Appendix 2

ST HELENS
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St Helens People's Plan
2024 – 2027

"From the Ground, Light" – Promoting a fresh start for health & wellbeing

Contents

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Our Journey to 2023

1. Our Context
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1. Our Context

St Helens is one of six local authorities in the Liverpool City region, and covers a total of 135 square kilometres, of which approximately half is rural, and half is urban. The borough is home to 183,049 people with St Helens CCG having 200,219 registered patients (the weighted list is 229,128 reflecting deprivation and health needs) in 31 GP practices.

From the late 1970s, St Helens suffered a decline in the coal mining and glass industries which employed many residents, and left a legacy of issues including poor health, inter-generational unemployment, along with low levels of enterprise and aspiration. Despite recent regeneration, there remains relatively high deprivation and inequality in areas of the borough. This deprivation and other lifestyle factors result in poor outcomes among residents such as suicide, alcohol-specific hospital stays, causes of early death, and life expectancy that is lower than the national average for both men and women.

St Helens had become more deprived compared to other areas, sliding from 36th to 26th in ranking as compared to other local authorities (indices of deprivation 2019). When it comes to health deprivation St Helens is ranked 8th most deprived out of 317 areas in England.

Around a quarter of children in year six are classified as obese, worse than the average for England, and levels of GCSE attainment and breastfeeding initiation are also worse than the England average. Though the smoking rate has decreased slightly since 2015, the prevalence of smokers in St Helens remains higher than we would like as smoking attributable mortality significantly higher. There is also a worrying trend of vaping amongst our young people.

St Helens is projected to have a population where more than a quarter will be aged over 65 by 2041. People in St Helens continue to live with day-to-day health challenges including the legacy of the pandemic in terms of their health and access to some services. The prolonged cost of living crisis places addition pressures on families and individuals that may also affect both physical and mental health.

Partners in the Borough have come together to support those who are most in need and we all recognise that there is much more work that needs to be done to make St Helens a healthier and fairer place to live well.

This plan is focused on gaining insights of needs of our local population which has in turn informed our strategic intent. There is also alignment with the Borough Strategy and NHS Cheshire and Merseyside strategic plans to ensure we target resources to best effect.

We live in an age of uncertainty, politically, economically and environmentally. This uncertainty is affecting society and institutions and so it is our duty to try to create a stronger and more stable environment for our residents with services and support we need is needed most

The common thread running through this People's Plan is about harnessing opportunities for everyone to make that fresh staring in life and begin to thrive. This chimes with the motto of St Helens:
Ex Terra Lucem – From the Ground, Light.

2. Our Strategic Intent 2024-2027

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Our Plan

The plan is organised around the needs of our local population which has informed our strategic intent. Our strategic intent has been developed with partners. It is our approach to integration and the harnessing the power of partnership that make St Helens stronger. The plan has a focus on delivering the key priorities as well as delivering statutory services.

Our vision has remained the same as when we first embarked on our St Helens Cares journey. Our priorities have a focus on the added value of partnership along with delivering for all ages and across a life course model

Our Vision

One Place, One System, One Ambition: Improving people's lives in St Helens together

Our Priorities

Start Well

A) Maternal Health
B) Teenage Pregnancy
C) Early Help
D) Family Hubs
E) Raising Aspirations

Live Well

A) Long-Term Conditions
B) Planned Care
C) Cancer
D) Women's wellbeing

Partner Priorities (All Age)

1) Mental Wellbeing
2) Health Weight
3) Care Communities
4) Inequalities

Age Well

A) Community Services
B) Dementia
C) Urgent & Emergency Care
D) Social Care

Our Values Based Principles

ST HELENS CARES

We will be compassionate and inclusive as we work to deliver quality services

We will strive to make a difference, continuously learning and improving what we do

We will be open and honest and work with integrity at all times

3. Our Population – Borough lens

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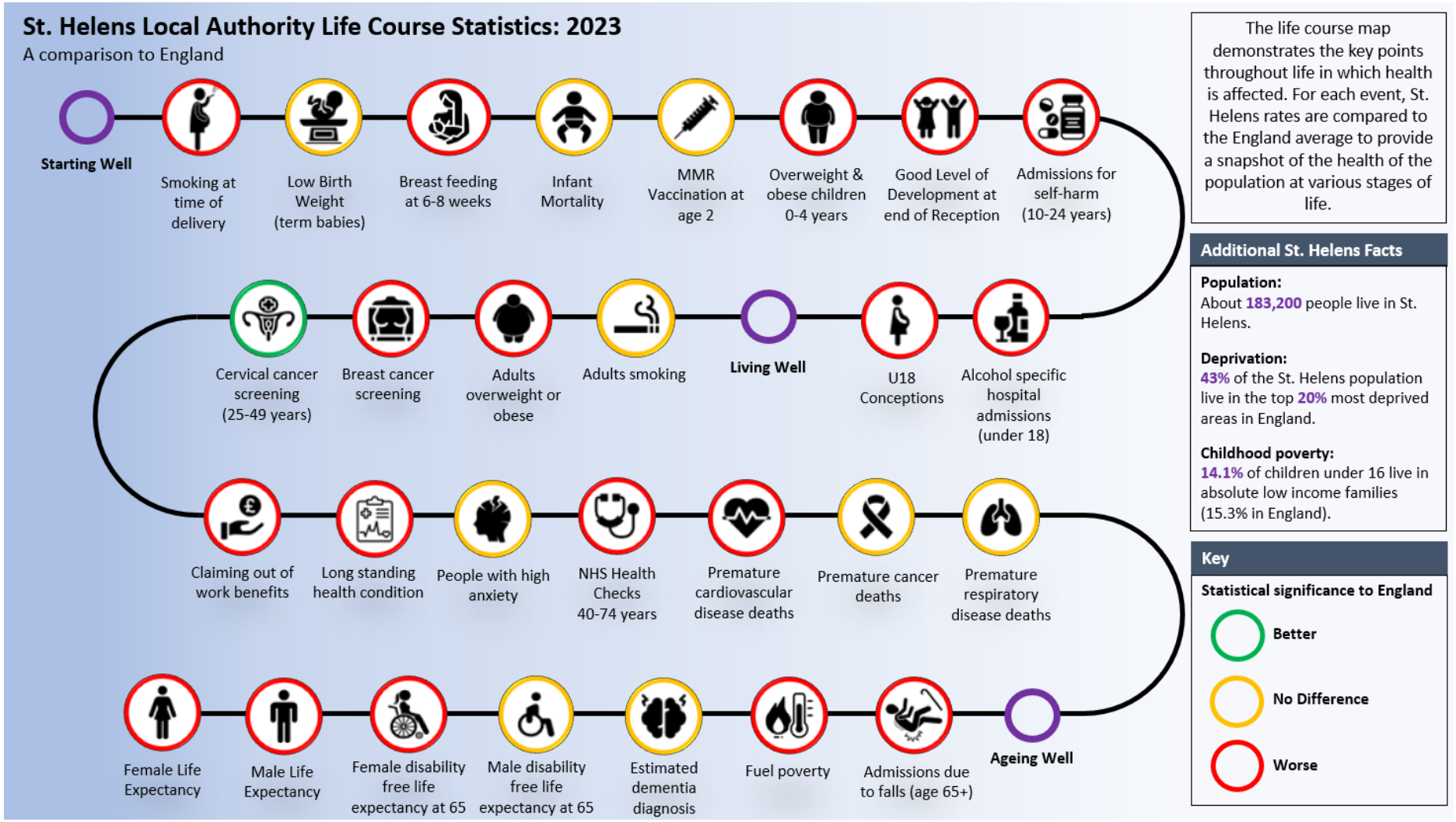
The Health of our Borough across the life-course

This infographic illustrates where St Helens performs in comparison to the England average.

The chart shows that there are far too many areas that are worse than the England average and this provides a focus for improvement.

It should be noted that St Helens is the 8th most deprived place in England for Health. 43% of residents in the Borough live in the top 20% most deprived areas in England.



3. Our Population – Ward lens

Health Inequalities within the Borough

Whilst there are health challenge across the Borough. Inequalities is also present between our most deprived wards and those more affluent. There is typically around a decade difference in life expectancy between populations in these wards.

The table opposite shows health outcomes for all our wards and these are colour coded in quintiles (segments of 20%).

Overall, there are very few 'bright greens' (top quintile), some 'pale greens' (4th quintile). The majority are shades of red (lowest and 2nd quintile)

You can also see that the Town Centre, Parr, Earlstown, bold and Sutton fair worse than most.

Quintile 1 – 5

Indicator	Central PCN		Newton & Haydock				North PCN			South PCN							St. Helens	England
	Parr	Town Centre	Blackbrook	Earlestown	Haydock	Newton	Billinge and Seneley Green	Moss Bank	Rainford	Bold	Eccleston	Rainhill	Sutton	Thatto Heath	West Park	Windle		
Total population	13,370	11,745	10,173	11,926	11,423	12,573	10,535	11,033	7,720	9,868	11,812	10,968	11,792	13,243	11,424	10,980		
Population aged 65 years and over	1,829	1,824	2,387	1,792	2,510	1,934	3,114	2,519	2,447	1,790	3,039	3,166	2,511	2,272	2,005	2,064		
Black and Minority Ethnic Population	1.9	2.7	1.6	2.7	1.3	2.6	1.2	1.1	1.2	1.4	1.9	3.3	1.4	3.7	1.8	1.2		
Accident and Emergency attendances in under 5s	1,175.6	1,349.6	1,161.4	934.8	952.0	852.2	917.9	1,077.9	1,105.0	1,117.8	1,051.8	1,228.9	1,199.2	1,027.5	1,111.9	1,064.4	255.9	277.7
Child Development at age 5	54.2	52.6	49.7	61.9	56.8	66.5	67.9	65.8	64.7	62.7	75.3	67.1	59.3	65.5	60.9	66.0	1,081.8	642.5
Child Poverty, English Indices of Deprivation, 2019	39.5	36.8	20.6	25.3	20.2	20.7	12.5	23.1	7.3	33.2	6.6	11.3	28.1	23.6	23.2	19.5	70.2	71.8
Deaths from all cancer, all ages	155.9	130.5	102.9	134.2	104.2	118.3	87.6	106.8	101.3	128.0	99.5	87.3	136.8	112.0	100.4	95.0	23.7	17.1
Deaths from all cancer, under 75 years	161.4	143.7	107.7	137.8	107.5	124.8	103.7	102.7	76.2	127.4	105.8	99.6	130.5	90.8	101.8	85.7	110.4	100.0
Deaths from all causes, all ages	186.1	177.2	107.1	132.5	119.3	121.1	88.6	99.1	97.9	124.4	98.6	99.3	145.9	129.8	114.2	109.3	111.8	100.0
Deaths from all causes, under 75 years	206.0	216.9	118.4	162.7	115.2	115.2	91.4	106.6	79.6	140.1	98.3	97.1	135.6	137.1	116.7	122.3	119.4	100.0
Deaths from causes considered preventable	229.1	206.2	127.6	158.3	107.4	121.4	91.6	103.4	68.8	130.9	85.0	101.2	130.3	147.7	117.0	113.0	126.4	100.0
Deaths from causes considered preventable, under 75 years, SMR	244.5	253.7	131.7	183.2	109.4	109.4	99.0	112.4	76.4	147.1	86.5	90.7	125.5	141.9	129.3	121.1	132.2	100.0
Deaths from circulatory disease, all ages	173.6	151.5	98.1	126.3	118.7	118.2	86.0	95.8	82.8	131.7	90.9	92.8	127.4	112.6	107.2	112.0	111.4	100.0
Deaths from circulatory disease, under 75 years	215.5	215.0	105.9	184.4	146.8	152.9	85.7	93.9	81.7	178.2	76.9	84.7	130.2	145.8	98.0	113.3	127.7	100.0
Deaths from coronary heart disease, all ages	186.8	164.3	112.1	152.1	128.9	128.6	94.2	95.1	80.7	122.6	78.7	88.4	116.5	124.2	113.1	101.0	114.3	100.0
Deaths from respiratory diseases, all ages	222.7	224.8	143.4	177.4	142.4	161.8	115.9	106.0	104.2	149.0	101.8	113.2	177.5	150.4	169.7	119.5	144.0	100.0
Deaths from stroke, all ages	165.4	136.4	103.0	96.6	96.3	114.6	64.4	83.0	77.6	114.2	99.4	94.7	149.8	79.8	122.1	115.7	105.2	100.0
Deliveries to teenage mothers	2.0	2.3			1.6					1.8			1.9		1.5		1.3	0.7
Emergency admissions for injuries in under 5s	17.2	14.9	14.5	16.8	15.8	12.0	19.4	14.5	17.5	13.2	11.4	14.5	19.2	15.4	14.3	10.1	15.1	12.3
Emergency admissions in under 5s	228.5	240.7	243.0	201.3	220.4	182.5	188.6	198.6	256.4	183.2	252.9	226.2	232.6	233.3	247.6	230.5	220.9	162.1
Emergency hospital admissions for all causes	156.2	184.0	125.2	146.2	135.0	122.5	99.3	127.1	103.2	140.1	101.9	119.2	140.4	154.5	144.6	118.1	133.0	100.0
Emergency hospital admissions for Chronic Obstructive Pulmonary Disea..	213.8	207.6	103.4	153.6	116.6	115.2	91.8	106.2	55.8	138.0	54.9	86.9	132.9	153.2	136.5	96.6	119.2	100.0
Emergency hospital admissions for coronary heart disease	139.6	170.5	163.8	166.5	151.4	138.7	110.3	124.9	115.8	182.7	106.5	126.1	141.8	153.2	156.5	140.3	140.7	100.0
Emergency hospital admissions for hip fracture in 65+	138.8	148.5	121.6	129.5	116.7	92.4	79.2	90.7	116.0	98.5	80.3	100.6	160.3	123.3	106.1	81.7	109.5	100.0
Emergency hospital admissions for injuries in 15 to 24 years old	285.7	417.6	244.8	246.1	179.7	206.3	141.5	254.1	218.7	270.4	202.3	253.4	242.8	233.4	289.4	215.4	251.3	132.1
Emergency hospital admissions for injuries in under 15 years old	136.7	115.7	123.8	148.5	114.0	107.7	136.5	123.0	126.4	131.8	92.2	142.0	185.7	115.3	109.5	107.1	124.9	97.8

4. Achievements

NHS Cheshire and Merseyside

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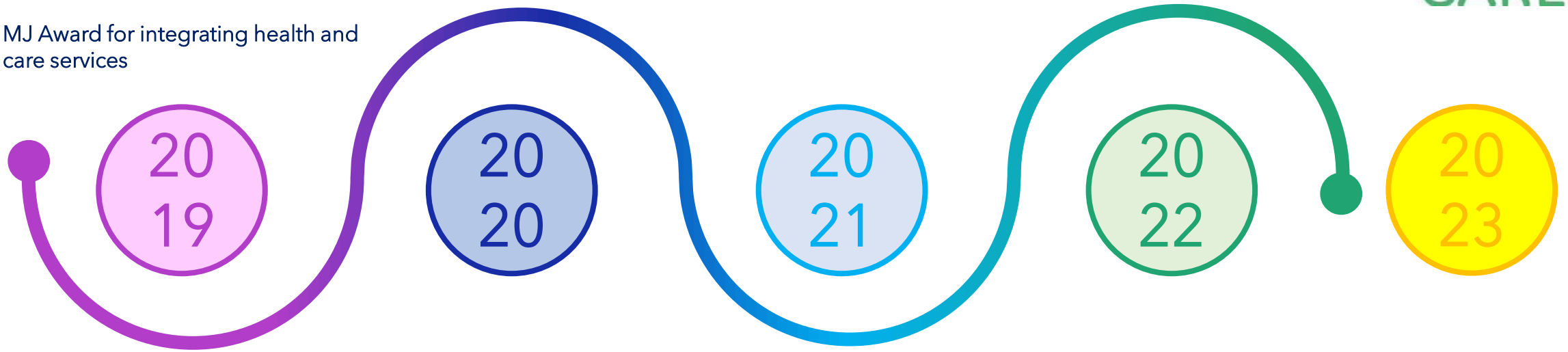
St Helens Cares Launched in 2018

MJ Award for integrating health and care services



Embedding Integration

- Integrated People's Services Leadership Team (LA/Trust/CCG)
- PCNs Established
- Shared Care Record fully implemented
- Launch of Contact Cares with single point of access
- MJ Award

Responding to the Pandemic

- Rapid pandemic response enabled by Integration & partnership
- CIPHA population health pilot established at Place
- First MVC in C&M delivering more than 500,000 jabs
- Cancer help line in place

Designing future Place Working

- New AO appointed
- New place plan launched with focused priorities
- Vax Bus roaming serving borough's underserved
- Children and Families Hub in place

Delivering at Place and System

- Establishment of Virtual Wards
- 2-hour Urgent community response service
- Establishment of an Inequalities Commission
- Roll-out of food pantries
- COPD winter warmth programme

Recognition and Business as Usual

- Children's Services rated GOOD by Ofted, and outstanding for care leavers
- MJ Award – 'A whole council approach to tackling health inequalities'
- Self-harm pathway launched
- Extension of virtual wards for frailty and cancer

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Partnership Priorities 2024-2027 (All Age)

5. Objectives 2024-27
6. Mental Wellbeing
7. Health Weight
8. Care Communities
9. Inequalities

5. Objectives: 2024-2027

Health and wellbeing are about a thriving economy, a healthy environment, having good quality housing in a safe place to live, education and skills, job opportunities and positive social networks These are the 'social determinants' of health and wellbeing and they are thought to determine around 50% of health outcomes.

Health behaviour contributes around 30% to health outcomes and we strive for and benefit from outstanding NHS clinical services, they only make up a fifth of what contributes to the quality of our health.

Our plan will look at involving all aspects of our health and wellbeing needs, and especially on preventing ill health and avoiding harm so that we can reduce pressure on overstretched services.

The objective we have set have a twin aim of:

1. **Improving** the **health** of the **whole population** ensuring that all residents benefit from investments and actions taken in partnership.
2. **Reducing inequalities** by giving more targeted support to those who need it most, based on evidence and intelligence gathered in partnership.

Two sides of the same coin

Health inequalities can be described as unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

6. Mental Wellbeing

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Context and Challenges

In St Helens, we are faced with a particular challenge of experiencing significantly poorer outcomes for a number of mental health indicators. ONS data from 2021 has highlighted that 11% of people in St Helens felt lonely often or always, compared to 7% nationally. Children and young people's well-being has been affected by the pandemic and continues due to the prolonged cost of living crisis.

What needs to be done

We will continue to work in collaboration with our Partners to improve mental wellbeing throughout the life course approach by:

- Reducing hospital admission for self-harm across all ages by 55% (in line with NW Average): 433.4 per 100,000 in 2019/2020
- Reducing hospital admission for self-harm aged 10-24 years 954.3 per 100,000 (2020/21
- Reduce mortality rate due to injury and suicide of undetermined intent 14.0 per 100,000 (2019/21)
- CYP & family: Increasing access to specialist community perinatal MH support for women with moderate perinatal mental health difficulties (Activity measure) Increase access for partners (of women with perinatal mental health difficulties) to Community-based services
- For CYP & family: Increasing to prevention services under the thrive quadrants of Getting Advice and Getting Help
- CYP & family: 50% of service users (CYP) achieve recovery and/or a positive improvement in outcome scores post intervention
- Reduce loneliness and social isolation

Our residents will achieve and maintain a sense of wellbeing . They will be supported when needed to maintain confidence, hope and resilience throughout their life.

By 2027, we will

A. Support people who are at risk of self-harm

1. Reduce the Emergency Admissions for intentional self-harm
2. Reduce the suicide rate

B. Reduce social isolation and loneliness in the Borough

3. Develop a co-produced plan that responds to community needs
4. Draw on lived experience and other evidence to make key interventions

C. Improve the emotional wellbeing and mental health of children and young people

5. Increase access to specialist community perinatal mental health support for women with moderate perinatal mental health difficulties.
6. Increase access to prevention services under the thrive quadrants of getting advices and getting help

D. Improve the capacity and capability for the VCSFE

7. Take learning from the above programmes to commission differently

Going forward our key work will be:

- Embed the mental health prevention concordat action plan across partners
- Track and evaluate the self-harm pilot pathway for adults
- Implement the 5-year MH suicide prevention strategy and action plan
- Continue the roll out of the Zero Suicide Prevention Training across partners
- Set out a plan to counter social isolation and loneliness making use of IVAR resources.

8. Healthy Weight

Context and Challenges

Data for academic year 21/22 showed the highest recorded level of overweight and obese reception children in St Helens (28.6%). This is the highest rate in the North West region and second highest in England. St Helens is also the second highest in the country with 44% of Year 6 children reported as overweight or obese.

Over two thirds (67.6%) of adults in St Helens are estimated to be overweight or obese, higher than both the North West and national averages.

What needs to be done

Additional resource (funding and personnel) and cross sector strategic leadership is required to deliver on the Healthy Weight Declaration commitments that will:

1. Support healthy eating choices in the Borough
2. Encourage residents to lead a more active life
3. Reduce diabetes Prevalence

The Healthy Weight Declaration commitments can be summarised into the following areas for action:

1. Strategic/System leadership
2. Commercial Determinants
3. Health Promoting Infrastructures/Environments
4. Organisational Change/Cultural Shift
5. Monitoring and Evaluation

A relaunch awareness raising campaign of the Healthy Weight Declaration is planned for Spring 2024. The work will be led by partnership Healthy Weight & Active Lives Strategy group and several focussed task groups will lead on four key priority actions.

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We will support our residents to invest in their health. Encouraging people to maintain a healthy weight through wholesome food and an active lifestyle.

By 2027, we will:

A. Support healthy eating choices in the Borough

1. Reduce the prevalence of obese Reception children (4-5)
2. Reduce the prevalence of obese Year 6 children (10-11)
3. Reduce the percentage of adults classified as overweight/obese

B. Encourage residents to lead a more active lifestyle

4. Increase the percentage of physically active residents

C. Reduce the prevalence of diabetes

5. Reduce the population prevalence of type 2 diabetes by 10%

Going forward our key area of work will be:

- Host a Healthy Weight Declaration relaunch campaign in Spring 2024
- Review and redesign community (Tier 2) and specialist weight management services (Tier 3) to explore different models of delivery
- Deliver 'Why Weight to Talk' training for frontline healthcare professionals in having difficult conversations: 'raising the issue of weight and/or sedentary lifestyle' and Making Every Contact Count (MECC) approach.
- Consult on the scope of the draft Food strategy and identify resources to lead and implement on food pantries and community allotments.
- Contribute to the Council's Review of Leisure Services and align with the Active Lives Strategy
- Target diabetes prevention including the remodelling diabetes care into our communities.

8. Care Communities

Context and Challenges

St Helens Borough Council is one of the most deprived Local Authorities in England (26th out of 317). Our population is ageing and developing an increasing number of physical and mental health problems. Thirty eight percent of our population currently have multiple long-term health conditions, which are developing at a younger than expected age.

What needs to be done

We have an embryonic model of care communities which has begun to operate in the North PCN. We are developing, learning and evaluating this approach to provide evidence of impact to support the wider roll out to other three PCN areas within the borough and to expand the scope of care provided. The mobilisation of Care Communities will factor in the following considerations:

1. **Proactive identification and support** - Cohorts identified with services signed up
2. **Multi-disciplinary team meetings** – In place with representation from required health and care professionals.
3. **Co-ordinated case management** – For prompt and effective decision making.
4. **Reactive support** – Process in place for rapid access to each professional group.
5. **Working in a multi-disciplinary way** – Awareness, buy-in and evidence by all.
6. **Understanding what works and what needs improving** – Process of feedback capture, evaluation, learning and reporting in place and accessible to all.
7. **Knowing whether we are improving outcomes** – Development of metrics and proxy measures, and an agreed format for reporting.
8. **Engagement and involvement** – Plan in place to engage with key stakeholders.

Our patients will experience a smooth patient journey that is integrated and joined up by multidisciplinary teams giving the right personalised care in the right setting

By 2027, we will have:

A. Rolled out care communities across four primary care networks

1. Activity data and Feedback data - North PCN
2. Activity data and Feedback data - South PCN
3. Activity data and Feedback data - Central PCN
4. Activity data and Feedback data - Newton and Haydock PCN

B. Developed metrics to evaluate the impact of Care Communities

5. Improved outcomes for patients
6. Reduced pressures on the health and care system
7. Generated higher rates of staff retention in care communities' roles

Going forward our key areas of work will be to:

- Support the early developments undertaken in the North PCN.
- Evaluate what is working well and learning from areas requiring development.
- Continue to capture evidence of impact for patients.
- Roll out the Care Communities model in St Helens across all PCNs.
- Expand the scope of the Care Communities model to bring in more partners and include more cohorts of patients applicable for this model of care.
- Continue to measure the impact of Care Communities.
- Sustain and grow the Care Communities approach.

10. Inequalities

Context and Challenges

St Helens was one of the areas most impacted by the pandemic, St Helens was ranked 8th highest for cumulative COVID-19 infection. Even prior to the cost-of-living crisis we had a high proportion of our children living in poverty, with 2021/22 data showing 6,594 (20.2%) children aged 0-15 in St Helens were living in low-income families (OHID).

There are also huge internal inequalities in St Helens. Our localities data shows variation between the wards in St Helens on a range of indicators. For example, there is a 11.8 year difference between the wards with the highest and lowest male life expectancy (Eccleston at 82.4 years compared to Town Centre at 70.6 years), and an 8.8 year difference in female life expectancy (Billinge and Seneley Green at 84.4 years and Parr at 75.6 years) (OHID).

What needs to be done

Since being established in September 2021, the multi-agency Inequalities Commission has implemented several actions, including key measures supporting fuel and food poverty provisions in the Borough, as well as expanding on the 'best start for children' offer. Various engagement events have helped the commission gauge themes important to key local stakeholders and members of the public.

The purpose of the Inequalities Commission is to give local people a voice, ask the questions which get to the heart of the issues, learn from experts and best practice and make recommendations to the system, with aims to identify key changes, interventions and actions on reducing inequalities.

The success of the concept was highlighted by St Helens winning the MJ award for a "whole council approach to tackling inequalities" in 2023. The commission currently meets six times annually, three of which are "deep dive" workshops.

Inequalities are avoidable, unfair and unjust. They lead to differences in the quality and length of life people experience. The Inequalities Commission will through evidence, insight and best practice, influence positive change by reducing inequalities in the Borough

By 2027, we will:

A. Improve our standing in Merseyside across a range of Marmot indicators

1. Half the number of indicators where St Helens are ranked 8th/9th in C&M
2. % of children achieving a good level development at 2-2.5 years
3. % of children achieving a good level development at the end of reception

B. Raise the aspirations of children and young people in St Helens

4. Act on the messages from the Vibe study and recommission in 2026

C. Continue influence partners to reduce inequalities

5. Undertake Core20+5 approaches to health provision (Cancer, Respiratory)
6. Remain live to the prevailing pressures of winter and cost of living

Based on the recommendations from Marmot and our engagement events, the eight priorities of the Commission are:

1. Best start in life, including school readiness
2. Improving the quality of jobs and employment
3. Tackling poverty and low pay
4. Supporting people in distress and tackling isolation
5. Tackling stigma and overcoming barriers
6. Tackling inequalities between and within and between wards and localities.
7. Services being focused on self-esteem and independence
8. Inclusive growth and St Helens pound

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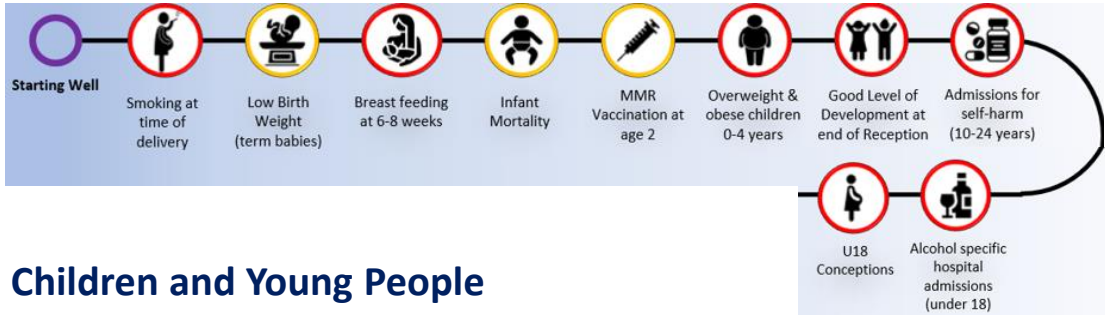
Priorities across the Life Course 2024-27

11. Start Well
12. Live Well
13. Age Well

10. Start Well

Context and Challenges

There are over 33,000 children and young people in the Borough, 29% live in poverty. We have 1,577 children in need with 1,307 social work cases and 490 children are looked after. 44% of 11-year-olds are overweight or obsess, 20% of children and young people have special educational need and disabilities.



Children and Young People

Our priority is **Care** and we will ensure that our children and young people are:

Safe and free from harm and abuse.

Healthy including; vaccination take-up, dental hygiene, fitness, obesity, teenage pregnancy and social, emotional, and mental health.

Aspirational so that our children and young people are encouraged to make the most of their potential.

We will be obsessive about **Education**:

Inclusion: we promote inclusion to reduce inequality. We actively work together to champion the needs of disadvantaged children and challenge every organisation and profession across the borough to do the same.

Attendance: all learners of all ages have the right to the best quality of education

Wellbeing: we focus on the needs of children and young people, rather than the needs of institutions or groups.

Early Help

'Early Help' means providing help for children, young people, and families as soon as problems start to emerge or where it is likely that issues will impact negatively on children's outcomes.

St Helens established its first Family Hub in April 2023. The Family Hub brings together a broad range of services, statutory, commissioned, and voluntary sector. It is envisaged that more will come on stream in the coming years.

An Early Help strategy was has recently been launched which set out five objectives to improve our offer in St Helens

Maternity

Partners continue to deliver the actions from the final Ockenden report as set out in the April 2022 letter as well as those that set out in the single delivery plan for maternity and neonatal services. All hospital maternity units will be inspected by the end of 2023. We have opened the community maternity suite at Lowe House and now seek to maximise its use.

The Lucy Letby conviction will have implications for the provision of health care services and we will monitor the outcome of the public enquiry.

Mental Health

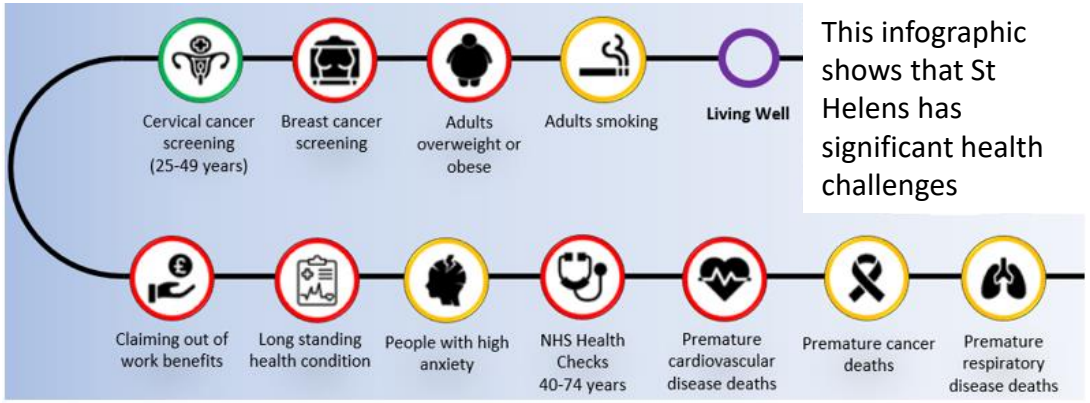
We have seen impressive improvements in in enhancing and delivering our local Thrive offer to enable increased access to MH support and provision for children and young people in line with national ambitions, meeting and exceeding national targets.

ADHD services have seen a significant increase in demand, a review is underway to ensure that future provision meets demand.

11. Live Well

Context and Challenges

Our post-industrial past, high level of deprivation and lifestyles of many residents have contributed to a poor health and multiple co-morbidities. More than two thirds of adults are overweight or obese. Poor health can affect people's economic ability which in turn can further affect health outcomes.



This infographic shows that St Helens has significant health challenges

Cancer

One in two people will have cancer within their lifetime. Whilst the cancer treatment are usually of a high quality, only 54% of cancers are detected early (stage 1 or 2) There is a national target for this to increase to 75% by 2028. Key projects include: 1) Tele-dermatology for suspected skin cancer, 2) Faecal Immunochemical Testing (FIT) colorectal cancers and 3) Targeted Lung Health Checks

Complex Lives

People with complex lives can typically find themselves homeless, rough sleeping, in and out of hostels and supported accommodation or 'sofa surfing' in the homes of friends or family They generally experience very poor physical and mental health, often using drugs and alcohol.

They may be viewed as 'hard to reach' due to their high risk, chaotic lives. Outcomes for people with complex needs are poor but their need for services is high.

Complex Cares is a programme which was established in October 2022 with an aim to: 1) Create a more systematic integrated approach to deliver the right support. 2) Help break the cycles people with complex lives are caught up in. 3) Create a learning and solutions environment for service.

Diagnostics

St Helens has a Community Diagnostics Centre in the Borough which offers a full range of services. A key target is for 90% of patients being treated within 6 weeks and meeting demands for the faster diagnosis cancer 28-day standard.

Learning Disabilities and Autism

We will aim to ensure the 75% of people aged over 14 on GP Learning Disability registers receive an annual health check and health action plan. We also want to reduce reliance on inpatient care, while improving quality in line with national objectives.

Long Term Conditions

There are a number of programmes to improve outcomes for COPD, casefinding pilots in primary care to proactively manage patients at risk of cardiovascular disease and diabetes. We have entered into an exciting partnership to map, understand and optimse diabetes pathways

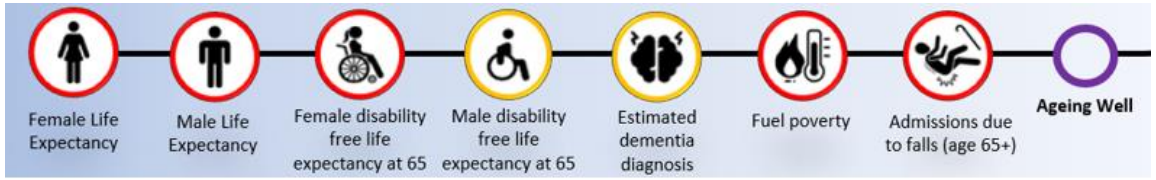
Women's Health

A family hub has been launched in Sutton; it is envisaged that more will follow. These will provide valuable support for women and their families. Following publication of the Women's Health Strategy for England, a Women's Health Hub will be developed in St Helens to support improved health outcomes.

12. Age Well

Context and Challenges

The population in St Helens is getting older, almost 21% of the population is aged 65 and older (up from 18% in the previous census). We also know that people spend 25% of their life in poor health and this is often occurring in older age. Both these factor place an increasing demand on services. Both male and female life expectancy is lower than the England average.



Community Services

The Communities programme (described earlier in the plan) will play a major role in providing anticipatory care avoiding admissions to hospital by providing care and support in their own home.

We are committed to meet or exceed the 70% 2-hour urgent community response standard.

Urgent and Emergency Care

We are working to sustain additional bed capacity to support step up and step-down provision to maximise hospital capacity.

Virtual wards for frailly has been launched in the Borough, care can be provided in the community whilst under the medial supervision from the hospital, negating the need to be admitted to hospital.

Dementia

We aim to improve the dementia diagnosis rate to 80% by working together with all partners to identify and resolve barriers .

Palliative and End of Life Care

Our Palliative and End of Life Care (PEOLC) Board have developed a priority plan that aims to meet the National Ambitions for PEOLC in relation to Access, Quality and Sustainability outcomes. We will complete a review with partners, patients and carers to deliver improved experience and outcomes for patients and staff.

Social Care

Adult social care is at a point of transition, an exercise is currently underway to develop a borough wide strategy for Adult Social Care. key areas of current development include:

1) **Adult Social Care Strategy**
   - Single vision for St Helens Adult Social Care
   - Co-produced with residents, service users, carers and staff.
2) **National Assurance Framework**
   - Preparing for inspection from 2024
   - Implement a development plan
3) **Demand Management**
   - Delivering a sustainable, robust & VFM care sector
   - Remodelling services and rebalancing demand
4) **Workforce and Skills Strategy**
   - Development of an integrated skills academy
   - Use of Better Care and Hospital Discharge Fund
5) **Commissioning and Market Sustainability**
   - Stimulation and management of the market
   - Redesign of Learning Disability Services

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Delivering Outcomes Together to 2027

13. Delivery Framework
14. Sentinel Measures
15. Partnership Governance

13. Delivery Framework

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Bringing the plan together, from plans and priorities to performance

This infographic illustrates our partnership activity, starting with our Partner Priorities at its core, radiating outwards for a healthier St Helens based on the life course model.

All of these themes have projects, service improvement and business as usual activities with appropriate metrics.

The third layer include activities and metrics to deliver national service standards and key deliverables set by NHS Cheshire and Merseyside.

A list of around 30 Sentinel metrics have been established to keep us on track – see overleaf.

Service Standards

- Urgent & Emergency 4 hour wait
- Urgent 2-hour Community Response
- Primary Care Access
- Cancer: 28-day rapid diagnostics
- Cancer: 62-day waits
- Planned Care: Eliminate long waits

Start Well

A) Children & Young People
B) Early Help
C) Best Start in Life
D) Family Hubs
E) Maternity

Live Well

A) Long-Term Conditions
B) Planned Care
C) Cancer
D) Long term Conditions
E) Women's wellbeing

Partner Priorities (All Age)

1) Mental Wellbeing
2) Health Weight
3) Care Communities
4) Inequalities

Age Well

A) Community Services
B) Dementia
C) Urgent & Emergency Care
D) Social Care

System Requirements

1) Achieve 92% bed occupancy rates
2) Improve non-criteria to reside (NCTR) rates
3) Ambulance turnaround 30min Cat 2 target
4) Deliver NHS Place financial plan
5) Deliver Place (NHS) efficiency targets

14. St Helens Sentinel Measures

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St Helens All Age Partnership Priorities

Mental Wellbeing

1) Reduce hospital admissions for self-harm
2) Reduce mortality rate due to injury/suicide - undetermined intent
3) Increase access to prevention services under the thrive model
4) Reduce loneliness and social isolation (Marmot)

Healthy Weight

1) Reduce overweight & obese children at reception and year 6
2) Reduce prevalence of obesity in adults (QOF)
3) Increase the Percentage of Physically active adults
4) Reduce population prevalence of type 2 Diabetes

Care Communities

1) MDT Activity in North
2) MDT Activity in Newton and Haydock
3) MDT Activity in Central
4) MDT Activity in South

Inequalities

1) Children good level of development (age 2-2.5) (Marmot)
2) School readiness (age 4-5) (Marmot)
3) Develop measures of Aspiration for our young people
4) Improve our standing for Marmot Indicators in C&M

Life Course Metrics

Starting Well

1) Smoking at the time of birth delivery
2) Breast Feeding Initiation
3) MMR Vaccination age 2
4) Under 18 conceptions
5) Alcohol specific hospital admissions (under 18)

Living Well

1) Adults Smoking rates
2) Cancer screening rates (Breast, Cervical, Lung)
3) Annual physical health checks for people with SMI
4) Annual health checks for people with learning disabilities

Ageing Well

1) Healthy Life Expectancy at 65+ (Marmot)
2) Reduce deaths (>75) from cancer, cardiovascular, respiratory
3) Injuries due to falls (65+)
4) Older people remaining at home 91 days after discharge

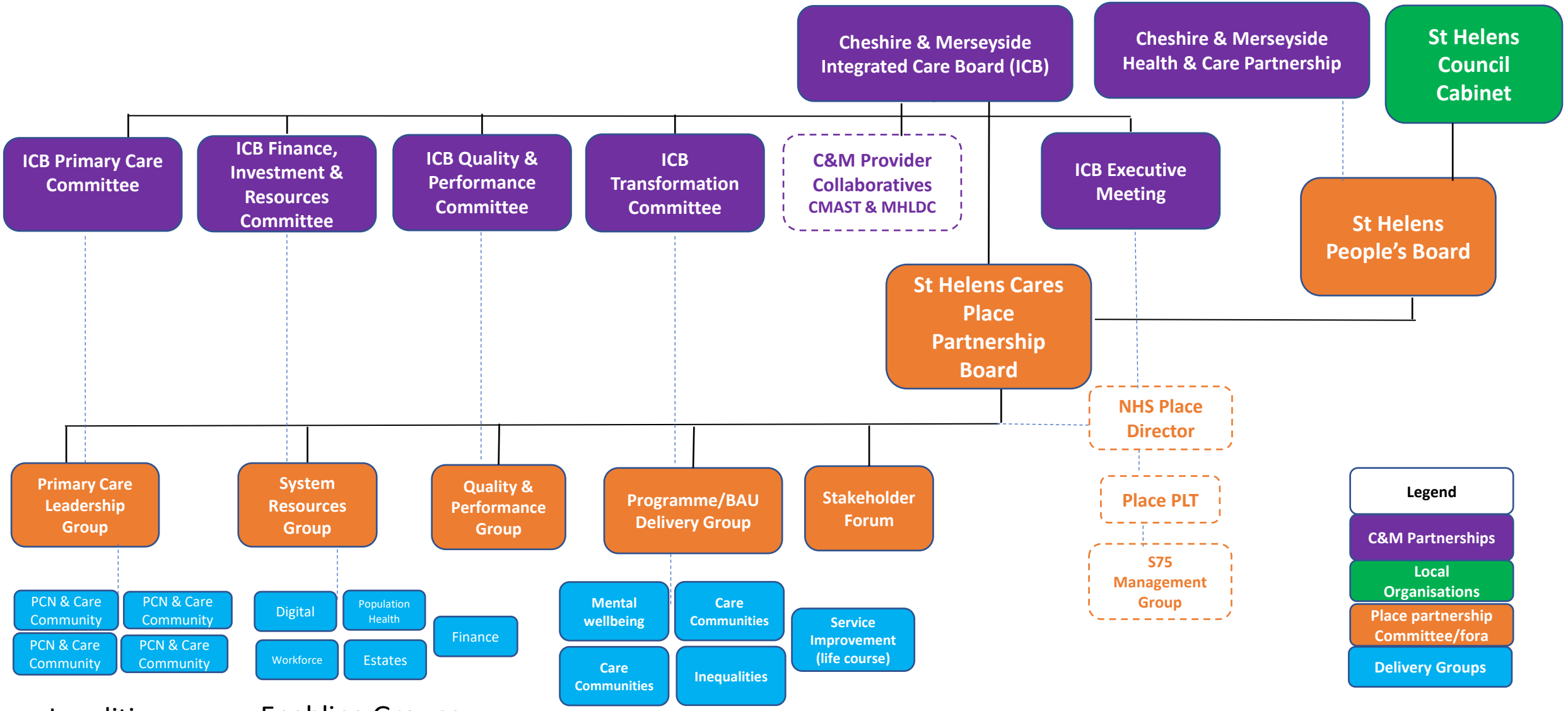
Service Standards

1) Achieving 4-hour emergency department waiting time
2) Improve planned care waiting times-65week wait elimination
3) Exceed the 70% 2-hour target - urgent Community response
4) Cancer: 28day Faster Diagnostics and 62day wait, staging
5) Primary Care access

System Priorities

1) Achieve 92% bed occupancy rates
2) Improve non-criteria to reside (NCTR) rates
3) Achieve ambulance turnaround times for Cat2 of 30 mins
4) Deliver the NHS financial plan for place
5) Deliver a 5% Place (NHS) efficiency target for 2023/24

15. St Helens Cares Place Governance



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