health outcomes. People living in deprived areas are less likely to physically active and more likely to develop ill health. Some people, such as those with a learning disability or sensory impairment, have particular challenges in being physically active.

Reducing harm from drinking too much alcohol

24. As well as **reducing consumption of alcohol** we will focus on **reducing risky behaviour** associated with drinking too much. Alcohol can influence people's decisions such that they do things that they would not have done without a drink – such as being careless, not practicing safe sex, or becoming aggressive. Alcohol is the biggest single cause of accidents in the home. It increases the likelihood of being a perpetrator or a victim of violence. It is associated with two third of suicide attempts.

- Alcohol is ranked by the World Health Organisation as the third leading cause of death and disability in the developed world
- Around three quarters of Emergency Department attendances at night time and 40% during day time are associated with drinking too much alcohol
- Drinking too much also have long-term social consequences such as family break-up, domestic abuse, unemployment, homelessness and financial problems.
- In Worcestershire 85,000 people drink more alcohol than the recommended limit, which puts their physical and mental well-being at risk

25. We will also focus on three groups:

Middle aged. Heavy drinking in middle age is a growing problem, and usually takes place outside of public places, making it harder to regulate. It increases blood pressure and cholesterol levels, both of which are major risk factors for heart attacks and strokes. A focus on this age-group will also address the links between heavy drinking and family break-up.

26. **Older people.** Alcohol has a greater effect on older people. The Royal College of Psychiatrists now recommends that people over 65 should not drink more than half the recommended maximum daily limits for adults under 65 years. A third of those who experience problems with alcohol do so for the first time later in life, often as a result of big changes like retirement, bereavement or feelings of boredom, loneliness and depression.

27. **Populations with poorer health outcomes.** People living in deprived areas are more likely to drink more alcohol than the recommended limit. This will include specific attention to young people since, although overall patterns of drinking among young people are becoming less risky, there remain some issues in disadvantaged areas.

From strategy to action

28. The Strategy requires action by a range of different organisations and individuals. The Board will ask that the statutory partners respond by:
    - Working together and with others to ensure the Strategy is implemented. Board members, commissioners, providers, elected members, communities and individuals will all have a role – as set out in 'Working Together' below.
    - Making sure that this Strategy is taken into account in drawing up organisational commissioning and service development plans. For the Clinical Commissioning Groups this will be a requirement for their authorisation and approval of their commissioning plans.

29. The Board will in addition support implementation by:
    - Ensuring that the Strategy is widely available and raising awareness of it at every opportunity.
    - Providing leadership and advocacy.
    - Seeking participation and contributions from the voluntary sector, businesses, schools and others.
    - Facilitating debate on difficult issues.
    - Building relationships and enabling partner organisations to align policies, services, resources and activities to increase their collective impact on health and well-being.
    - Publicising examples of good work
    - Overseeing progress and offering challenge and support where necessary.

30. The Board will hold statutory partners to account for implementation of the Strategy by:
    - Delegating to the Health Improvement Group (HIG) the responsibility to agree a set of detailed Plans with clear actions, responsibilities, milestones and timescale.
    - Receiving bi-annual reports from the HIG about progress against these Plans.
    - Tracking progress against a set of performance indicators which will be reported bi-annually to the Board.

Measuring progress

31. A range of performance indicators will be used to measure the impact of this Strategy – as set out below. These will be presented as a single outcome framework with baseline data, direction of travel and targets. These are selected from indicators which are already embedded in the performance frameworks of partner organisations and are intended to enable sharper focus and a new opportunity for the Board to challenge, debate, and support progress.

Partner Responsibilities

32. To improve the health and wellbeing of Worcestershire residents we all need to work together.

Health and Wellbeing Board Members will

33. Encourage integrated working between health and social care commissioners across the system.

34. Encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services

35. Provide a forum where agencies in Worcestershire can focus on reducing health inequalities.

All Partners will

36. Co-produce services and resources with other health, social care and voluntary and community organisations

37. Tailor services and resources and target them according to where they are most needed

38. Plan services that are person centred and developed with input from service users

39. Design services that promote independence rather than impose dependence

40. Support communities and individuals to become more empowered and resilient

Commissioners will

41. Commission services and resources that support the priorities of the Health and Wellbeing Board and Strategy

42. Ensure that services and resources are measured for effectiveness

43. Engage with and seek the views of individuals and communities

44. Consider the physical, mental and emotional wellbeing of individuals needing care

Providers will

45. Ensure that services and resources are measured for effectiveness

46. Engage with and seek the views of individuals and communities

47. Support communities and individuals to become more empowered and resilient

Councillors will

48. Act as leaders for their communities, and catalysts for change

49. Promote the importance of prevention to improve health and wellbeing to its communities

50. Engage with and seek the views of individuals and communities

51. Support communities and individuals to become more resilient and empowered.

Communities will

52. Take ownership and responsibility for their own health and wellbeing

53. Be proactive and access those services and resources readily available to them to increase their resilience

54. Work with organisations and commissioners to coproduce services and resources

55. Support more vulnerable members of the community to maintain good health and develop strong social connections.

Individuals will

56. Take ownership and responsibility for their own health and wellbeing

57. Be proactive and access those services and resources readily available to them to increase their resilience

58. Use services and resources that are limited and high cost wisely and only when essential.

Performance indicators

Priority	Performance indicators
Good Mental Health and Well-being throughout life	• Satisfaction with life measure (National Wellbeing Survey) • School readiness: all children achieving a good level of development at the end of reception as a % of all eligible children by free school meal status • Hospital admissions as a result of self-harm (10-24 years) • Referrals to Child and adolescent mental health services • Diagnosis rate for people with dementia • Health-related quality of life for people with long-term conditions • % of adult social care users who have as much social contact as they would like • Proportion of adults in contact with secondary mental health services in paid employment
Being Active at every age	• Age standardised mortality rate from all cardio-vascular diseases under 75 years of age • % of children meeting Chief Medical Officer guidelines for physical activity • Length of time spend in sedentary activities by children • % of children aged 4 - 5 classified as overweight or obese • % of children aged 10 – 11 classified as overweight or obese • Cycling Walking travel measures for adults to be confirmed • % of adults taking 30 minutes physical activity on 5 days a week • Numbers of older people taking up Strength and Balance training • Numbers of people taking part in health walks • Numbers of people training as volunteers for health walks
Reducing harm from Alcohol at all ages	• Age-standardised rate of mortality considered preventable from liver disease in those aged under 75. • Under 18s hospital admissions for alcohol related conditions • All hospital admissions for alcohol related conditions • Alcohol related crime

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