St. Helens Joint Strategic Needs Assessment

A Picture of health and Wellbeing

Refresh 2012
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Context</td>
<td>4</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>5</td>
</tr>
<tr>
<td>Developing an Asset Based Approach</td>
<td>7</td>
</tr>
<tr>
<td>Life Expectancy and Health Inequality</td>
<td>10</td>
</tr>
<tr>
<td>Changing Population</td>
<td>17</td>
</tr>
<tr>
<td>Creating Healthy and Sustainable Communities</td>
<td>22</td>
</tr>
<tr>
<td>Children and Young People</td>
<td>30</td>
</tr>
<tr>
<td>Young Adults</td>
<td>43</td>
</tr>
<tr>
<td>Working Age People</td>
<td>49</td>
</tr>
<tr>
<td>Older People</td>
<td>68</td>
</tr>
</tbody>
</table>
Introduction

What is the Joint Strategic Needs Assessment?

The Joint Strategic Needs Assessment (JSNA) is a statutory requirement introduced by the Local Government Health and Public Involvement in Health Act (2007). Its purpose is to support the effective commissioning, development and delivery of local health and social care services.

The JSNA is an ongoing process which identifies the current health and wellbeing needs of St. Helens residents and anticipates how these needs may change in the future within the context of significant reform of health and social care services and increasing pressures on public sector finances. Work completed for the JSNA has helped to build an understanding of trends, identify the areas and groups of people in the greatest need and support the development of commissioning priorities.

This refresh of the assessment has been co-produced by St. Helens Council and NHS Halton and St. Helens with input from a wide range of stakeholders including St. Helens Clinical Commissioning Group (CCG) and voluntary and community sector organizations. The assessment makes use of both statistical and qualitative data to understand the current health and social care needs of the borough’s residents.

**Joint Strategic Needs Assessment Process**

Information from the JSNA will be used to establish priorities for the St. Helens Health and Wellbeing Strategy and support the development of a high level commissioning framework for the borough.

The JSNA is not a single, one-off exercise, but an ongoing piece of work which will support partners to develop a comprehensive understanding of local needs and assets.

This summary highlights the key information from the JSNA; it is accompanied by an online resource which provides access to further data and analysis for each area of the JSNA. For further information please visit: [http://share.sthelens.gov.uk/IAS/](http://share.sthelens.gov.uk/IAS/)
Context

How Health Services are changing?

The Coalition Government has set out plans for major health reform within the Health and Social Care Act. These proposals set out a radical shift in responsibilities with the aim of ensuring that patients are at the heart of the NHS, to improve health outcomes, and to give more control to local organisations and professionals.

The key elements of the act include:
- Establish GP led commissioning with budgets for £70bn being devolved to Clinical Commissioning Groups (CCGs) from 2013.
- Transfer local public health functions to local councils from 2013.
- Abolish Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs).
- Establish a new NHS Commissioning Board to oversee the allocation of resources across the new system.

Joint working between councils and the NHS has a long history reflecting the close links between health care and social care. In St.Helens there is a strong history of partnership working with a focus upon improving outcomes for local residents and further integration between health and social care services is one of the central principles of the reforms.

As part of the Health and Social Care Bill there is a requirement for each local authority area to establish a Health and Wellbeing Board. This board will be established as a committee of the Council to strengthen democratic legitimacy in health and to lead on the strategic coordination of commissioning across NHS, social care, and related children’s and public health services.

St.Helens has established a Shadow Health and Wellbeing Board to drive and support the transition process and is part of the Department of Health National Early Implementer Network. The JSNA will be integral to the work of the Health and Wellbeing Board and will support the development of the new Health and Wellbeing Strategy for St.Helens.

The current Local Involvement Networks (LINks) will be replaced by a local healthwatch organisation, which will report to Healthwatch England forming a part of the Care Quality Commission. Local healthwatch will be a consumer champion for local health services and place a key role in ensuring that health services are shaped around local communities. These structural changes are aimed at achieving better health outcomes, a more patient-centred service which is clinically-led and more focused on prevention and early intervention.

Alongside these significant reforms, local public services are facing ongoing financial pressures, although this needs assessment is not primarily concerned with economics, the immediate and emerging impact of spending cuts will inevitably inform local health and wellbeing and the following issues must therefore be considered:
- Financial pressures experienced by local residents may have an impact on health and wellbeing and risk taking behaviours.
- The likelihood that there will be ongoing pressures on services in light of financial constraints and potentially rising demand for services.
Social Determinants of Health

Health outcomes are influenced by a wide range of social, economic and environmental factors. These social determinants of health have been described as ‘the causes of the causes’. They include the day to day quality of life and wider structural influences at global, national and local levels. There is a clear link between the social determinants of health and health inequalities, defined by the World Health Organisation as “the unfair and avoidable differences in health status seen within and between countries”.

Low income, inappropriate housing, unsafe workplaces and poor access to healthcare are some of the factors that affect the health of individuals and communities. Similarly, good education, public planning and support for healthy living can all contribute to healthier communities.

Barton and Grant and the United Kingdom Public Health Association (UKPHA) strategic interest group (2006) developed the health map based on Dahlgren and Whitehead’s earlier model (Dahlgren and Whitehead 1991) which shows how individual determinants including a person’s age, sex and hereditary factors are nested within the wider determinants of health which include lifestyle factors, social and community influences, living and working conditions and general socio-economic cultural and environmental conditions.

The Marmot review of health inequalities published in 2010 highlights the differences in health and wellbeing between people from different social groups.

The Marmot Review into health inequalities proposed an evidence based strategy to address the social determinants of health. It argues that, traditionally, government policies have focused resources only on some segments of society. To improve health for all of us and to reduce unfair and unjust inequalities in health, action is needed across all social groups.

The key to Marmot's approach for addressing health inequalities is to create the conditions for people to take control of their own lives. This requires action across a wide range of factors going beyond the reach of the NHS.
The Marmot review places renewed emphasis on the role of local Councils and the voluntary and community sector in reducing health inequalities.

There are some key messages that have come out of this review:

- the report estimates 2.5 Million years of life are potentially lost to health inequalities by those dying prematurely each year in England alone;
- By knowing the nature and size of the problem and understanding how we can make a difference, we are now in a position to take action to reduce health inequalities;
- It is time to move beyond economic growth as the sole measure of social success; and
- The Health Inequalities and Sustainability agendas must come together.

The review sets out a framework for action under two goals:

- to create an enabling society that maximizes individual and community potential; and
- to ensure social justice, health and sustainability are at the heart of all policies.

One of the key elements of the review is the recognition that disadvantage starts before birth and grows throughout life. This is reflected in the 6 policy objectives and to the highest priority being given to the first objective.

**Policy Objective A**
- give every child the best start in life

**Policy Objective B**
- enable all children, young people and adults to maximize their capabilities and have control over their lives

**Policy Objective C**
- create fair employment and good work for all

**Policy Objective D**
- ensure a healthy standard of living for all

**Policy Objective E**
- create and developing sustainable places and communities

**Policy Objective F**
- strengthen the role and impact of ill-health prevention.

*Figure 3: MARMOT OBJECTIVES*
Source: Marmot Review of Health Inequalities 2010

The JSNA presents data about health, wellbeing and the wider determinants of health across the population life course.
Developing an Asset Based Approach

The Joint Strategic Needs Assessment considers a wide range of health and wellbeing issues, as part of the overall approach and commissioning cycle it is important to consider ‘assets’ as well as ‘deficits’ within the Borough.

An asset based approach describes the capacity, skills, knowledge, connections and potential of a community. It encourages commissioners to celebrate the existing strengths of the community and can be used to empower residents to take responsibility and control over their health and wellbeing.

A ‘deficit’ approach focuses on the problems, needs and deficiencies in a community such as deprivation, illness and health-damaging behaviours. It designs services to fill the gaps and fix the problems.

What is a health asset?
“An asset based approach describes the capacity, skills, knowledge, connections and potential of a community. It encourages commissioners to celebrate the existing strengths of the community and can be used to empower residents to take responsibility and control over their health and wellbeing.

A ‘deficit’ approach focuses on the problems, needs and deficiencies in a community such as deprivation, illness and health-damaging behaviours. It designs services to fill the gaps and fix the problems.

What is a health asset?
“A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life’s stresses.” ANTONY MORGAN, ASSOCIATE DIRECTOR, NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (NICE) 2009

An asset can be any one of a number of things:
• The practical skills, capacity and knowledge of local residents.
• The passions and interests of local residents that give them the energy for change.
• The networks and connections - known as ‘social capital’ - in a community, including friendship and neighbourliness.
• The effectiveness of local community and voluntary associations.
• The resources of public, private and third sector organisations that are available to support a community.
• The physical and economic resources of a place that enhance well-being.

The concept of an asset based approach is new within the Joint Strategic Needs Assessment for St.Helens, and this is an area that needs to be further developed in the future. However, consideration of what communities can do to keep themselves well and contribute to improving wellbeing is central to health promotion and is a key part of the commissioning cycle.

The starting point for an asset based approach is looking at the resources people and communities already have and exploring how they could be used more effectively. There are a wide range of assets in St.Helens including:
• Strong, vibrant local communities
• Physical assets and infrastructure
• Partnership networks
• Voluntary, community, faith, youth and sport sector
**Strong, Vibrant Local Communities**

The greatest asset within St.Helens is the community itself. People of St.Helens see themselves as tough, northern, industrial, resilient, reliable, proud of the past, proud of “Saints”, on the up and with a strong sense of local identity and a strong affinity to the Northwest.

In general feelings of belonging and neighbourliness are very strong, 60% of residents feel they belong to their immediate neighbourhood and three quarters of people believe that people from different backgrounds get on well together. One in five people carry out some kind of volunteering activity at least once a month and at least one fifth of the community provide unpaid care for a friend or family member.

**Physical Assets and Infrastructure**

Over recent years significant investment has been made to improve the quality of community and health facilities within the borough. Specific developments include:

- Garswood Primary Care Centre
- Newton Community Hospital
- Lowe House Health Care Resource Centre
- A joint GP and primary care initiative in the development of Fingerpost surgeries
- Development of both Whiston and St.Helens hospital
- Cowely International College
- Hope Academy
- St.Helens College

**Figure 4: St.Helens Health Services**

Source: NHS Halton and St.Helens

Over recent years significant investment has been made to improve the quality of community and health facilities within the borough. Specific developments include:

- Garswood Primary Care Centre
- Newton Community Hospital
- Lowe House Health Care Resource Centre
- A joint GP and primary care initiative in the development of Fingerpost surgeries
- Development of both Whiston and St.Helens hospital
- Cowely International College
- Hope Academy
- St.Helens College
Additionally the borough benefits from an excellent and well connected road and transport system, high quality children’s centres and well established community centres and libraries.

**Partnership networks**
There is a strong heritage of joint working in St.Helens in 2002 one of the first public/private regeneration partnerships in the country was widened to include partnerships improving community safety, services for children and young people and, most recently, addressing health, social care and health inequalities issues, to become the St.Helens Local Strategic Partnership (LSP). The LSP is chaired by the Council Leader and includes representation from St.Helens Chamber, NHS Halton and St.Helens, Merseyside Police, Halton and St.Helens Voluntary and Community Action, St.Helens College, Helena Partnerships, Citizens Advice Bureau, Jobcentre Plus, Merseyside Fire and Rescue Service, Merseytravel and community faith representatives.

The Local Strategic Partnership acted swiftly to establish a shadow St.Helens Health and Wellbeing Board in order to maintain an overview of the impact of health reforms and maximise opportunities for health improvement in the borough.

**Voluntary, community, faith, youth and sport sector**
Voluntary, community, faith and voluntary sports sector organisations in St.Helens make a vital contribution to improve the quality of health and wellbeing in the Borough. They provide a network of support, a means by which individuals can contribute to the community and they assist health partners and local government to engage effectively with the community. They promote citizenship, social inclusion, equality and cohesion in our communities. The voluntary and community sector within St.Helens is very strong with high quality support network.

**Asset based work in practice**
There are also a number of examples of asset based working in practice. These include:

- **Social Prescribing**
The Wellbeing Project in Halton and St Helens which is a social enterprise that offers social prescribing to people with mental health concerns. They run community-based courses, self-help groups, and training and leisure activities and connect people with sources of support.

- **Service Redesign**
An asset based approach was also applied to the development of a specification for drug and alcohol treatment service. A series of recovery themed debates were held to involve users of current drug and alcohol services, people in active addiction outside of services, individuals in recovery both, families, friends and carers, volunteers, peer mentors and members of the public. A number of principles were developed to support a holistic, recovery centred service including promotion of citizenship, improved wellbeing, addressing offending, include families, address housing and homelessness.

- **Peer Support**
Volunteers working with the public as lay health trainers working closely with Health Improvement staff. These volunteers take lifestyle and early detection of cancer messages out to the local community using their variety of personal skills and expertise. By identifying champions from within the community who people trust and can relate it makes it possible to reach a wide range of resident who may not ordinarily engage with services.
Life Expectancy and Health Inequality

Life expectancy and health inequalities
There is a strong link between health and wider social, economic and environmental factors. In St Helens a significant proportion of the population live within the 20% most deprived areas in the country, inevitably this has an impact on the health status of our population. The factors indicated in the previous section all interplay with each other so that poor health can affect economic status and likewise economic status can affect poor health.

Key messages
- Overall, health in St. Helens is improving and people are living for longer. Death rates have fallen which has been in a large part due to reductions in the number of people dying from heart disease and cancers.
- There is significant variation in life expectancy based on deprivation. Males from the least deprived areas of the borough can expect to live 11.5 years longer than those from the most deprived areas, for females the gap is 8.4 years.
- Health inequalities do not just apply to mortality and life expectancy but also to wellbeing and quality of life issues.
- Inequalities also apply to specific groups within the population, for example, people with learning disability have more difficulty identifying health problems and seeking treatment. Homeless people and transient populations such as Gypsy and Travellers may also find it more difficult to access services resulting in worse health and wellbeing outcomes.
- In the most deprived wards people are more likely to be admitted as an emergency patient than in the least deprived wards. However, the pattern of planned health care does not correlate with deprivation even though healthcare needs are likely to be the greatest in the most deprived wards, these factors may indicate inequality in terms of health care or access to services.
- Circulatory diseases and cancers are the two biggest killers in St Helens and are within the top 10 causes of hospital admissions.
- Respiratory diseases are the third biggest killer. Pneumonia, COPD and asthma are the some of the most significant causes of hospital admissions.
- Fractured neck of femur and poisonings are in the top 10 causes of hospital admissions.
Data Summary

Life expectancy at birth is a key means of measuring health i.e. the higher the average life expectancy in an area the more likely a population is to be healthy.

In St Helens there has been an improvement in life expectancy over time for both males and females, however, the improvement has not been as great as for England as a whole.

Life expectancy at birth (2008-10) for males is 76.3 compared with 78.58 for England and for females is 81 compared with 82.57 for England.

The map shows variation in life expectancy at ward level. Areas of highest deprivation have the lowest life expectancy. The areas in pale pink are those with the lowest life expectancy, these correlate strongly with deprivation.
The figures below show that for men there is an 11.5 year gap between life expectancy in the least and most deprived areas of St Helens. For females that gap is 8.4 years between the least and most deprived.

**Figure 7: Life expectancy by deprivation decile in St Helens Males**
Source: Association of Public Health Observatories

**Figure 8: Life expectancy at birth by deprivation decile in St Helens, Females**
Source: Association of Public Health Observatories
Identifying the major causes of death help us to understand which interventions have the greatest potential to deliver improvements to health outcomes and reduce mortality. The chart below shows a summary of the major causes of death, it illustrates that circulatory diseases (including heart disease and strokes) and cancers are the biggest causes of death in St.Helens. Respiratory diseases such as pneumonia and chronic obstructive pulmonary disease and digestive diseases such as chronic liver disease also have a significant impact on the number of deaths in St.Helens.

**FIGURE 9: UNDERLYING CAUSE OF DEATH IN ST HELENS IN 2009**

Healthcare activity and health inequalities

Health inequalities can also be seen in relation to health care activity, in particular emergency admissions to hospital (non elective).

Ideally, people who need treatment in hospital should be admitted before their illness reaches a critical stage where they have to be admitted as an emergency. Where illnesses are left to a late stage, this often involves more suffering on the part of the patient and poorer outcomes of treatment. Emergency admissions are also less satisfactory as less advance planning is possible and patients are commonly seen by more junior staff.

Lack of advance planning is particularly relevant for people with learning or physical disability where it is helpful if staff can make reasonable adjustments in anticipation of the patients needs.
Figure 10 shows that areas that are more deprived such as Town Centre, Parr, Thatto Heath, Bold and Haydock have a significantly higher rate of emergency admissions than the rest of the borough.

However, in terms of planned admissions to hospital there is not the same degree of correlation between admission rates and highest rates of need. This may suggest that people from more deprived areas may not have sought health interventions early enough to prevent an emergency admission.
The top 10 reasons based on directly age standardized rates to hospital for emergency admissions are shown below. The highest cause of admission is not related to any one condition but relates to health where there is no definite diagnosis. However, in relation to emergency conditions with a specific diagnosis injury and poisonings and respiratory conditions are the highest two causes.

### Top 10 emergency admissions to hospital 2010/11

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>2179.31</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>1861.53</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>1492.52</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>1132.90</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>824.31</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>638.20</td>
</tr>
<tr>
<td>Certain infectious and parasitic diseases</td>
<td>495.27</td>
</tr>
<tr>
<td>Mental and behavioural disorders</td>
<td>468.72</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>408.14</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>220.80</td>
</tr>
</tbody>
</table>

**Figure 12: Top 10 reasons for emergency admissions in 2010/11**

In order to ensure that we improve health outcomes it is important that the correct people are being targeted for health interventions and that there is good access to services. This should reduce the need for emergency hospital admissions and ensure that there is planned health care.

In terms of planned admissions to hospital, problems of the digestive system and genitourinary system problems account for the greatest number of people.

### Top ten causes for planned admissions to hospital 2010/11

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the digestive system</td>
<td>2540.22</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>1735.08</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>1498.53</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>1358.64</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>1176.29</td>
</tr>
<tr>
<td>Diseases of the eye and adnexa</td>
<td>972.51</td>
</tr>
<tr>
<td>Factors influencing health status and contact with health services</td>
<td>876.98</td>
</tr>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>726.70</td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>424.87</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>393.63</td>
</tr>
</tbody>
</table>

**Figure 13: Top 10 reasons for planned admissions to hospital 2010/11**
Injury and poisonings account for a high proportion of planned and emergency admissions. Although there are many different causes of injuries covered in this section, two areas that need to be targeted in relation to health interventions are fractured neck of femur and poisonings of many causes.
How the population is changing

Establishing the demographic characteristics of an area, for example, how many people there are from particular age or ethnic groups, and how these groups are projected to change over time is an important aspect of understanding local needs. Developing a detailed profile of the make up of local communities enables services to be planned that meet current levels of demand and are also fit for the future. Commissioners must take the following considerations into account:

- Increases or decreases in the total number of people living in an area will have an impact on the overall demand for health and social care services.
- Significant population change can affect the sustainability of services, through either too great or too little demand.
- Changes in certain age groups can affect the demand for particular types of services, for example, an increase in the number of older people may increase pressures on social care services and housing whilst an increase in the younger population would have an impact upon education services.
- Some ethnic groups have a higher prevalence of certain diseases.
- Increases in the size of transient populations, for example travellers, or increased inward migration may increase demand for services, require new approaches to service delivery or additional support to ensure good access to services.

Key Messages

- Between 2001 and 2011 the population of St.Helens has decreased by 1,500 people.
- Birth rates in St.Helens have increased significantly over the last decade and are forecast to continue to rise until 2017/18.
- National projections suggest that the population of St.Helens will increase by 4% by 2020. However, this growth in population will vary considerably by age group, the proportion of people in the 15-24 year old group is projected to fall by 17% whilst the number of people aged 65 and over is projected to increase by 22% by 2020.
- Over the longer term the number of older people is projected to grow significantly. By 2035, it is forecast that 47,000 residents will be aged 65 and over, making up 24% of the total population a growth of 40% from 2010.
- Between 2002 and 2008, the number of National Insurance Number (NINo) registrations to overseas nationals of working age was 2340. Over half of these registrations (58%) were to nationals from EU accession states.
- Non-white ethnic groups are currently estimated to make up around a 3% of the total resident population of the area, this is significantly lower than the North West and England average.
Data Summary

Age and Gender

There are 175,300 residents in St.Helens (2011 Census). 49% of residents are male and 51% are female. The total number of residents in the borough has fallen by 1,500 people since 2001.

Demographic change is one of the most pressing challenges facing St.Helens. As life expectancy improves and people live longer the number of people aged 65 and over continues to grow, increasing pressure upon local services.

In 2010 there were approximately 2,100 live births to women in St.Helens. The total fertility rate has increased over the last decade echoing the national trend. The current level of births is projected to continue at a similar level until 2017/18 when it is predicted to decrease slightly.

Since 2001 there has been a 10% reduction in the number of people aged 15 and under, over the same period the number of people aged 65 and over has increased by 11%.

Overall the population of St.Helens is projected to increase by 3% over the next 20 years, a slower growth than the national and regional rates. However, the age structure of the population is expected to change significantly. National population projections suggest that the number of older people will continue to rise and latest data from ONS suggests that nationally, 1 out of 3 babies born in 2012 will live to be 100 years old.

In the medium term the number of people aged 65 and over is predicted to rise by 22% by 2020. Over the longer term, the number of people aged 65-84 is projected to increase by over 40% by 2035. The number of very elderly people aged 85 and over is predicted to rise by over 150% over the same period, increasing from 3,300 to 8,300.
There are approximately 76,000 households in St. Helens (2011 Census), this number is forecast to increase by around 10% over the next decade, much faster than population growth. The change in household composition is important as it implies that a greater number of people will be living alone, this is particularly likely to apply to older people and increases the risk of social isolation.

**Ethnicity**

In common with most areas across England, St. Helens population is becoming increasingly diverse. Since the 2001 census there is estimated to be a growth in the number of people from black and ethnic minority groups in the borough.

Non-white ethnic groups are currently estimated to make up around a 3% of the total resident population (2009), this has increased from 1.2% in 2001 but remains significantly lower than the North West and England average.

![Figure 16: Percentage of People by Ethnic Group](source)

**Figure 16: Percentage of People by Ethnic Group**

Source: Office of National Statistics 2009

In terms of ethnicity, there is variation across age groups within the borough. Approximately 2.1% of young people aged 0-15 are mixed race and 1.2% are asian or asian british. This is much higher than the proportion of people of pensionable age from ethnic minorities where which accounts for only 0.3% of this age group.

Although the number of people from ethnic minorities overall is low, this provides a challenge to ensure that the health needs of these small communities and individuals are appropriately met. It is essential to work across partner organisations to ensure a good understanding of the varying needs this growing diversity brings. Prevalence of some diseases (heart disease, diabetes and stroke) vary by ethnic origin. Individuals from different ethnic minorities may have different religious backgrounds. Health and social care education providers must be aware of differing religious requirements regarding aspects of in and out patient treatment and personal care, particularly around beliefs concerning birth, death and dying.
Migration

St. Helens is subject to very low levels of population churn with one of the lowest rates of migration in the country. Internal migration refers to migration from within the country. Levels of internal migration into and out of the borough remain low, in 2010, 4,400 people moved into the borough and 4,500 moved out of the borough, a net loss of 100 people.

One indicator of international migration is the number of migrant workers who have registered for a National Insurance Number (NINo). National Insurance Numbers are legally required for employment/self-employment or to claim benefits and tax credits. However, there is no de-registration process, so NINo registration does not show when the overseas nationals leave the UK, they also do not record if the individual moves after registration. Between 2002 and 2008, 2,340 non-UK nationals registered for a National Insurance number in St. Helens. 58% of these registrations were from individuals from the EU accession states.

Although the number of people from migrant communities remains small, it is important to ensure good access to services. St. Helens Local Involvement Network (LINk) identified difficulties for members of the Polish community in accessing local health services. Friends and relatives were relied upon to interpret information and the LINk found a lack of awareness of translation services amongst front line staff. The LINk Access to Information Task Group raised the issue resulting in guidance for all front line staff and an ongoing communication channel between the network and a community member representing issues for European Union Migrants.

Unregistered and Transient Populations

Individuals who are not registered with general practitioners may have unmet or unknown levels of need. This group might include, homeless people or people living in transient populations such as Gypsies and Travellers. For those people not registered with GPs it can be difficult to access early intervention services leading to a higher likelihood of emergency hospital admissions. People from these groups may access health services through alternative channels, for example, via community pharmacy services.

Gypsy and Traveller Communities

Gypsies and Travellers experience some of the worst education, health and wellbeing outcomes of any group. Nationally in 2011 just 12% of Gypsy, Roma and Traveller pupils achieved five or more good GCSEs, including English and mathematics, compared with 58.2% of all pupils. The prevalence of miscarriage, stillbirth, neonatal deaths in Gypsy and Traveller communities is much higher than average and research shows that often these communities are subjected to hostility and discrimination.

Gypsies and Travellers are a small but significant group who continue to suffer from poor health and lower life expectancy. National research show differences in life expectancy of over 10% less than the general population, with evidence that the health of Gypsies and Travellers starts to deteriorate markedly when individuals are over 50.

Other health issues such as low child immunisation levels, mental health issues, substance misuse issues and diabetes are also seen to be prevalent in the Gypsy and Traveller communities.

Gypsies and Travellers, along with other vulnerable groups, experience a range of health needs, which are exacerbated by social factors. Those with multiple complex needs make chaotic and greater use of health care services than other groups and experience a range
of barriers, in particular when accessing primary care services. Gypsies and Travellers often lack trust in health professionals to provide appropriate care and to engage with their community on equitable terms.

In 2007 an assessment of the accommodation and service needs of Gypsies and Travellers across the Cheshire Partnership Area was undertaken, this included Cheshire, Halton, Warrington and St Helens. The assessment found that 12.3% respondents reported that someone in their household had either a disability or long-term illness, lower than the population average. The type of illness varied although complaints such as asthma, epilepsy, heart problems and arthritis were particularly common. Despite the low number of Gypsies and Travellers reporting ill-health or disability, when an individual or household did experience health problems, it was often the case that there were multiple disabilities or health concerns. Such multiple incidences of ill health can increase an individual’s vulnerability and impact on independence. For some people, ill health or disability acted as a catalyst to move to bricks and mortar accommodation. The worst living conditions are commonly experienced by Gypsies and Travellers living on unauthorised encampments who do not have easy access to water or toilet facilities as well as difficulties in accessing education and health services.

**Homeless People**

Homelessness describes a wide range of circumstances where people have no secure accommodation. It can include:

- single homeless and rough sleepers (SHRS)
- statutory homeless - those defined in law as being in priority need and entitled to housing support from local authorities
- hidden homeless and those at risk of homelessness – those not recognised by local authorities or services (thought to be much larger than the two other groups together)

In 2010/11, 224 households were classified as statutory homeless in St.Helens, this represents an increase from 213 households since 2009/10. In order to prevent rough sleeping in the borough St.Helens has adopted the ‘No Second Night Out’ protocol. A study of rough sleepers in 2012 found 2 people sleeping rough.

There is a great deal of overlap between these groups with people frequently moving in, out and between them. Homelessness is complex and there is rarely a simple explanation for someone becoming homeless. A number of factors can contribute towards people becoming homeless such as poor health, unemployment, imprisonment or poverty. Healthcare, social services and criminal justice systems all impact on homelessness. The current economic climate and reforms to the welfare benefit may lead to an increase in the number of homeless people in the borough.

Compared to the general population, homeless people experience poorer health outcomes. Physical health, drugs, alcohol, mental health and wellbeing have been recognised as priority health issues among the homeless. However, homeless people generally experience difficulties with accessing health services; this poor access also impacts on their health status.
Developing healthy and sustainable communities

When considering health and wellbeing needs of residents it is important to take account of the socio-economic characteristics of the area. People living in more deprived areas are more likely to experience higher levels of chronic disease, disability and premature death; come into contact with services at a later stage in their condition and suffer poorer health outcomes; fail to engage with health promotion and disease prevention activities; achieve poorer educational outcomes and live in poor housing.

Key Messages

- St.Helens is the 51st most deprived local authority in England. Over a third (36%) of Lower Super Output Areas (LSOAs) in the borough are in the most deprived 20% of areas in the country.
- Social cohesion and community engagement is high in St.Helens with a strong network of voluntary and community organizations.
- There are significant pockets of child poverty within St.Helens with a quarter of children aged 0--15 living in income-deprived families.
- In line with national and regional trends the number of unemployed and under employed people has been growing over recent years. The number of unemployed women and young people has increased significantly since 2009.
- The quality of housing has increased in the borough over recent years, particularly across the social housing stock, however work continues to address the quality of housing of private rented sector.
- The Marmot Review highlighted that improvements in housing conditions have been shown to have a number of positive impacts on health, including lower rates of mortality, improved mental health and lower rates of contact with GPs. Good housing can also reduce the risk of falls in the home.
- Adequate heating systems improve asthma symptoms and reduce the number of days off school. In St.Helens Around 19% of households are experiencing fuel poverty.
- There are four locations within St.Helens, where air quality monitoring has revealed that the National Air Quality Objective for oxides of nitrogen (NOx) are being exceeded. The principal source of pollution in these areas are motor vehicles.
- When compared to both national and regional figures there appears to be a higher rate of reported injuries to employee within St.Helens.
Data Summary

Overall Satisfaction

Many factors contribute to making somewhere a good place to live, for example affordable decent housing, clean streets, access to nature, levels of crime, cultural facilities such as libraries or museums. Knowing how satisfied local communities are with the area they live is important, and whether they feel they belong to their immediate neighbourhood gives a good insight into the quality of a place. The table below shows the general satisfaction level of residents with their local area.

<table>
<thead>
<tr>
<th>General satisfaction</th>
<th>St Helens %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of people satisfied with their Local Area as a Place to Live</td>
<td>74.2</td>
</tr>
<tr>
<td>Percentage of people who feel they belong to their immediate neighbourhood</td>
<td>61.1</td>
</tr>
</tbody>
</table>

**Figure 17: General Satisfaction**
Source: St. Helens Council, 2009

In general feelings of belonging and neighbourliness are very strong. Information from the place survey tells us that six out of ten respondents feel they belong to their immediate neighbourhood. One in five people carry out some kind of volunteering activity at least once a month. One in five respondents believe that parents take enough responsibility for their children’s behavior and three-quarters of respondents believe that people from different backgrounds get on well together in their area.

The table below shows three measures of the strength of the volunteering and local participation in the local area: The percentage of people who have been involved in decisions that affect the local area in the past 12 month, the proportion of people who have given unpaid help at least once per month over the last 12 months and the proportion of third sector organisations who agree ‘positively’ or ‘very positively’ that local statutory bodies in their local area influence their organisation’s success.

<table>
<thead>
<tr>
<th>Measure</th>
<th>St. Helens</th>
<th>North West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of people who have been involved in decisions that affect the local area in the past 12 months (2008)</td>
<td>8.8</td>
<td>12.71</td>
<td>13.84</td>
</tr>
<tr>
<td>Percentage of people who have given unpaid help at least once per month over the last 12 months (%) (2008)</td>
<td>20.8</td>
<td>20.06</td>
<td>22.77</td>
</tr>
<tr>
<td>Proportion of third sector organisations who agree positively or very positively that local statutory bodies in their local area influence their organisation’s success (%) (2009)</td>
<td>27.9</td>
<td>18.22</td>
<td>16.29</td>
</tr>
</tbody>
</table>

**Figure 18: Thriving Third Sector**
Source: Place Survey/Cabinet Office (CO)
Indices of Multiple Deprivation

The Index of Multiple Deprivation (IMD) 2010 is a measure of deprivation for small geographical areas. It combines a number of different indicators of deprivation (income, employment, health and disability, education, skills and training, housing, crime and living environment) into a single measure that reflects the overall experiences of individuals living in an area.

The IMD 2010 ranks St. Helens as the 51st most deprived local authority in England. This is an improvement on the IMD 2007, which ranked the borough as the 47th most deprived local authority. As shown in the map the greatest concentrations of deprivation are in the town centre and the south east of the borough.

The domains of greatest concern are the Employment domain, the Health and Disability Domain and the Income Domain

- In terms of the Employment domain 6 SOAs (5%) are within the most deprived 1% of SOAs nationally and 65 SOAs are within the top 20%.
- In terms of Health and Disability 58 SOAs (49%) fall within the top 20% most deprived nationally.
- The number of SOAs falling within the most deprived 5% in terms of Income Deprivation has increased from 37 in 2007 to 45 in 2010.
Children in poverty

Reducing the percentage of children living in poverty is a key priority for St. Helens. It is estimated that 25% of children in St. Helens are living in poverty compared with the England average of 21% (Child poverty unit, 2011). These estimates use tax credit data to calculate the percentage of children on low incomes within local authorities.

Between 2010-11 and 2013-14 average incomes are forecast to stagnate and both absolute and relative poverty among children and working-age adults are expected to rise, according to projections funded by the Joseph Rowntree Foundation.

Economy and Income

The jobs that people do have a major impact on their health and on the health of the population as a whole. Being out of work can put people at increased risk of ill health and premature mortality. Research has shown employment has clear links to mental health – work can provide purpose and structure, develop relationships, and build confidence and self-esteem. Nationally, only 24% of adults with a long-term mental health problem are in work, and people with mental health problems are at more than double the risk of losing their job than those without.

The working environment and working conditions also have potential to influence an individual’s health either positively or negatively and the right working conditions can assist someone with the transition back into work following illness or injury.

<table>
<thead>
<tr>
<th></th>
<th>St Helens (numbers)</th>
<th>St Helens (%)</th>
<th>North West (%)</th>
<th>Great Britain (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All people</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economically active¹</td>
<td>85,300</td>
<td>73.6</td>
<td>74.6</td>
<td>76.2</td>
</tr>
<tr>
<td>In employment¹</td>
<td>78,200</td>
<td>67.4</td>
<td>68.4</td>
<td>70.2</td>
</tr>
<tr>
<td>Employees¹</td>
<td>70,600</td>
<td>61.5</td>
<td>59.9</td>
<td>60.7</td>
</tr>
<tr>
<td>Self employed¹</td>
<td>7,100</td>
<td>5.5</td>
<td>8</td>
<td>9.1</td>
</tr>
<tr>
<td>Unemployed (model-based)⁶</td>
<td>7,800</td>
<td>9</td>
<td>8.1</td>
<td>7.7</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economically active¹</td>
<td>44,900</td>
<td>77.9</td>
<td>80.3</td>
<td>82.5</td>
</tr>
<tr>
<td>In employment¹</td>
<td>41,500</td>
<td>71.8</td>
<td>73</td>
<td>75.4</td>
</tr>
<tr>
<td>Employees¹</td>
<td>35,000</td>
<td>61.7</td>
<td>60.5</td>
<td>62.2</td>
</tr>
<tr>
<td>Self employed¹</td>
<td>6,100</td>
<td>9.4</td>
<td>11.9</td>
<td>12.8</td>
</tr>
<tr>
<td>Unemployed (model-based)⁶</td>
<td>3,400</td>
<td>7.7</td>
<td>8.9</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economically active¹</td>
<td>40,400</td>
<td>69.5</td>
<td>68.9</td>
<td>69.9</td>
</tr>
<tr>
<td>In employment¹</td>
<td>36,800</td>
<td>63.2</td>
<td>63.8</td>
<td>65</td>
</tr>
<tr>
<td>Employees¹</td>
<td>35,600</td>
<td>61.2</td>
<td>59.3</td>
<td>59.2</td>
</tr>
<tr>
<td>Self employed¹</td>
<td>#</td>
<td>#</td>
<td>4.2</td>
<td>5.4</td>
</tr>
<tr>
<td>Unemployed⁷</td>
<td>3,600</td>
<td>8.9</td>
<td>7.2</td>
<td>6.9</td>
</tr>
</tbody>
</table>

Source: ONS annual population survey

**Figure 20: Employment and Unemployment (July 2010 – June 2011)**

Source: NOMIS
Overall, unemployment in St.Helens remains above the regional and national rates. The rate of male unemployment is lower than the national average. In recent years women and younger people have been the hardest hit by the economic climate.

The percentage of young people Not in Employment, Education or Training (NEET) is 7% in St.Helens, slightly higher than North West (6.7%) and England (5.4%) levels (2010).

**Working conditions and workplace health**

There are almost 5,000 workplaces within St.Helens. Approximately 80% of these employ less than 10 staff. Around 80% of these workplaces are part of the services industry with the remaining shared between the construction and manufacturing sectors. The profiles are broadly similar both regionally and nationally.

In 2009/10, 78 fatal and major injuries were reported to employees within the borough, which equated to a significantly higher injury rate than reported at both a regional and national levels. The estimated cost for accidents in St.Helens has been estimated between £19.1 and £34.6 million. The principal causes of injury reported relate to handling and slips and trips.

In respect of occupational diseases such as asbestosis, asthma and dermatitis it is accepted that incidents are widely under reported and difficult to assess.

Analysis of the injuries reported to the Council's Environmental Health Section under reporting regulations for the last 3 years provides a relatively stable picture with 197 notifiable injuries reported 73 of which were classified as major injuries.

**Pupil absence**

All schools are committed to improving pupil attendance and tackling absence, with particular efforts focused on the most vulnerable children and young people. An authorised absence is when a child has permission to be away from school. For example, if he or she is sick. Unauthorised absence from school is reported as truancy. The table below compares the total number of authorised and unauthorised pupil absences in the local and comparator areas. Overall, the rate of pupil absence is better than the North West and England rate. There are currently 1250 pupils classified as persistent absentees, this is lower than the national and region rates. Also it should be noted that children in receipt of free school meals have a higher rate of absence than the overall rate at 8.8%.

<table>
<thead>
<tr>
<th></th>
<th>St.Helens</th>
<th>North West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pupil enrolments (2010/11)</td>
<td>21,775</td>
<td>880,885</td>
<td>6,382,835</td>
</tr>
<tr>
<td>Pupil overall absences (%) (2010/11)</td>
<td>5.6</td>
<td>5.8</td>
<td>5.8</td>
</tr>
<tr>
<td>Pupil authorised absences (%) (2010)</td>
<td>4.2</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Pupil unauthorised absences (%) (2010)</td>
<td>1.4</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Pupil persistent absentees (%) (2010)</td>
<td>(1250) 5.7</td>
<td>6.3</td>
<td>6.1</td>
</tr>
</tbody>
</table>

**Figure 21: Pupil absences 2010/11**
Housing
High quality housing is recognized as an important determinant of good health. Poor housing contributes to a range of physical conditions, including influenza, tuberculosis, some cancers and respiratory conditions arising from insufficient ventilation and indoor pollutants such as nitrogen dioxide and radon. In March 2010, a study commissioned by the National Housing Federation, estimated that poor housing costs the NHS £2.5bn a year in treating people suffering from a wide range of illnesses linked directly to living in cold, damp or dangerous homes.

In St.Helens the quality of housing has increased over recent years, particularly within the social housing stock. However, the condition of privately owned housing stock remains a major challenge, particularly in the private rented sector.

The decency standard is a minimum, 'non statutory' standard set by the Government. For a property to be 'decent' it must not have any significant hazards, must be in a reasonable state of repair, have reasonably modern facilities and provide a reasonable degree of thermal comfort. Major hazards in the home which would lead to failure of the decency standard include excess cold, falls on stairs or on the level, and damp or mould growth. In the private rented sector in St.Helens over 50% of the stock fails the decency standard. People over 75, the main users of health and social care services, are the most likely group to live in non-decent private sector housing.

Nationally there are higher levels of mortality in the winter than in the summer. There is some evidence to suggest that excess winter mortality is preventable as mortality in winter increases more in England compared to other European countries with colder climates, suggesting that it is more than just lower temperatures responsible for the excess mortality in winter.

Diseases of the circulation, including heart attack and stroke, account for around 40% of excess winter deaths. Around one third of excess winter deaths are due to respiratory illness.

The inability to heat homes adequately, because of low income, poor design or poor insulation, contributes to temperature-related deaths in winter, through hypothermia and increased susceptibility to coronary and cerebral thrombosis and respiratory disease. By targeting fuel poverty it may be possible to reduce excess winter deaths in the borough, nationally about 16% of the population, are classified as ‘fuel poor’ but this figure is much higher in St.Helens at 20% (2010, DECC) affecting 15,300 households. Additionally there are some areas of the borough with much higher rates of fuel poverty, in some of these areas up to 28% of households are fuel poor. Work continues by the Council and housing partners to tackle fuel poverty.

Data for St.Helens and the North West can be found in the graph below. It shows the annual averages of the EWD Index (a ratio expressed as a percentage) for St.Helens is significantly higher than the regional and national average, between 2007 and 2010 there have been an average of 149 excess winter deaths per year.
Most accidents and injuries occur in the home and older people are the most likely group to suffer a serious injury, for example an injury related to falls. As outlined in the older people’s section falls are a leading cause of mortality due to injury amongst older people aged 65 and over. The risk of having a fall is increased by ill-fitting footwear, medication, the lack of appropriate mobility aids and adaptations and poorly maintained housing. Early interventions to remove hazards from the home and to provide adaptations and aids to meet the needs of occupants will improve safety and independence in the home, reducing the risk of injury and associated high cost medical and care implications.

Poor quality housing and overcrowding are associated with a range of problems including stress, anxiety, depression and insomnia which affect mental health. Poor housing which fails to meet the needs of occupants can therefore undermine independence and carer support, leading to an increased likelihood of hospital admission. The Council operates a fully integrated Home Improvement Agency and Occupational Therapy Service specifically aimed at enabling vulnerable people to remain living in their homes.

**Air pollution**

There are four locations within St. Helens where air quality is currently below the standards set down in the National Air Quality Strategy. The areas of concern relate to the M6 as it passes through the borough, High Street, Newton and both Borough Road and Linkway within the St. Helens Town Centre. The air pollutants of concern are oxides of nitrogen (NOx). In each of these locations Air Quality Management Areas (AQMA) have been declared. Compared to neighbouring authorities neither Knowsley or Wirral have identified a need to declare AQMAs, Liverpool have declared a city wide AQMA for NOx and Sefton have declared three AQMAs (two for particulates and one for NOx).

The principal source of NOx in St. Helens is motor vehicle pollution. Motor vehicles are also the primary source of PM2.5 particulate matter, which are identified within the Public Health Outcomes Framework, and have the ability to penetrate deep into the lungs and can adversely affect the cardio-vascular system. Interventions, which reduce source emissions of
air pollutants will lead to improvements in air quality, therefore the actions aimed at reducing motor vehicle emissions of NOx will therefore also influence local concentrations of PM2.5 (St Helens Council Air Quality Updating and Screening Assessment 2012).

Environmental Nuisance and Crime
Neighbourhood problems relating to issues of nuisance (noise, odour etc.), pests in homes, environmental crime (fly tipping, graffiti, dog fouling etc.) and door step crime (rogue builders, legal money lending etc.) all impede the creation and development of healthy places and sustainable communities. The stresses created by such problems in and around the home environment negatively influence local communities sense of emotional and financial well-being.

Although data to provide direct comparison of incidents arising in St.Helens compared to the regional and national pictures is not readily available in these particular areas in St.Helens during the course of 2011/12 over 6,000 nuisance complaints were reported to the Council which compares similarly to previous years.

Food poisoning and food-borne disease
It is estimated that each year in the United Kingdom approximately 1 million people will suffer from a food borne illness, around 20,000 people will receive hospital treatment and approaching 500 deaths will be caused by food borne illness. It has been determined that incidents of food poisoning costs the country almost £1.5 billion each year.

Campylobacter remains the most common cause of bacterial food poisoning in the United Kingdom followed by Salmonella. The tables below provide an indication of incidents of infection reported in St.Helens in 2011 and provide comparison to neighbouring authorities in Merseyside and Cheshire
Give every child the best start in life

Introduction
The Marmot Report on Health Inequalities ‘Fair Society, Healthy Lives’ describes 6 policy areas across the life course, the first of these policy areas is giving ‘Every child the best start’. Within this Marmot describes 3 priorities:

- Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
- Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
- Build the resilience and well-being of young children across the social gradient.

Understanding local changes in the health of mothers, children and young people is extremely important. Ill health and poor lifestyles in childhood is often associated with poorer health and social outcomes later on in life and prevention activities focused on this group can be effective in reducing future levels of illness and the need for services. There are strong links between the health and lifestyle of children and some of the broader socioeconomic outcomes in areas such as educational attainment, crime and employment potential.

Key Messages
Although overall infant mortality and child mortality rates are not high in St Helens many of the health and wellbeing statistics are at levels that warrant further attention. A summary of these are highlighted below:

- Breast feeding initiation levels are some of the poorest in the country.
- Smoking in pregnancy levels are still high in St Helens compared to the rates in England.
- Vaccination rates especially for the second dose of MMR by 5 are lower than the rate for England.
- Obesity levels in year 6 have remained static and not reduced as they have in reception.
- Smoking and alcohol statistics show that the levels in St Helens are high in young people.
- Throughout the national reform process it is vital to maintain a focus upon safeguarding children and young people.
Data Summary

Population
There are currently 10,300 children in St Helens under the age of 5 (2011 Census) and there are, approximately 2,150 births per year. The birthrate in St.Helens has increased steadily since 2001 echoing the national trend.

Total Fertility Rate (TFR) represents the average number of children per woman that would be born to a group of women if current age-specific patterns of fertility persisted throughout their childbearing life. In 2010 the total fertility rate in England and Wales was 2 children per woman, this rate is the highest than for the previous two decades. Patterns of fertility in St.Helens have followed the national trend and in 2010 were just slightly higher than the England and Wales average.

**Source:** ONS, Total Fertility Rate 1982-2010.

The current level of births is projected to continue at a similar level until 2017/18 when it is predicted to decrease slightly.
Pregnancy and first years of life

The wellbeing of a child in the first year of life is heavily influenced by the social context, lifestyle and general health of the mother. It is known for example that smoking, alcohol and drug use and poor diet has an impact on the health of the baby. These factors can be influenced whereas there may be other genetic factors that cannot be controlled, however early knowledge of these genetic factors may improve treatment and support families to prepare for the birth of the baby.

Access to good maternal healthcare can help to make sure parents receive reliable information and advice and adopt healthy lifestyles during pregnancy and in the early years of the babies’ life. In Halton and St Helens 85.5 % (Q1-3, 2010/11) of women access maternity services within 12 weeks of pregnancy, although this is above the target set, this means that on average within St Helens over 300 women receive maternity care after 12 weeks of pregnancy.

Infant Mortality

Infant mortality relates to deaths in the first year of life. It is often used as an indicator of both maternal health and health in the first year of life.

Generally the number of deaths is small and therefore small fluctuations in these numbers can significantly affect the infant mortality rate.

In St.Helens the rate has reduced steadily over time and the current rate for 2008-10 show that St.Helens is below the national and North West average.

Child Mortality rate

Child Mortality rate is the mortality rate in children from the age of one to 17. In the first year of life the causes of death for infants tend to be linked to maternal health. Whereas, above the age of one and up to 17, deaths are more likely to be linked to infections and accidents or injuries.

Child mortality in St.Helens remains lower than the England rate. St.Helens rate is 13.6 per 100,000 compared with 16.5 for England (directly age standardized rate per 100,000 - 2002/10). However, even though mortality statistics for young people are not high in St Helens there are many health and lifestyle factors in need of further improvement.
Hospital admissions

In the early years of life problems relating to pregnancy, infections, injuries, some childhood cancers and genetic problems are the main causes of admission to hospital. The two tables below show the top 10 admissions to hospital either as an emergency or planned admissions.

There are four times more emergency admissions than elective admissions in this age group. This is due to the fact that many admissions are the result of infections which young children may not have the immunity to fight effectively, therefore these can be serious and present a significant risk.

### Emergency admissions 0-4 years 2010/11

<table>
<thead>
<tr>
<th>Condition Type</th>
<th>% of total</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the respiratory system</td>
<td>30.4%</td>
<td></td>
</tr>
<tr>
<td>Certain infectious and parasitic diseases</td>
<td>18.8%</td>
<td></td>
</tr>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>13.2%</td>
<td></td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>9.6%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>8.6%</td>
<td></td>
</tr>
<tr>
<td>Certain conditions originating in the perinatal period</td>
<td>8.3%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>1.9%</td>
<td></td>
</tr>
<tr>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>1.0%</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>2200</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Planned admissions 0-4 years 2010/11

<table>
<thead>
<tr>
<th>Condition Type</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>21.8%</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>19.2%</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>11.3%</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>9.6%</td>
</tr>
<tr>
<td>Factors influencing health status and contact with health services</td>
<td>7.3%</td>
</tr>
<tr>
<td>Diseases of the eye and adnexa</td>
<td>6.6%</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>6.0%</td>
</tr>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>4.5%</td>
</tr>
<tr>
<td>Diseases of the ear and mastoid process</td>
<td>3.6%</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>2.8%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>532</strong></td>
</tr>
</tbody>
</table>
Smoking in pregnancy
Smoking in pregnancy can have an impact on the weight of the baby, increase the likelihood of premature delivery, still births and breathing problems and increase the risk of cot death.

Good progress has been made to reduce the number of women smoking during pregnancy. In 2009/10, 24.17% of mothers were smoking at time of delivery, this has fallen considerably to 21.8% in 2010/11. However, locally smoking in pregnancy remains much higher than the national rate of 13.6% in the country as a whole.

Breast feeding initiation
Breast feeding is known to help to protect the baby from infections and diseases. Breastfed babies have fewer chest and ear infections and are therefore less likely to have an attendance at hospital, they are less likely to suffer from diarrhoea and vomiting, less likely to become obese and develop type II diabetes and have less chance of developing eczema. Breast feeding can also have an impact on both infant mortality and life expectancy at birth.
In addition to these health benefits for the baby breastfeeding can increase the development of the bond between mother and baby, reduce the mothers risk of developing breast and ovarian cancer and use up to 500 calories a day therefore naturally impacting on weight loss post birth.

In St Helens 48.7% of mother initiate breastfeeding, compared with 74.5% nationally. By 6-8 weeks this has reduced to 19.5%, compared with 45.2% nationally.

Childhood vaccination
Childhood infections can have a significant impact on mortality, overall health and wellbeing and can also have an impact throughout schooling. Therefore, increasing the uptake of vaccination for children helps to minimise the risk of preventable childhood illnesses and reduces the pool of infections in the community, therefore reducing the population risk.

Vaccinations include Diptheria (D), Tetanus (T), Pertussis (aP) Polio (IPV), and Haemophilusinfluenzae type b (Hib) which is a 5 in one vaccine; MMR (Measles, Mumps and Rubella), Meningitis C, Meningitis C and Haemophilusinfluenzae type b booster and pneumococcalconjugate vaccine. The percentage uptake by the age of 2 in Halton and St Helens is lower than the uptake for both England and the North West but local data shows that when St Helens information is analysed uptake is similar to England levels and is better for some vaccination areas.
By the age of 5, the uptake of DTaP primary is higher than the national average and both doses of MMR are similar to the national average. However, the booster for DTaP/IPV and Hib have low uptake.

Figure 26: Vaccination uptake at age 2 2010/11
Source: Information Centre and local data from Paris

Figure 27: Vaccination uptake at age 5 2010/11
Source: Information Centre and local data from Paris
Dental Health

Child dental health in St. Helens is significantly worse than the rest of England. The latest available national data (2007/8) suggests that only 3 wards in the borough have child dental decay levels similar to the national average of 31% of 5-year-olds with decay experience, and 1.11 teeth affected by decay. In the remaining 13 wards, child dental health is worse.

In 2008, the PCT implemented an evidence-based dental preventive programme designed to address the high levels of dental disease found in local children. The two key elements include:

- All children aged 3-11 years living in St. Helens receive through the post, twice yearly, a toothbrush and a tube of fluoride toothpaste. There is a wealth of research evidence to suggest that fluoride toothpaste helps to prevent tooth decay.
- All children attending their dentist are offered fluoride varnish three times per year.

Evaluation of the preventive programme in 2011, suggests that there has been a 21% reduction in the level of active decay in 5-year-olds in St. Helens and the percentage of 5-year-olds totally free from decay experience has increased by almost 6%. The evaluation has also identified that the programme had a greater impact on children from the more deprived sections of the community.

The key challenge for those responsible for improving child oral health is to ensure that the necessary resources continue to be made available in order that this evidence-based dental preventive programme remains embedded as part of a wider St. Helens oral health strategy.
Enable all young people to maximize their capabilities

Childhood (5 to 15 years)

Introduction
The early years help to shape a young person going into formal education. Both the health and wellbeing of the child and the people around them will help to shape their potential to achieve throughout school. The Marmot review showed a strong correlation between social deprivation and education attainment. The figure below shows that children with a low IQ at 22 months of age who live in more wealthy families improve their IQ over time. However the converse is true, so those with a high IQ at 22 months but who live in more deprived families experience a decrease in IQ.

![Figure 28: Inequality in early cognitive development of children in the 1970 British cohort study, at ages 22 months to 10 years](image)

As well as socio economic status, health status is linked with the ability of the family to work and be prosperous. We know that in St Helens 26.3% or 8560 of young people under 16 are classified as living in poverty this is higher than the overall levels for England as a whole 21.9%. The following statistics identify some of the health, education and welfare factors for young people that need to be a focus for attention in St. Helens.
Children achieving a good level of development at age 5

The highest priority in the Marmot review was the aim to give every child the best start in life, as this is crucial to reducing health inequalities across the life course.

Good development, emotional health and wellbeing of children and young people is vital both to themselves and society as a whole. Evidence shows that making a difference to children’s achievement in the early years is critical. Pupils who start off in the bottom 20 per cent of attainment at the Early Years Foundation Stage Profile (EYFS) aged five are six times more likely to be in the bottom 20 per cent at Key Stage 1.

This indicator is based on data collected from the EYFS. Children are normally assessed by a teacher in the year in which they turn five. The assessment is based on observation of the child’s behaviour and understanding. 55% of children in St.Helens were considered to have reached ‘a good level of development’ in 2010, this is slightly below the England average of 56%.

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>St.Helens</td>
<td>51</td>
<td>55</td>
<td>57</td>
<td>55</td>
</tr>
<tr>
<td>North West</td>
<td>49</td>
<td>51</td>
<td>52</td>
<td>55</td>
</tr>
<tr>
<td>England</td>
<td>46</td>
<td>49</td>
<td>52</td>
<td>56</td>
</tr>
<tr>
<td>DFES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 29: School Readiness 2007 -2010

Obesity in children

Obesity represents the point where weight gain poses a serious threat to health. It results from an energy imbalance, taking in more energy than is used. Getting the right balance in children is difficult as a child’s growth is only possible if energy intake (food and drink) exceeds the energy spent. If the intake exceeds that needed for growth, then the excess is stored as fat and the child becomes overweight.

Early diet has an impact on the health of young people and their health into adulthood. Due to an increase in the number of obese children more young people are being diagnosed with type II diabetes at an early age and overweight children are more likely to grow up with problems such as heart disease. Nationally, almost a third of children are either overweight or obese and projections by the Government Office for Science's Foresight programme, demonstrate that without serious action, this figure will rise to two-thirds by 2050.

In St Helens 10.1% of children weighed in reception class in school (age 4-5) were classified as obese compared with 9.4% nationally (2010/11). Although higher than national rates, age 4 to 5 year old rates are not significantly high and there has been a decrease in each cohort since 2006/07.
By the time young people have reached year 6 (age 10-11) the percentage of children who are obese increases to 21.9% compared with 19% nationally. There have been small improvements in obesity levels in St.Helens over the last few years however this is still an area for continued work especially in the period between reception and year 6 to stop reduce the increase in obesity.

Adult obesity is greatly linked with childhood obesity it was found that only 3% of overweight or obese children have parents who are not overweight or obese (Cross-Government Obesity Unit, 2008). Therefore an important part of tackling childhood obesity is linked with the whole family.

Young people and alcohol

Alcohol specific admissions to hospital for young people under 18 have remained constant in St Helens over the period 2003/06 to 2007/10. However the rate remains significantly higher than England. This corresponds with the percentage of young people who report being drunk in the past 4 weeks. In St Helens the percentage is 19% compared with 15% in England as a whole. Risk taking behavior associated with alcohol can not only have a health impact for the young person but links to other poor outcomes such as poor sexual health, violence and crime.

Admissions to hospital for self harm in young people in St.Helens is high as well as other risk taking behaviours such as substance misuse and teenage conceptions, these are indicators which are affected by mental health and wellbeing of young people and therefore this is an area for further improvement.

Children and young people smoking

Data on young people who reported to have smoked in the last 4 weeks is significantly higher than national levels in St Helens 5% compared with 4% nationally.
Looked After Children

Children and young people come into the care of the local authority, either on a voluntary basis with the agreement of parents or through a decision in the Family Courts. This may be necessary to protect the child from harm, or because the family is in need of support due to a crisis or particular circumstance. These are referred to as Looked after Children (LAC).

Looked after children (LAC) are one of the most vulnerable groups in society and it is recognised that children in care often have higher levels of needs than children and young people from similar backgrounds. A poor start in life, neglect, placement moves and many transitions mean that these children may be at risk of having inequitable access to health services, both universal and specialist.

Nationally all children in care are subject to a health plan. Health assessments must be undertaken twice a year for children under 5 years, and annually for children and young people 5 years and over. These assessments for the younger age group monitor; attachment behavior, physical health, growth, diet, immunizations, oral health and developmental milestones for example, speech and language, motor function, vision and hearing and play skills. Government standards also require that all children who had been looked after continuously for at least 12 months should have an up-to-date immunisation record and their teeth checked by a dentist.

Over the last year all LAC in St. Helens had up to date immunizations and a greater number of children had their teeth checked by a dentist and received their annual health assessment than in 2010/11. The most recent data for 2011/12 for St. Helens is captured in the table below and comparative data for 2010/11 is in the table at the bottom.

<table>
<thead>
<tr>
<th></th>
<th>Number of children looked after at 31 March who had been looked after for at least twelve months</th>
<th>Number of children whose immunisation s were up to date</th>
<th>Number of children who had their teeth checked by a dentist</th>
<th>Number of children who had their annual health assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Helens</td>
<td>271</td>
<td>100%</td>
<td>95%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Figure 32a: Looked After Children health outcomes return 2011/12

<table>
<thead>
<tr>
<th></th>
<th>Number of children looked after at 31 March who had been looked after for at least twelve months</th>
<th>Number of children whose immunisation s were up to date</th>
<th>Number of children who had their teeth checked by a dentist</th>
<th>Number of children who had their annual health assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Helens</td>
<td>270</td>
<td>100.0</td>
<td>85.2</td>
<td>83.3</td>
</tr>
<tr>
<td>North West</td>
<td>8390</td>
<td>75.6</td>
<td>86.4</td>
<td>90.0</td>
</tr>
<tr>
<td>England</td>
<td>46090</td>
<td>79.0</td>
<td>82.4</td>
<td>84.3</td>
</tr>
</tbody>
</table>

Health outcomes for looked after children 2010/11

Figure 32b: Looked After Children health outcomes 2010/11
Children with speech and language needs

The Child and Maternal Health Observatory provides estimates of the incidence of issues requiring speech and language development support. Although it does not provide data on the total number of children and young people who have speech and language difficulties (the prevalence), it is helpful in determining an estimate of service demand.

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens</td>
<td>91</td>
<td>46</td>
<td>138</td>
</tr>
</tbody>
</table>

2008, Chimat

Figure 33: Estimated incidence of speech and language needs

Children with disabilities

Children with long-term disability are a diverse group. Some will have highly complex needs requiring multi-agency support across health, social services and education – the most extreme example perhaps being those who are technology-dependent. Other children will require substantially less support, although nevertheless have a long-term disability.

There have been many attempts to provide accurate estimates of disability in children and young people. Some of these have provided condition based estimates based on the literature and others have utilised specific survey data. Information on self-reported (by the parent) long-standing illness or disability is provided from the General Household Survey. Routine data are collected by local authorities on children with statements of Special Educational Needs, but this does not reflect the spectrum of disability and is only a weak proxy measure for severity.

The number of disabled children in England is estimated to be between 288,000 and 513,000 by the Thomas Coram Research Unit (TCRU). The mean percentage of disabled children in English local authorities has likewise been estimated to be between 3.0 percent and 5.4 percent. If applied to the population of St Helens this would equate to between 1,645 and 2,960 children experiencing some form of disability.

In 2011-2012 there were 269 child (under 19) referrals to the St.Helens Occupational Therapy Service. Due to improvements in healthcare children with disabilities now have a greater chance of survival and an increased life expectancy, this has resulted in an increase in demand for occupational therapy services.

The table below presents information about children with disabilities who have been referred to the Community Paediatric Occupational Therapy Service, these can be young people with a range of disabilities from emotional, psychological, cognitive and physical disabilities which affects their ability to function within their own homes.

<table>
<thead>
<tr>
<th></th>
<th>2009-2010</th>
<th>2010-2011</th>
<th>2011-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex referrals</td>
<td>57</td>
<td>79 (38.6% increase)</td>
<td>128 (62% increase)</td>
</tr>
<tr>
<td>Non Complex referrals</td>
<td>79</td>
<td>83 (5.1% increase)</td>
<td>141 (69.9% increase)</td>
</tr>
<tr>
<td>Total</td>
<td>136</td>
<td>162 (19.1% increase)</td>
<td>269* (66% increase)</td>
</tr>
</tbody>
</table>

Figure 34: Referrals to the St.Helens Occupational Therapy Service
The aims of the Community Paediatric Occupational Therapy service are:

- To provide advice and support for people who have a disabled child within their family.
- To assess children from age 0 - 19 years.
- To provide a thorough assessment within the home to look at all the problems the family are facing.
- To provide various pieces of prescriptive equipment to increase a client’s independence and function, and also to prevent injury or risk to carers.
- To regularly review the equipment prescribed to ensure suitability, size and function for the child.
- To assess the child’s long-term needs in relation to major adaptations and can assist in the process of designing the facilities required for that individual.
- If the property cannot be adapted, we can also help to find a more suitable home.

The increase in referrals and complexity of cases, are attributed to:

- An increased range of medical conditions. There are now more referrals for children with complex health needs, such as children at home with technology, for example, tracheostomy, ventilators, home dialysis, total perinatal nutrition etc.
- The number of referrals for the under 3 age group is also increasing. This is due to the improved survival rates of premature births, now it is not uncommon for children to be born and survive at 26 or 27 weeks gestation. However with the ability to preserve life, these children will often have complex medical needs and require intervention from OT at an early stage, and will may need support throughout their lives.
- With medical advances and health staff being able to support and preserve life through medical advances and medication, children are now living for longer periods following critical health problems.

Mental Health and Self Harm

Self-harm has been defined by NICE as ‘self-poisoning or self-injury, irrespective of the apparent purpose of the act’ and is reported as part of the child health profiles nationally which indicates that St Helens is statistically significantly higher than England for admissions to hospitals for young people that self-harm.

Self harm indicates that the young person may be experiencing other problems, for example:

- Being bullied at school
- Not getting on with parents
- Stress and worry about academic performance and not getting on with examinations
- Parental divorce
- Bereavement
- Unwanted pregnancy
- Experience of abuse in earlier childhood (whether sexual, physical, neglect and/or emotional) - severe and prolonged sexual abuse is known to lead to a higher incidence of self-harm.
- Difficulties associated with sexuality - lesbian, gay, bisexual and transgender young people are estimated to be two or three times more likely to self-harm than heterosexual young people, and homophobic bullying at school is implicated in higher rates of self-harm.
- Problems to do with race, culture or religion
- Low self-esteem
- Feeling rejected.
The data below shows how St Helens admissions for self harm compare to other areas in the North West and England as a whole. As can be seen St Helens has the third highest rate across the North West.

![Graph showing hospital admissions for self harm](image)

**Figure 35: Hospital Admissions for self harm**

Rate of emergency hospital admissions for self-harm (0-18 years) per 100,000 population. North West local authorities, 2007/08-2009/10 Source: North West CHIMatters July 2011

Being admitted to hospital for self harm in children is recommended NICE guidance and local hospitals indicate they are following this guidance. North West Chimat report states that females are 3.7 times more likely to self-harm than males. An analysis of local data shows over the last 4 years that the method most likely to be used is overdosing on over the counter medicines but the second most common method is using a sharp instrument. In order to understand more fully the implications and potential upstream interventions to improve this statistic an audit of the information is being carried out. However with other risk factors in young people being negative and this is an indicator of emotional health and wellbeing of young people this area should be a priority area.

**Young Carers**

A young carer can be defined as a child or young person under the age of 18 who provides or intends to provide care, assistance or support to another family member. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility which would normally be associated with an adult.

By applying the latest available research to the population of St.Helens it is estimated that up to 2,440 young people are providing some form of care. Currently only a small proportion of young carers are identified and supported by services. Accurate data is difficult to obtain, as often young people do not think of themselves as being a young carer. Local anecdotal evidence suggests than many young carers suffer from mental and physical ill health and stress. Young carers also report missing school because of their caring responsibilities and being the victim of bullying.
Young People

Introduction
Inequalities in educational attainment can have an impact on health and wellbeing of young people. By the time a young person has reached the age of 15 and throughout the early adult years young people will be extending their learning and skills development. How successful they are in relation to education and skills will set them on the pathway for their life in relation to employment. Young people will achieve if they have life skills where they can take control of their life, as well as work specific skills. However, the current economic climate presents significant challenges for young people in St.Helens. National research shows that as well as material wellbeing, recession negatively affects emotional wellbeing and mental health. Conditions arising from or made worse by economic recession range from worry to clinical depression and anxiety. Over a quarter of 17-19 year olds say they are worried about what they see on the news about the recession. 12% of 16–25 year olds feel that life is ‘meaningless’, with 27% feeling ‘often’ or ‘always’ down or depressed.

Key messages

- This age group is facing significant social challenges. Youth unemployment has grown significantly over recent years and changes to the welfare system make it very difficult for young people to be independent as access to affordable housing remains a problem.
- Mortality is low in this age group but infections and accidents and injuries are the most likely causes of death.
- The main causes of hospital admissions are also infections, accidents and injuries.
- Hospital admissions for substance misuse are some of the highest rates in the country and alcohol misuse remains a concern.
- Teenage pregnancy rates remain too high and the rate of abortions for Halton and St Helens are higher than for England.
- Prescribing of evidence based contraception (long acting reversible contraception) in general practice is lower than for England.
- There is an effective Chlamydia screening programme that is identifying high levels of Chlamydia in the 15-24 year old age group.
Data Summary

Mortality
Overall mortality in this age group is very low, however where there are deaths they often related to injuries and accidents. In 2009 the total number of deaths of 15-24 year old was 13 and the majority were male deaths.

Hospital Admissions
In relation to hospital admissions, injuries and poisoning are a major cause with genitourinary, digestive, respiratory and pregnancy also feature for both emergency and planned admissions showing the major hospital health priorities for this age group.

<table>
<thead>
<tr>
<th>Emergency admissions 15-24 year olds 2010/11</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>29.4%</td>
</tr>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>21.2%</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>7.6%</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>7.3%</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>6.8%</td>
</tr>
<tr>
<td>Pregnancy, childbirth and the puerperium</td>
<td>6.7%</td>
</tr>
<tr>
<td>Mental and behavioural disorders</td>
<td>5.9%</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>3.1%</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>2.7%</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1860</strong></td>
</tr>
</tbody>
</table>

Figure 36: Emergency admissions in the 15-24 year old 2010/11 by top 10 causes

<table>
<thead>
<tr>
<th>Planned admissions 15-24 year olds 2010/11</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the digestive system</td>
<td>17.9%</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>12.1%</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>10.7%</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>8.6%</td>
</tr>
<tr>
<td>Factors influencing health status and contact with health services</td>
<td>7.3%</td>
</tr>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>7.1%</td>
</tr>
<tr>
<td>Pregnancy, childbirth and the puerperium</td>
<td>6.9%</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>6.8%</td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>6.6%</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>5.1%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1384</strong></td>
</tr>
</tbody>
</table>

Figure 37: Planned admissions in the 15-24 year olds 2010/11 by top 10 cause
Alcohol

Alcohol specific admissions to hospital start to rise in this age group, this can be seen in the chart in the working age adult section of the report. Between 2007/08-2009/10 the rate of under 18s being admitted to hospital for alcohol specific conditions was 133.6 per 100,000, this is one of the highest rates in the country, and much higher than the national and regional average. Young women aged 15 to 19 are more likely to admitted than males. However, after the age of 20 this males are the most likely to be admitted to hospital.

Risk taking behaviour in this age group can have an impact on the ability to achieve either academically or within employment. In the short term alcohol can make young people vulnerable and unsafe, and in the long term it can cause serious harm to a person’s health. Drinking alcohol can be linked to a higher prevalence of sexually transmitted infections and unwanted pregnancies resulting in termination.

Substance misuse

Hospital admissions for substance misuse in the 15-24 years olds in St Helens are one of the highest in the country at 162.2 per 100,000 15to 24 year olds, the highest rate in the country is only slightly higher at 163.6. The rate for the whole of England is 63.5, showing St Helens is an outlier in this area. The numbers are small and so will show variation never the less the figures are very high.

Sexual health

Teenage years and early adulthood are important times when young people discover sex. Our aim is to provide information and advice so that young people embarking upon sexual activity can have a positive experience. Teenage pregnancy has already been identified as an area that remain a priority. Young people 15-24 are categorized at risk of STIs and unwanted pregnancies.

Teenage Pregnancy

Teenage conceptions are linked with poor health and social outcomes for both mother and where there is a live birth the baby, perpetuating a cycle of poverty. Teenage mothers are less likely to finish education and opportunities that come with this and so are more likely to live in poverty. The infant mortality rate for babies born to teenage mothers is 60% higher than babies born to older mother. Teenage mothers are 3 times more likely to suffer postnatal depression than older mothers and have a higher risk of poor mental health 3 years after the birth. Children of teenage parents have an increased risk of living in poverty, low educational attainment, poor housing and poor health and have lower rates of economic activity in adult life.

Teenage conceptions are the rate of conceptions in females under age 18 expressed as a rate per 1,000 of the 15-17 year old population. The rate of conceptions in 1998, which was the baseline year for the national Teenage Pregnancy Strategy in St Helens was 55.5 and by 2010 the rate was 51.2. Although there has been a 7.7% reduction over this time period the rate in St Helens is still higher than England and the North West rate and therefore still a priority.
Abortions

Abortions are an indicator of unwanted pregnancies and for Halton and St Helens national information indicates that age standardised abortion rates are higher than they are nationally (20 per 1000 compared with 17.6 for England). This means that women of all ages who do not wish to have a baby are either not using contraception or not using it effectively. The crude rates of abortions are particularly high in the 18-19 and 20-24 year old age group compared with national data.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Crude Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>17.6</td>
</tr>
<tr>
<td>North West</td>
<td>18.3</td>
</tr>
<tr>
<td>Halton and St Helens</td>
<td>20.0</td>
</tr>
</tbody>
</table>

Figure 39: Abortion rate 2010

Contraception

Access to contraception is dependent on the type of contraception that is being delivered. The majority of contraception in Halton and St Helens is delivered either by your local doctor (GP) or your community sexual health service. Local doctors provide contraception as part of their core contract but this does not include all methods. Methods of contraception called Long Acting Reversible Methods are generally
provided by general practitioners who have been trained and provide this as an additional service and community sexual health clinics. All GP's should however have a conversation with a women about which method of contraception would be best for them and refer them to a local clinic if they do not provide this service. Long Acting Methods of Contraception (LARC) are evidence based and more effective according to NICE (National Institute of Clinical Excellence). In Halton and St Helens in order to try and reduce unwanted pregnancies services have been asked to ensure that LARC methods are discussed and offered as an option as a result there has been an increase in the use of LARCs in community sexual health clinics. In 2010/11 34% of women seeking advice for contraception chose a LARC this compares with 28% nationally. However uptake of LARC within General Practice is low, despite training opportunities being offered to Doctors and Nurses in General Practice and knowledge that LARC prescribing has increased in primary care, 2009/10 data shows that 28.8 per 1000 14-44 year old women were offered LARC in primary care this compared with 46.9 per 1000 women nationally.

Sexually transmitted infections

Chlamydia

With high levels of sexual activity in this age group and high levels of risk taking behaviour, this age group is more likely to have a sexually transmitted infection. Many sexually transmitted infections can be present with no or few symptoms and so pro-active advice and testing is encouraged for those ‘at-risk’. As a result the most prevalent bacterial sexually transmitted infection Chlamydia became a national screening programme in this age group. Targets have been set to test 35% of the 15-24 year old population for Chlamydia which is changing this year 2012/13 to proactively finding 2400 per 100,000 populations in this age and treating them appropriately.

![Percentage of the 15-24 year old population screened for Chlamydia 1st April 2011 to 31st March 2012](source: The Health Protection Agency, 2012)

Figure 40: Chlamydia
Unverified data for 2011/12 shows that St Helens exceeded the uptake target and screened 38% of young people 15-24 years old. Community screening and testing in GUM services means that locally the levels of positive cases in the community in 2011/12 were 2623 per 100,000 15-25 year olds. This means that locally our services are proactively finding young people and ensure that they are treated and partners are also tested and treated. Moving forward screening needs to be more targeted within this age group as data from the services suggests which young people are more likely to be positive for this infection.

**Other sexually transmitted infections**

In Halton and St Helens diagnosis of most sexually transmitted infections are lower than North West levels apart from Herpes. HIV and AIDS diagnosis are low but have seen steady increases with the latest data for 2010 indicating 53 people with a diagnosis lived in St Helens this is a 61% increase since 2005 when just 33 people in the authority were diagnosed with HIV/AIDS. The new public health outcomes framework has a target to reduce the number of people with HIV being diagnosed late. In St Helens in 2010 there were 3 new cases and 1 was asymptomatic and diagnosed early whereas the other 2 the stage of disease was not known. Of all the cases in St Helens 32.1% are asymptomatic and only 17% with AIDS, however 34% the stage of disease is not known from the data collection, therefore difficult to ascertain if patients are being identified early. Sixty two percent of cases are infected through men who have sex with men and 34% are heterosexual, so a priority is working with the gay men to ensure health protections measures are being effectively delivered.
Working Age People

Introduction
It has been well established that being in good employment helps with positive health and conversely unemployment is bad for health. Therefore access to employment opportunities are essential to reduce health inequalities, this is challenging during periods of recession especially for areas such as St.Helens that have had high unemployment, as already stated unemployment locally has hit women and young people hardest during this recession. Whilst employment and income are important for health lives the environment and communities in which live also have an impact on our health. Communities can help to create environments that are conducive to healthy behaviours this can be both in relation to the physical environment but also the resources and interaction within communities.

Key messages

- Deaths in the age group are similar to those of our peer areas and the North West as a whole but higher than the England rate.
- Deaths over time for the two major causes of death cancers and circulatory (heart disease, stroke and other) have reduced significantly.
- Cancer is the major cause of death in this age group.
- Alcohol issues are prevalent in this age group and St Helens has some of the worst statistics in the country.
- Improving healthy lifestyle choices such as healthy weight, exercise, reducing alcohol consumption, reducing smoking prevalence will help to reduce the risks of developing problems due to circulatory problems, diabetes and certain cancers. Therefore improving access to evidence based interventions for these lifestyle factors will help improve health outcomes in St Helens.
- Early identification of and chronic conditions in general practice needs to improve such as, hypertension, diabetes, heart disease, stroke.
- Improving uptake of cervical and bowel screening and the variance by general practice within all cancer screening programmes will improve health outcomes for adults and older people.
- Although some surveys show that mental wellbeing in Halton and St Helens is good, some statistics show there are still underlying problems such as deaths from suicide and injury undetermined is increasing with men being most greatly affected. Hospital admissions for injuries and poisonings are high and whilst many will be accidental there will be an element of these that are deliberate.
Data Summary

Mortality

The main causes of death begin to change in this age group, environmental and mental health mortality are the main causes of deaths in the younger age groups, for example, accidental injuries and suicides and injuries undetermined. In the working age population health related problems linked to lifestyles, genetics and the wider environment, account for the majority of deaths, for example cancers and circulatory diseases such as heart disease.

Trend data for mortality due to all causes in the 15-64 age group shows that in St Helens rates have decreased over time but at the same rate as those of its peer group of authorities, Industrial Hinterlands and the North West but are still higher than England as a whole and the gap between St. Helens and England has not decreased.

![Trends in mortality for all causes, 15-64 year olds, Directly age standardised mortality rates per 100,000 population](image)

Figure 41: Trends in mortality from all causes 15 -64 year olds, directly standardised rates per 100,000 population

The major causes of death in this age group are cancers, circulatory diseases, digestive diseases mainly liver disease, external causes such as accidents and respiratory, in that order. Liver disease in this age group is the third biggest cause of death, showing that alcohol related deaths have a particular impact on this age group.

The biggest causes of cancer deaths in this age group are digestive cancers, then lung and breast cancer. Most of the cancers are in the older age groups in this age group, liver disease deaths however are more evenly spread. The biggest single cause of circulatory disease deaths is due to heart disease and this is more prevalent in the older age groups in this age cohort.

Both Cancer and Circulatory disease deaths have been subject to local targets under the age of 75, as these two causes are the most significant cause of early death. Deaths from circulatory disease in St Helens have reduced since 1993 and although there has been variation in the rate over time by 2008/2010 the rate had reduced as had the gap between England and St Helens. We expect to see a further improvement in the rate for 2011.
As mentioned cancers are the biggest causes of death in the 25 to 64 year old age group. Data on early deaths from cancer have been monitored and interventions have been in place to detect cancers to reduce the death rates in the under 75’s. St Helens death rates have been reducing over time but have been on a par with the North West in the past 17 years. There has been a slight narrowing of the gap between St Helens and England but the rates still are significantly higher than England.

**Hospital admissions**

Thirty eight percent of all admissions to hospital are emergencies, the highest proportion of these are due to signs and symptoms not classified in the major disease categories. Within emergency admissions, injuries and poisonings are the biggest cause of admission. Mental health also appears within the top 10, this could be related to some poisoning admissions.

In order to ensure that health services are meeting health needs we would want to see more people receiving care for the health issues early and therefore only be admitted to hospital in a planned way and not as an emergency, therefore we would like to see the proportion of emergency admissions reduced.

<table>
<thead>
<tr>
<th>Emergency admissions</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>22.4%</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>17.3%</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>11.6%</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>8.1%</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>7.4%</td>
</tr>
<tr>
<td>Mental and behavioural disorders</td>
<td>6.8%</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>5.7%</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>4.7%</td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>3.2%</td>
</tr>
<tr>
<td>Pregnancy, childbirth and the puerperium</td>
<td>2.8%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8520</strong></td>
</tr>
</tbody>
</table>

**Figure 42: Emergency Admissions**

In terms of planned admissions to hospital the biggest causes are digestive disease, followed by diseases of the genitourinary system and musculoskeletal system.

<table>
<thead>
<tr>
<th>Planned admissions</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the digestive system</td>
<td>21.5%</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>16.1%</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>14.3%</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>9.5%</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>8.0%</td>
</tr>
<tr>
<td>Symptoms, signs and abnormal clinical &amp; laboratory findings, not elsewhere classified</td>
<td>6.3%</td>
</tr>
<tr>
<td>Factors influencing health status and contact with health services</td>
<td>6.0%</td>
</tr>
<tr>
<td>Diseases of the eye and adnexa</td>
<td>3.3%</td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>3.2%</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>13588</strong></td>
</tr>
</tbody>
</table>

**Figure 43: Planned Admissions**
Lifestyle factors
Lifestyle choices such as what we eat and drink and how much exercise we take will have an effect on our health but very rarely will these lifestyles have an impact on health immediately and a cumulative effect on years of different lifestyle choices will have an impact normally later in life, but as seen with the mortality the effects of liver disease are having an impact on younger populations. In this section we summarise those factors which have the biggest impact on health in St Helens.

Smoking prevalence
Smoking is still the single biggest factor in terms of preventable mortality and whilst there has been a decrease in smoking prevalence nationally and in St.Helens there is an inequality between smoking prevalence in routine and manual groups and the rest of the population. This links with inequalities relating to health problems and deaths where those populations in the most deprived areas are more likely to have poorer health outcomes.

Stopping smoking using smoking cessation services with support and Nicotine Replacement Therapies are evidence based and cost effective. Data from the Integrated Household survey (April 2010 – March 11) indicates that smoking prevalence is 20.5% which is lower than the North West (22.8%) and England average (20.7%). However in manual workers local prevalence is 32.3% showing that smoking cessation services need to focus on more deprived areas to make a difference to health outcomes and health inequalities.

Data from smoking cessation services shows that 4 week quit rates as a percentage of those people accessing the service are not linked necessarily linked to areas where manual workers are more likely to be. Despite good access to services in all areas it may be that current services are not effective and therefore current provision in these areas may need to be reviewed.
Alcohol issues

Alcohol misuse is the most recent public health issue, causing health related problems such as liver disease but having a large impact on the NHS in relation to activity such as A&E attendances but also a greater issue relating to crime and disorder and loss of economic activity due to under performing individuals or people off sick from education or employment. Alcohol has already been highlighted as an issue in young people but the health effects start to take hold in the 25-64 year old age group. Hospital admissions for alcohol in men are highest in the 50-54 year olds but it can be seen in the figure 45 that it is high throughout this age group for both men and women.
The exact prevalence of alcohol problems locally is unknown as is the percentage of the local population exceeding the recommended levels of alcohol units per week, however St.Helens generally has high levels of mortality relating to chronic liver disease and higher levels of alcohol admissions to hospital. A summary of the statistics in the Alcohol Profiles where St Helens is worse than national levels is shown below. St.Helens has the second highest rate of Chronic Liver Disease for females in the country.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>National Rank</th>
<th>Regional average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol specific mortality</td>
<td>21.9 (M), 15.4 (F)</td>
<td>301 (M), 324 (F)</td>
<td>19 (M), 9.9 (F)</td>
</tr>
<tr>
<td>Mortality from chronic liver disease</td>
<td>22.1 (M), 17.9 (F)</td>
<td>299 (M), 325 (F)</td>
<td>20.6 (M), 11.3 (F)</td>
</tr>
<tr>
<td>Alcohol attributable mortality</td>
<td>65.3 (M), 24.6 (F)</td>
<td>322 (M), 319 (F)</td>
<td>45.7 (M), 19.6 (F)</td>
</tr>
<tr>
<td>Alcohol specific hospital admissions</td>
<td>894.7 (M), 478.4 (F)</td>
<td>320 (M), 324 (F)</td>
<td>666.4 (M), 348.1 (F)</td>
</tr>
<tr>
<td>Alcohol attributable hospital admissions</td>
<td>2083.3 (M), 1155.4 (F)</td>
<td>316 (M), 311 (F)</td>
<td>1807.4 (M), 1044.8 (F)</td>
</tr>
<tr>
<td>Claimants on incapacity benefit - working age</td>
<td>129.8</td>
<td>268</td>
<td>173.4</td>
</tr>
<tr>
<td>Employees in bars as a % of all employees</td>
<td>2.7</td>
<td>239</td>
<td>2.1</td>
</tr>
</tbody>
</table>

**Figure 46: Local Alcohol Profile England profiles**

**Obesity**

People who are obese are at an increased risk of a number of chronic conditions, such as
- Type 2 diabetes - 90% of people with type 2 diabetes have a body mass index (BMI) of greater than 23 kg m$^{-2}$. 
- Hypertension - 5× risk in obesity, 85% associated with a BMI greater than 25 kg m$^{-2}$, 66% linked to excess weight.
- Coronary artery disease (CAD) and stroke - 3.6× risk of CAD for each unit change in BMI.
- Cancers - 10% of all cancer deaths among non-smokers are related to obesity (30% of endometrial cancers).
- Maternal obesity has been related to higher levels of infant mortality amongst Routine and Manual groups. A reduction in the prevalence of obesity amongst this group to 23% has been modelled as an evidence based intervention to reduce infant mortality (Department of Health, 2007).

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

In St.Helens data from the Health Survey for England indicates that local obesity rates affect around a quarter of the adult population and this has remained static in the past 2 surveys.
These rates are slightly higher than the North West and England obesity levels. General practices measure obesity in people aged over 16 as part of the quality and outcome framework for 2010/11 overall prevalence in St Helens was 13.98.

This indicates that recording of obesity in general practice is lower than the expected rate, therefore, it is possible that health promotion information and health interventions are not being offered to as many people in St Helens that are obese as possible. Late identification of health issues such as obesity could have an impact on overall health outcomes.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens</td>
<td>25.3</td>
<td>25.4</td>
</tr>
<tr>
<td>North West</td>
<td>24.5</td>
<td>23.4</td>
</tr>
<tr>
<td>England</td>
<td>23.6</td>
<td>24.2</td>
</tr>
</tbody>
</table>

Source: APHO 2010

Figure 47: Estimates of Obesity rates in St Helens 2003/05 - 2006/08 HSfE

**Healthy eating and physical activity**

Linked with obesity is healthy eating and physical activity. A healthy diet and exercise will reduce the risk of overweight and obesity and the associated health problems. It has been recognised that a diet high in fruit and vegetables but low in salt and saturated fats can reduce the risk of cardiovascular disease. Increased consumption of wholegrains reduces the risk of heart disease by 25% and an increased portion of fruit or veg can reduce the risk of heart disease by 4% and stroke by 5% (Joshipura KJ, et al (2001) The effect of fruit and vegetable intake on risk for coronary heart disease. Annals of Internal Medicine; 134: 1106-14.). Following a low fat diet on average lowers blood cholesterol levels by 5.3% over 6 months (Press V. (2004) Nutrition & food poverty: a toolkit for those involved in developing or implementing a local nutrition and food poverty strategy London: National Heart Forum).

In St.Helens only 22% of the population eat 5 portions of fruit and vegetables a day based on the Health Survey for England and this has only increased by 1% between surveys, whereas the North West as a whole and England have seen increases and the levels of fruit
and veg consumption in both is statistically significantly higher than in St Helens. Data locally shows that consumption of fruit and veg decreases in areas of high deprivation.

<table>
<thead>
<tr>
<th></th>
<th>Fruit and Veg prevalence % 2009 (using 2003-05 HSFE)</th>
<th>Fruit and Veg prevalence % 2010 (using 2006-08 HSFE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens</td>
<td>21</td>
<td>22.05</td>
</tr>
<tr>
<td>North West</td>
<td>23.6</td>
<td>26.18</td>
</tr>
<tr>
<td>England</td>
<td>26.3</td>
<td>28.65</td>
</tr>
</tbody>
</table>

**Figure 48: Fruit and Vegetable Consumption** Source: APHO 2010

Being physically active can help to reduce weight and also can have an impact on blood pressure and cholesterol levels. The table below shows that the percentage of the population in St Helens that takes part in physical activity 3 times a week has slightly increased since 2006 although it is slightly lower than England and the North West as a whole.

The proportion of the adult population regularly exercising is less than a quarter, increasing this uptake is a challenge, however there is evidence to show that the correlation with physical activity and being less deprived i.e. more active in the less deprived areas. The health benefits are in the less deprived areas so negative health is correlated with deprivation.

<table>
<thead>
<tr>
<th></th>
<th>St. Helens</th>
<th>North West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult participation in sport (%) (2006)</td>
<td>19.6</td>
<td>20.6</td>
<td>21.0</td>
</tr>
<tr>
<td>Adult participation in sport (%) (2009)</td>
<td>20.1</td>
<td>22.11</td>
<td>21.74</td>
</tr>
</tbody>
</table>

**Figure 49: Adult participation in sport**
Source: Sport England

**Chronic Diseases**
Many of the risk factors identified above are an accumulation of long periods of unhealthy behaviours starting often in childhood but if continued through to adulthood have an impact on the prevalence of chronic diseases. The following sections show the prevalence of chronic diseases in St Helens.

**Hypertension**
Hypertension or high blood pressure which is persistently high is a risk factor for heart disease and stroke. Chronic hypertension is known as the ‘silent killer’ as it is often present with few symptoms. It is thought that around 3/5ths of men and around half of women have hypertension but are not receiving treatment.

Hypertension is considered to be one of the most important modifiable risk factors that can
help prevent early death relating to Cardiovascular conditions.

Modelled estimates of hypertension prevalence indicate that in St Helens prevalence is around 32.37% however based on quality and outcomes framework for 2010/11 in general practice just over 16% of patients were recorded as hypertensive. This means there is more work to be undertaken to ensure practices are testing, recording and treating hypertension effectively as this will impact on early deaths from Cardiovascular conditions. Although mortality from hypertension is low with only 15 deaths in 2010 it is on the increase and so it is important that high blood pressure is diagnosed early and treated appropriately.

**Coronary Heart Disease (CHD)**

Coronary heart disease is a condition in which the coronary arteries that provide the heart muscle with its blood supply become narrowed or blocked, reducing blood supply and depriving the heart of oxygen (ischaemia), resulting in chest pain (angina). A heart attack (myocardial infarction) occurs as a result of a complete or partial obstruction of a coronary artery causing death of cells in an area of the heart muscle. Risk factors for CHD can be subdivided into two groups - firstly, non-modifiable risk factors which include age, sex and ethnicity, and secondly, modifiable risk factors which include smoking, lack of regular physical activity, lifestyle, unhealthy diet, high alcohol intake, high blood pressure and diabetes. Coronary heart disease is the UK’s biggest killer, with one in every five men and one in every nine women dying from the disease.

Coronary heart disease deaths in St Helens have reduced significantly over the past 10 years. However the rate of deaths is still higher than England as a whole and the North West.

<table>
<thead>
<tr>
<th>Area</th>
<th>DSR per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens</td>
<td>91.69</td>
</tr>
<tr>
<td>North West</td>
<td>89.48</td>
</tr>
<tr>
<td>England</td>
<td>74.21</td>
</tr>
</tbody>
</table>

*Figure 51: Mortality rates due to CHD 2010*

Data from general practice’s (2010/11 Quality and Outcomes Data) shows the prevalence of CHD locally ranges from 2.9% to 6.2% of the practice population. For St Helens it is expected that the prevalence rate based on our demographics should be around 6.6%, this is based on data produced in 2011 from the Association of Public Health Observatories. Data is extrapolated to General Practice data which shows that only 6 practices have registered more people than expected with CHD based on prevalence models. This indicates that locally we are still under diagnosing CHD which will help improve management and life expectancy and overall death rates locally.
Stroke

Stroke is one of the diseases of the arteries and happens when blood supply to part of the brain is cut off. This can happen by a blockage of an artery cutting off oxygen to parts of the brain (ischaemic stroke) or bleeding from an artery in the brain (haemorrhagic stroke). Ischaemic strokes are the most common. A Transient Ischaemic Attack (TIA) or mini stroke is caused by brief delay in blood supply to part of the brain. Neurological dysfunction lasts for less than 24 hours, but this is often an important warning sign of a more serious stroke, heart attack or vascular event.

In St Helens the prevalence of Stroke is around 2% of the general practices population which is slightly lower than expected levels of 2.75%. Therefore many practices are effectively finding those who have had a stroke.

The recent publicity around FACE campaign will have helped the population as a whole to identify those who maybe suffering from a stroke and seek urgent help and treatment which will have an effect on health outcomes and disability.

Mortality rate due to Stroke are low in St Helens with 31 deaths in 2010. The rate has varied over time but over the past 3 years has been on par with England and lowers than the North West and peer authorities ’Industrial Hinterlands’.
Diabetes
Diabetes is a condition where the amount of glucose in your blood is too high because the body cannot use it properly. This is because your pancreas does not produce any insulin, or not enough, to help glucose enter your body’s cells – or the insulin that is produced does not work properly (known as insulin resistance). Diabetes is a chronic and progressive disease that has an impact upon almost every aspect of life. Diabetes is the leading cause of blindness in people of working age in the UK. It affects infants, children, young people and adults of all ages and is becoming more common. There are 4 sub-categories of diabetes; Type 1, Type 2, gestational and other. Type 2 is the most common and often used to be referred to as age onset diabetes as it affected people as they got older and put on weight, however due to the increase in obesity this Type is being seen in younger age groups.

Incidence and prevalence of diabetes is greater in areas of higher deprivation. People from ethnic minorities have six times higher than the average risk of developing diabetes. At least 5% of the NHS budget (10% of hospital in-patient spend) is spent on treating diabetes and its complications.

Models developed by the Association of Public Health Observatories expect that Diabetes prevalence will increase, they suggest that prevalence in St Helens is around 9.2%, however recorded prevalence in general practices in St Helens is 6.2% (2010/11 Quality and Outcomes Framework).

![Reported versus expected prevalence for Diabetes 2010-11, St Helens practices](Image)

Figure 54: General practice expected levels for diabetes against actual recorded 2010/11

Early detection is important to ensure that blood glucose is managed and health conditions such as diabetic retinopathy, limb loss, cardiovascular problems, renal failure are prevented. Deaths rates due to Diabetes are notoriously low, however it is often other associated health problems such as cardiovascular disease that Diabetics die from. It can be seen that no General Practice is identifying the expected number of their population with Diabetes.
Mental Health

Mental health is influenced by diverse biological and social risk factors, including fixed factors such as genetic factors and biographic characteristics (age and sex) and modifiable factors such as family and socio-economic characteristics (marital status, number of children, unemployment), individual circumstances (life events, social support, immigrant status, debt) household characteristics (accommodation type, housing tenure), geography (urban/rural, region) and societal factors (crime, deprivation index). (Foresight (2008). Mental Capital and Wellbeing Project (2008) Final Project Report The Government Office for Science, London)

The level of mental health issues in the population is often difficult to estimate effectively as not all people will seek help for their problem. It is estimated that around 1 in 4 people will suffer from mental health problems in any one year. The most common problem is anxiety and depression. Women are more likely to be treated for a mental health problem than men, this may relate to health seeking behaviour rather than prevalence. British men are 3 time more likely to die of suicide than British women. Self harm statistics show that the UK has the highest levels in Europe 400 per 100,000 population. Only 1 in 10 prisoners have no mental health problem.

A Mental Wellbeing Survey produced by the North West Public Health Observatory surveyed 500 people across Halton and St Helens and showed that based on the Warwick-Edinburgh Mental Wellbeing Scale (WEMWEBS) that mental wellbeing was positive in Halton and St Helens and only Warrington had a higher score (35.4% above average wellbeing in Halton and St Helens compared with 20.4% in the North West.

Data from general practice shows a variation in diagnosis of mental illness at practice level, with Eldercare the practice which has only older and patients with complex health needs registered has levels over 6%. The levels across the PCT are less than 1% in line with national and regional levels.

Data based on the Adult psychiatric morbidity survey in England 2007 indicates the expected

![Observed prevalence of Mental Health, QOF 2010-11, St Helens practices](image)

Figure 55: Observed levels of mental health in general practice 2010/11

numbers of mental health problems in St Helens and how this may change by 2020. Overall it is expected that numbers will decrease with all types of mental health problems.
People aged 18-64 predicted to have a common mental health disorder

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17,555</td>
<td>17,523</td>
<td>17,406</td>
<td>17,322</td>
<td>17,302</td>
<td>17,290</td>
<td>17,005</td>
</tr>
</tbody>
</table>

People aged 18-64 predicted to have a borderline personality disorder

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>491</td>
<td>491</td>
<td>487</td>
<td>485</td>
<td>484</td>
<td>484</td>
<td>476</td>
</tr>
</tbody>
</table>

People aged 18-64 predicted to have an antisocial personality disorder

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>377</td>
<td>376</td>
<td>374</td>
<td>372</td>
<td>372</td>
<td>372</td>
<td>366</td>
</tr>
</tbody>
</table>

People aged 18-64 predicted to have psychotic disorder

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>436</td>
<td>436</td>
<td>433</td>
<td>431</td>
<td>430</td>
<td>430</td>
<td>423</td>
</tr>
</tbody>
</table>

People aged 18-64 predicted to have two or more psychiatric disorders

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7,831</td>
<td>7,817</td>
<td>7,766</td>
<td>7,730</td>
<td>7,722</td>
<td>7,715</td>
<td>7,592</td>
</tr>
</tbody>
</table>

Figure 56: Predicted levels of mental problems in St Helens
Source: This table is based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009.

Suicide and injury undetermined deaths are an indicator of mental health mortality. Although the numbers are small the rates in St Helens have increased over time, however they are lower than the rates in the North West. In St Helens in the past 3 years there have been 42 deaths of which 33 were male.

Figure 57: Mortality trends from Suicide and injury undetermined, 1993/95 to 2008/10
Learning Disabilities

The World Health Organisation defines learning disabilities as a ‘state of arrested or incomplete development of mind’. Somebody with a learning disability is also said to have ‘significant impairment of intellectual functioning’ and ‘significant impairment of adaptive/social functioning’. This means that the person may have difficulties understanding, learning and remembering new things, and in generalising any learning to new situations. Because of these difficulties with learning, the person may have difficulties with a number of social tasks, for example communication, self-care, awareness of health and safety. A final dimension to the definition is that these impairments are present from childhood, not acquired as a result of accident or following the onset of adult illness.

It is difficult to establish the true number of people with learning disability within St.Helens but the size of the population is estimated as approximately 3500 people. However only around 22% of people are known to services. GPs record how many of the adults on their practice list have learning disability. In 2010/11, 848 patients were identified, 5.67 people per 1000 population. During the same period adult social care and health identified 560 clients with learning disabilities aged between 18-64. 360 of these are in receipt of services (2010/11).

Learning disabilities are often categorized as mild, moderate or severe. People with a learning disability vary a great deal in the support they may need, some people may require help with washing and dressing for example, while many others will live quite independently with much less support.

<table>
<thead>
<tr>
<th>Estimates of learning disability</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population aged 18-64 predicted to have a moderate or severe learning disability</td>
<td>592</td>
</tr>
<tr>
<td>Total population aged 18-64 predicted to have a severe learning disability</td>
<td>157</td>
</tr>
<tr>
<td>Source PANSI, 2012</td>
<td></td>
</tr>
</tbody>
</table>

Figure 58: Predictions of Learning Disability

People with learning disabilities have a shorter life expectancy and increased risk of early death when compared to the general population. However, life expectancy is increasing, in particular for people with Down’s syndrome, with some evidence to suggest that for people with mild learning disabilities it may be approaching that of the general population. Nonetheless, nationally all cause mortality rates among people with moderate to severe learning disabilities are three times higher than in the general population, with mortality being particularly high for young adults, women and people with Down’s syndrome.

People with learning disability have more difficulty than others in recognising health problems and getting treatment for them and national research suggests than people with learning disabilities have much lower rates of uptake for breast or cervical screening. Therefore, each year GPs offer regular health checks to make sure health problems are identified and treated. In 2010/11 only 30% of eligible adults in St.Helens received a health check, much lower than the national rate.

People with learning disability are more likely to be admitted to hospital as an emergency than the population as a whole. Ideally, people who need treatment in hospital should be admitted before their illness reaches a critical stage where they have to be admitted as an emergency. Well planned care can reduce distress suffered by the patient and improve the
outcome of treatment. During 2008/09, 58% of admissions to hospital for people with learning disability were emergency admissions, higher than the national rate of 50%.

**Autistic Spectrum Disorders**

Autistic spectrum disorder (ASD) is a lifelong condition that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. Autistic spectrum disorder is the term that is used to describe a group of disorders, including autism and Aspersers syndrome. The word ‘spectrum’ is used because the characteristics of the condition vary from one person to another. Those with autism may also have a learning disability. There is no cure for ASD and it continues throughout life. However, many treatments and different types of support are available. An early diagnosis can help to put appropriate support into place for both the individual and their families.

<table>
<thead>
<tr>
<th>People aged 18-24 predicted to have autistic spectrum disorders</th>
<th>2011</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 25-34 predicted to have autistic spectrum disorders</td>
<td>206</td>
<td>226</td>
<td>232</td>
<td>216</td>
<td>198</td>
</tr>
<tr>
<td>People aged 35-44 predicted to have autistic spectrum disorders</td>
<td>240</td>
<td>215</td>
<td>212</td>
<td>242</td>
<td>248</td>
</tr>
<tr>
<td>People aged 45-54 predicted to have autistic spectrum disorders</td>
<td>251</td>
<td>257</td>
<td>243</td>
<td>212</td>
<td>212</td>
</tr>
<tr>
<td>People aged 55-64 predicted to have autistic spectrum disorders</td>
<td>225</td>
<td>219</td>
<td>233</td>
<td>245</td>
<td>231</td>
</tr>
<tr>
<td>Total population aged 18-64 predicted to have autistic spectrum disorders</td>
<td>1,073</td>
<td>1,061</td>
<td>1,046</td>
<td>1,039</td>
<td>1,022</td>
</tr>
</tbody>
</table>

*Figure 59: Predictions of people with Autistic Spectrum Disorder*

PANSI (Projecting Adult Needs Service Information) have used information about ASD is based on *Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007* to estimate the prevalence of ASD for local authority areas. ASD is more prevalent amongst men (1.8% population) than women (0.2%).

**Disability**

Disability can impact upon the length and quality of an individual’s life, and can make it more difficult to access local services. However, the lack of inclusion of disability in routine data recording makes it difficult to measure equity of access and treatment for disabled people.

The Disability Discrimination Act (DDA) 1995 defines disability as:

A mental or physical impairment; which has an adverse effect on an individual's ability to carry out normal day-to-day activities; where the adverse effect is substantial; and, the adverse effect is long-term (meaning it has lasted for 12 months, or is likely to last more than 12 months or the rest of an individual’s life).

Accurate numbers for disabled people are scarce, but many studies have shown that ‘long-term limiting illness’ (LLTI) is a good proxy indicator of disability. The 2001 census recorded numbers who reported having a long term condition which limits their daily activities in any way. The proportion of working age residents with a limiting long term illness stands at 23%, this is higher than the national average (18%) across all wards in St Helens. The
highest levels of LLTI can be found in Parr, West Park and Town Centre wards. The lowest levels of LLTI can be found in Newton and Billinge and Seneley Green wards. Current estimates suggest than in 2012 approximately 11,400 people aged 18-64 have a moderate or severe disability. 8,762 people are expected to have a moderate disability and 2624 are expected to have a severe disability.

The St.Helens 2006 Housing Needs Survey identified that 29% of households included at least one person with a disability. Over 20% of respondents had walking difficulties, and 16% had asthmatic/respiratory problems.

Estimated disability-free life expectancy figures suggest that both males (56.4) and females (59.4) in St.Helens have a lower disability-free life expectancy at birth than the North West and England average. Disability Living Allowance is a contribution towards the disability-related extra costs of severely disabled people under the age of 65. The Allowance has two components: a care component - for people who need help with personal care and are likely to go on needing that help; and a mobility component - for people who have walking difficulties and are likely to continue to have those difficulties. and need help with personal care and/or getting around. In November 2011, 8140 people aged 18-64 in St.Helens received the Allowance.

Disability rates are also associated with the relative deprivation of a local area. National research indicates that disabled people have lower household incomes on average and are more likely to be in the lowest income groups; they are also more likely to have no educational qualifications and less likely to be employed.

Disability and poor-health often go hand-in-hand, for example, the Disability Rights Commission found that people with a learning disability or mental health conditions are far more likely to have diabetes, respiratory illness, coronary heart disease and other heart conditions. One national study estimated that people with learning disabilities or long-term mental health problems are 58% more likely to have significant health problems and die before the age of 50.

Disability can also have an adverse affect on people's access to and experience of health services, national research shows that:

- disabled people are more likely to find dentists’ or doctors’ surgeries inaccessible or inadequate
- 21% of disabled people and 64% of profoundly deaf people find A&E units inaccessible or inadequate
- 40% of visually impaired people believe that their GPs are not fully aware of their needs
- 24% of deaf or hearing-impaired people miss appointments and;
- 19% miss more than five appointments because of poor communication

**Carers**

Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid. This includes adults looking after other adults, parent carers looking after disabled children and young carers under 18 years of age looking after siblings, parents or other relatives. The 2001 census identified that in total 12% of the population are carers (compared with 9% nationally), and 15% of these consider themselves to be in poor health.
Military Veterans

The term veteran refers to anyone who has experienced military service, or who is an ex-military personnel, the Ministry of Defence definition of a veteran is:

“anyone who has served in HM Armed Forces at any time, irrespective of length of service… including National Servicemen and Reservists.”

Military veterans are a diverse group with differing needs & experiences; including older World War II or National Service veterans, others who were not engaged in combat, younger veterans from more recent deployments, & Reserve personnel.

Estimating the current and future size of the veteran population is important to enable effective planning and allocation of veteran health and support services. At the present time there is no definitive data about the total number of veterans in the UK although estimates were produced by ONS in conjunction with the Royal British Legion in 2007. Data from the 2007 Adult Psychiatric Morbidity Survey of England were extrapolated to the whole population to estimate the number of veterans currently residing in private households in England. It was estimated that in 2007 there were 3.77m veterans living in residential households in England.

Figure 60: Estimated numbers of veterans by age band by PCT

<table>
<thead>
<tr>
<th>PCT</th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halton and St.Helens</td>
<td>566</td>
<td>1082</td>
<td>2262</td>
<td>2346</td>
<td>2613</td>
<td>5923</td>
<td>7329</td>
<td>22122</td>
</tr>
<tr>
<td>North West</td>
<td>13,702</td>
<td>25,800</td>
<td>52,107</td>
<td>52,599</td>
<td>56,923</td>
<td>135,684</td>
<td>189,611</td>
<td>526,425</td>
</tr>
<tr>
<td>England</td>
<td>97,376</td>
<td>209,254</td>
<td>397,788</td>
<td>385,358</td>
<td>414,363</td>
<td>966,295</td>
<td>1,301,100</td>
<td>3,771,534</td>
</tr>
</tbody>
</table>


Using this data it can be estimated that the total veteran population for St.Helens at 2007 was likely to be approximately 13,000 people; 11,500 men and 1,500 women. 5,300 veterans in St.Helens in 2007 were likely to be aged 16-64.

Many health needs of armed forces personnel and veterans are similar to those experienced by the general population. However, some of these needs are compounded by the peculiarities of active service and service family life. Some key concerns include the risk of traumatic injuries and death, pressures exerted on relationships and parenting and the frequent changes of location impacting on employment, childcare, schooling, healthcare and the proximity to other family members.

The Kings Centre for Military Health Research conducted research with Iraq and Afghanistan Army veterans which idiscovered a link between combat, trauma, and violence at home, often directed at their partners. The study identified the prevalence of violence on homecoming from deployment was 12.6% with symptoms of Post Traumatic Stress Disorder, common mental health disorders and heavy drinking strongly associated with post-
deployment violence. Thus highlighting the need for appropriate and accessible mental health services.

NHS Merseyside have identified a number of needs and issues facing military veterans within the area. These include, rehabilitation needs, audiology, prosthetic support, mental health needs, substance misuse services and services for families and children. Ensuring registration with a GP from transition is also important in ensuring high quality support.

Early detection of diseases

Cancer screening

Deaths from cancer account for 29% of all deaths in St Helens and are the biggest cause of early death below the age of 75. Many lifestyle factors already discussed will impact on the risks of developing cancers, however evidence based cancer screening programmes have been introduced in this country to ensure that ‘at-risk’ populations are screened and interventions are introduced early to improve health outcomes for those populations and will contribute to reducing deaths from cancers, all age all cause mortality and improve life expectancy at birth.

There are three cancer screening programmes nationally breast screening, cervical screening and bowel screening. The data below show the uptake into these screening programmes benchmarked against England and the North West where available.

Breast screening

Although it is not clear what the exact cause of breast cancer, new cases of breast cancer do increase with age, especially in post-menopausal women and therefore the breast cancer screening programme is set to screen women for abnormalities in their breast over the age of 50 year of age. When abnormalities are detected the women are referred for further investigation and if found to have breast cancer early treatment will help to improve health outcomes and survival rates.

Figure 61: Breast screening coverage 31/03/2011 – 53 to 70 year olds
Source: Information centre, 2012

Uptake of screening is important to maximise the number of women that can be detected early with abnormalities in their breast, in Halton and St Helens coverage is lower than overall coverage in England but higher than the North West, however the variance within general practice in St Helens is from 61.5% to 82.9% (GP practice data, Warrington breast screening unit 2008-10). The minimum uptake targets are that 70% of women will be screened. Therefore there is an inequality in uptake locally which needs to be addressed.
**Cervical screening**
This programme has been set up to detect early abnormalities in the cervix in women aged 25 – 65. If overall coverage of 80 per cent can be achieved, the evidence suggests that a reduction in death rates of around 95 per cent is possible in the long term (www.cancerscreening.nhs.uk).

Data shows that coverage in Halton and St Helens is below 80% and statistically significantly lower than England as a whole. The variance within general practice is from 71.3% to 89.9%. Uptake of cervical screening needs to be improved to improve health outcomes and the variance in uptake needs to be addressed.

![Cervical screening coverage aged 24-64, 2010/11](Image)

**Source:** Information Centre

**Bowel cancer screening**
About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year (CancerResearch UK, 2005. Cancerstats). Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16 per cent (Cochrane Database of Systematic Reviews, 2006. Screening for colorectal cancer using the faecal occult blood test: an update).

Bowel cancer screening is the newest cancer screening programme and has been set up to detect early signs of problems in the bowels in people between the age of 60-69 (60-75 from 2010 onwards) with an uptake rate of 60%. The programme was just fully rolled out nationally in 2010 so benchmark data is not available. Locally there is great variation of uptake of bowel screening by general practice with an overall uptake in St Helens of 52.6% with a variance by practice between 10% and 66%. Improvements in the overall uptake but especially the variance is needed to ensure this programme works effectively locally.

Bowel cancer screening and cervical cancer screening uptake/coverage rates need to improve in order to be more effective. All the programmes need to ensure they reduce the variance in uptake.
Healthy Ageing & Independent Living: Older People

Introduction
There is a higher incidence among older age groups of many health conditions, disabilities and incapacities. This means that our ageing population poses a great challenge to the health and social care systems in terms of managing demand for services with increasingly tight resources.

Older people are the main users of health and social care services. They are three times more likely to be admitted to hospital following attendance at an emergency department and once there are more likely to stay. Increased life expectancy in the borough implies longer periods for individuals where health, social care and support may be required and necessitating increased levels of support for carers. In addition, the forthcoming welfare reforms, particularly those related to housing benefit and disability benefits, will impact on a number of groups, but especially older people and those with disabilities.

The conditions most commonly associated with ageing are: coronary heart disease and stroke, diabetes, cancer, chronic pulmonary obstructive disease, incontinence, Alzheimer's disease, osteoporosis and osteoarthritis. There is also some decline in hearing, vision, physical strength and balance and there may be some loss in mental acuity. However, many of the diseases experienced in old age are preventable.

Key Messages
- An increase in the number of older people will put additional pressure on older people's specific services and carers.
- Falls in older people is still a significant issue with high rates of admission to hospital (in injuries and poisoning section) and variations within geographical areas, a review of interventions may be useful to understand the gaps.
- Mental health issues and dementia are set to rise in this age group.
- Chronic health conditions and multiple health issues alongside mental health issue are also increasing in this age group.
- There will be a greater need in future to support people to manage long term conditions effectively.
- A variety of social, community and housing support will be necessary to enable people to remain independent and in their own homes.
- There are wider wellbeing issues for older people at risk of loneliness and isolation particularly as the number people living alone increases..
- Throughout the national reform process it is vital to maintain a focus upon adult safeguarding.
Demography

There are an estimated 31,400 people aged 65 or over living in St. Helens (2011 Census). 56% of the older population are female and 44% are male. Within this age group there is very little ethnic diversity, at mid year 2009 it was estimated that over 99% of people within this age group were from white ethnic groups, this includes British, Irish and other white groups.

The age structure of the St. Helens population has changed significantly over the past ten years. Since 2001 the number of people aged 65 and over has increased by 11% and population projections indicate that the ageing population is set to continue with the proportion of older people growing at a faster rate than the national average. According to projections, the total 65+ age group is set to rise by 22% over the next decade. Within this older population, the comparatively small 90+ age group is set to increase by 400 (40%).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65-64</td>
<td>9,300</td>
<td>11,400</td>
<td>10,100</td>
<td>10,700</td>
<td>11,900</td>
</tr>
<tr>
<td>70-74</td>
<td>8,000</td>
<td>8,400</td>
<td>10,500</td>
<td>9,300</td>
<td>9,900</td>
</tr>
<tr>
<td>75-79</td>
<td>6,100</td>
<td>6,800</td>
<td>7,300</td>
<td>9,200</td>
<td>8,200</td>
</tr>
<tr>
<td>80-84</td>
<td>4,100</td>
<td>4,600</td>
<td>5,300</td>
<td>5,800</td>
<td>7,400</td>
</tr>
<tr>
<td>85-90</td>
<td>2,300</td>
<td>2,500</td>
<td>3,000</td>
<td>3,600</td>
<td>4,100</td>
</tr>
<tr>
<td>90+</td>
<td>1,000</td>
<td>1,100</td>
<td>1,400</td>
<td>1,800</td>
<td>2,400</td>
</tr>
<tr>
<td>TOTAL</td>
<td>30,800</td>
<td>34,800</td>
<td>37,600</td>
<td>40,400</td>
<td>43,900</td>
</tr>
</tbody>
</table>

Total Percentage Change from 2010: / 13% 22% 31% 43%

Figure 63: Population Projections for older people in St Helens 2010 to 2030

Figure 64: Population Projections for older people in St Helens 2010 to 2030
Demand for Services
As the number of older people increases so does the demand for health and social care services, however, the relationship between demographic change and demand is complex, particularly with regard to older people.

Some of the variables that will influence future demand include:

- Access to services and customer expectations: If the potential benefits of services are poorly understood or difficult to access this may reduce demand.
- Interconnectivity between services: Health and care services can influence demand as well as respond to it. For example, good performance in relationship to stroke recovery by the health service reduces the demand for social care, whilst equally the quality of home care may influence demand for community health services. Housing can also have a significant impact upon the demand for both health and social care services.
- Health improvements: improvements in health have been a major influence on increased longevity. However, whilst new treatments may reduce demand for services by improving wellbeing, other health interventions may increase demand through reducing mortality but not morbidity.
- Social care interventions: If a particular intervention is encouraged at the expense of another then demand may appear to increase. For example, the use of state funded residential care has not increased in line with population growth. This reason may be based on a series of interconnecting factors such as the availability of a wider range of alternatives or local authorities encouraging people to take up other interventions.

The NHS provides a universal health service whereas social care services are provided based upon eligibility criteria, this makes it difficult to establish an accurate picture of social care need within the borough. Although the demand for social care services is increasing, services provided must be delivered within the resources available. Priority is therefore given to those with the highest level of need with local authorities determining eligibility criteria appropriate to their area.

Personalisation aims to allow people who need help from social care services to have more control and choice of the way their needs are assessed and the type of support they wish to purchase in order to meet their care needs. The Government’s intention is that by 2013 all adults receiving social care will do so by way of a personal budget allowing them to purchase their own care or be supported to do so. Nationally a 30% of those eligible in England currently use self-directed support, such as personal budgets or direct payments, for their social care provision. In St.Helens the rate is slightly higher than the England and North West average at 31.6%.
Hospital Admissions
The National Service Framework for Older People stresses the importance of preventing unnecessary hospital admissions. Such admissions arise when there is inadequate health and social support available in the community to meet the needs of this age group. The tables below summarise the main causes of hospital admissions.

<table>
<thead>
<tr>
<th>65+ years Emergency Admissions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>18.2%</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>16.8%</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>14.7%</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>13.4%</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>9.5%</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>7.7%</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>4.3%</td>
</tr>
<tr>
<td>Neoplasms (cancers)</td>
<td>3.8%</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>2.1%</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8417</strong></td>
</tr>
</tbody>
</table>

Figure 15: Emergency Admissions

Avoiding emergency hospital admissions is a priority for all age groups not only because of the high costs of emergency admission compared with other forms of care, but also because of the disruption it causes to elective health care such as inpatient waiting lists - and to the individuals admitted. Age is a risk factor for emergency hospital admissions, with younger people and older people being at higher risk of admission.

<table>
<thead>
<tr>
<th>65+ years Planned</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the eye and surrounding area</td>
<td>19.4%</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>16.2%</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>14.4%</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>13.0%</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>9.4%</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>7.8%</td>
</tr>
<tr>
<td>Factors influencing health status and contact with health services</td>
<td>7.3%</td>
</tr>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
<td>4.0%</td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>2.5%</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10707</strong></td>
</tr>
</tbody>
</table>

Figure 66: Planned Admissions
A large proportion of hospital admissions cannot be prevented or avoided even with the most effective care. However, it is important that wherever possible conditions should be prevented from becoming serious, and that people should be supported to recover effectively.

The rate of unplanned readmission to a hospital after a previous hospital stay is used as an indicator of the success of health and social care services in helping people to recover. Readmission to hospital with a surgical wound infection is an example of a readmission which is considered to be avoidable. In addition, readmissions may be unrelated to the previous admission, but occur within defined the time period.

In 2011/12 the rate of non elective readmission rate within 28 days for St.Helens was 16.6% which is similar to the North West average as shown below. The rate of non elective readmissions within 90 days was 27.2% slightly higher than the regional average.

![Figure 67: Non Elective Re Admission Rate](image)

Improving hospital discharge and the availability of support services for individuals leaving hospital can have a significant impact on reducing non elective admissions. The initial findings from the recent enhanced integrated discharge and community care pilot funded by NHS Mersey Winter Pressures funding has proved successful in reducing the number of people declared medically fit and occupying acute beds from 40 to an average of 5 people per week. There has also been an improvement in service user outcomes by ensuring patients get placements which are more suited to their needs and a reduced risk of non elective readmission to hospital.

There is a national indicator in place to measure independence for older people through rehabilitation/intermediate care. This measures the benefit to individuals from intermediate care and rehabilitation following a hospital episode, capturing the joint work of social services and health staff and services commissioned by joint teams. In St.Helens 93.3% of older people discharged from hospitals achieve the goals agreed between the local authority and health practitioners, this is significantly higher than the national rate of 83.1%.
Falls

Over a quarter of the 65 and over population are estimated to have fallen at least once in the last 12 months.

<table>
<thead>
<tr>
<th>Total population aged 65 and over predicted to have a fall</th>
<th>2011</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8,118</td>
<td>9,047</td>
<td>9,856</td>
</tr>
</tbody>
</table>

**Figure 68: Predicted Falls**
**Source:** Projecting Older Peoples Population Information, 2012

Hip Fracture (Fractured Neck of Femur)

Maintaining good mobility in older age is a key factor in ensuring good health and wellbeing and maintaining living at home. Falls resulting in Fractured Neck of Femur are a significant cause of morbidity and mortality amongst older people, with up to 20% of sufferers requiring long term care and a further 30% not regaining their pre fracture functioning.

Hospital stays following Fractured Neck of Femur can vary in length between 17-40 days, with patients often requiring significant input from community care services following discharge. Additionally, long stays in hospital also increase the risk of acquiring a hospital associated infection.

The figure below outlines the crude rates per 100,000 population for fractured neck of femur 2010/11 for the St Helens population. What can be seen is that rates of admissions for Thatto Heath are considerably higher compared to other wards in the area.

**Figure 69: Admissions due to Fractured Neck of Femur by Ward**

Inappropriate or poorly maintained housing is a significant cause of falls and trips. The average cost to the State of a fractured hip is £28,665. This is 6.8 times the cost of a major housing adaptation in St Helens and more than 100 times the cost of fitting hand and grab
rails to prevent falls. The majority of older people would like to stay living in their own home where possible and by postponing entry into residential care by just one year through adapting people’s homes saves £28,080 per person. The average cost of a Disabled Facilities Grant pays for a stair lift and level access shower which can last over 5 years. The same expenditure would be enough to purchase the average home care package for just one year and 3 months (Source: APPG on Housing and Care for Older People – Living Well at Home Inquiry)

**Obesity**

Obesity can be defined as having a body mass index of more than 30. The likelihood of suffering from obesity increases with age. Obesity increases the risk of suffering from several serious illnesses, including diabetes and heart disease. Without the intervention of a healthy diet and appropriate exercise, obesity may develop into diabetes over a relatively short period of time.

The table below shows that the number of people aged 65 and over, forecast to become obese is set to increase by approximately a third by 2025 to over 9727 people. This is likely to put an increased burden upon local health and social care services.

![Table showing estimated obesity rates](image)

**Figure 70: Predicted Obesity**
Chronic and Long Term Illness

Long-term conditions refer to those conditions that cannot currently be cured but can be controlled by medication and other therapies. Long-term conditions, such as coronary heart disease, stroke and cancer, are among the leading causes of premature mortality and make a major contribution to the life expectancy gap between St.Helens and the national average.

People with long-term conditions are the most intensive users of the most expensive services, not only in terms of primary and specific acute services, but also in social care and community services, urgent and emergency care.

At present there are an estimated 17,700 people aged 65 or over with a limiting long-term illness, this is 56% of the older population. Over a quarter of people in this age group, 8100 are expected to have a fall. By 2025, many chronic and long term illnesses are projected to increase by more than 30% as shown in the table.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population aged 65 and over with a limiting long-term illness</td>
<td>17,696</td>
<td>19,678</td>
<td>21,247</td>
<td>23,001</td>
<td>30%</td>
</tr>
<tr>
<td>Total population aged 65 and over predicted to have a fall</td>
<td>8,118</td>
<td>9,047</td>
<td>9,856</td>
<td>10,753</td>
<td>32%</td>
</tr>
</tbody>
</table>

**Figure 71: Predicted long term illness and falls**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>With longstanding health condition caused by a stroke</td>
<td>708</td>
<td>796</td>
<td>860</td>
<td>942</td>
<td>33%</td>
</tr>
<tr>
<td>With longstanding health condition caused by a heart attack</td>
<td>1,510</td>
<td>1,694</td>
<td>1,818</td>
<td>1,971</td>
<td>31%</td>
</tr>
<tr>
<td>With diabetes</td>
<td>3,872</td>
<td>4,341</td>
<td>4,634</td>
<td>4,952</td>
<td>28%</td>
</tr>
<tr>
<td>With dementia</td>
<td>1,989</td>
<td>2,211</td>
<td>2,525</td>
<td>2,950</td>
<td>48%</td>
</tr>
<tr>
<td>With depression</td>
<td>2,695</td>
<td>3,012</td>
<td>3,208</td>
<td>3,448</td>
<td>28%</td>
</tr>
</tbody>
</table>

**Figure 72: Predicted long term conditions**

Physical and Sensory Disability (PSD)

In 2011 it is estimated that over 17,500 people were living with a limiting long term illness in St.Helens. In 2010/11 4885 people received support from social services due to a physical or sensory disability, although there are people of all ages with physical disabilities, 76% of service users with physical or sensory disability are aged 65 and over. Service users with PSD account for almost three quarters (74. 1%) of all social care service users.
Dementia

Dementia is the loss of some mental ability including memory and reasoning and is often associated with the elderly. There are many different types of dementia, each with their own causes. The most common dementia symptoms include loss of memory, confusion, and changes in personality, mood and behaviour. 60% of dementia cases are caused by Alzheimer’s disease; other factors include stroke, AIDS, and Huntington’s disease. Although dementia itself is prevalent it is likely to be secondary to other illnesses. This could have particular ramifications on services. Through the recognition of this patients can receive a better standard of care and specialists will be in a position to make informed decisions and give information regarding the assessment of the patient and their care needs.

As shown in the table below the number of older people with dementia is predicted to rise to almost 2,950 by 2025, a rise of almost 50%. Dementia can pose a significant burden on health services, hospital beds, families and carer services.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>With dementia</td>
<td>1,989</td>
<td>2,211</td>
<td>2,525</td>
<td>2,950</td>
<td>48%</td>
</tr>
</tbody>
</table>

FIGURE 73: DEMENTIA PREDICTIONS
SOURCE: PROJECTING OLDER PEOPLES POPULATION INFORMATION, 2012

People with learning disabilities are at particular risk of being affected by Dementia. Although there are more older women than men requiring care and support, the projected increase in older men with dementia will have a significant impact on workforce planning.

Quality and Outcomes Framework (QOF) data for 2009-10 indicates that 996 patients across St Helens GP practices were registered as having dementia, this is 0.5% of the population. However, the number of people in receipt of social care services is significantly lower.

Number of clients in receipt of services with Dementia as their primary client type, by service (2010/11)

<table>
<thead>
<tr>
<th></th>
<th>Community Based Services</th>
<th>Residential Care</th>
<th>Nursing Care</th>
<th>Dementia Total Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 65 and over</td>
<td>120</td>
<td>100</td>
<td>75</td>
<td>250</td>
</tr>
<tr>
<td>Total</td>
<td>125</td>
<td>105</td>
<td>75</td>
<td>255</td>
</tr>
</tbody>
</table>

FIGURE 74: SOURCE: NATIONAL ADULT SOCIAL CARE INTELLIGENCE SERVICE, 2012

*Total may not sum as clients may receive more than one type of service during the year.

It has been estimated that there will be 3341 St Helens residents aged 65 and over with dementia by 2030. Based on percentages of severity it is estimated that in 2010, 1306 of those with dementia will live in the community and 653 will require a care home. This will rise to 2227 living in the community and 1114 requiring a care home by 2030.

The Dementia Links Service is operated alongside the Council’s Home Improvement Agency and aims to allow people with dementia to live well at home for as long as possible. Practical solutions are offered such as memory prompts and low-level housing interventions such as gas isolator switches as well as family centred advice and sign-posting on to suitable additional support.
Promoting Independence

During 2010/11, 4,400 people over 65 year old received temporary or long term support from adult social care. This group accounts for 67% of all people in receipt of services. As previously stated the majority of older people would like to stay living in their own home where possible, and would prefer to receive services in a community setting close to where they live.

<table>
<thead>
<tr>
<th></th>
<th>Community Based Services</th>
<th>Residential Care</th>
<th>Nursing Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 65 and over</td>
<td>3895</td>
<td>460</td>
<td>320</td>
</tr>
<tr>
<td>Total</td>
<td>5900</td>
<td>585</td>
<td>360</td>
</tr>
</tbody>
</table>

*Figure 75: Older people by service received*
2012 The Health and Social Care Information Centre

*It should be noted that the number of supported packages exceeds the number of recipients as one individual may have several care packages.

Every year a survey is conducted with users of social care services. In general service users report a high level of satisfaction, in 2010/11:

- 91.8% service users were satisfied with the care and support received
- 90.67% service users were positive about their quality of life
- 96.04% service users felt they had control over their daily lives

However, the survey also identified a number of issues, for example:

- 63.15% of service users have some difficulty dealing with finances or paperwork
- 15.67% of service users have some difficulty finding information and advice about support, services or benefits
- 37.03% felt they some difficulty getting to visit places they would like to go.

Community Based Services

Community-based services are provided to people who live in their own homes (this includes supported/sheltered accommodation and extra care housing). This section provides information on the different community-based services provided or commissioned by the Local Authority that help people to live independently in their own home for as long as possible.

Community-based services (for example, home care, day care and meals) were provided to 3895 service users aged 65 and over during 2010-11.

The majority of older people want to remain independent and to remain in their own homes for as long as possible. Factors which can impact on an older person's ability to remain independent include:

- Ability to manage domestic tasks and personal care
- Mobility
- Falls
- Continence
- Eyesight and hearing
- Support from a carer
- Long term conditions
- Dementia
- Poverty, isolation, and social exclusion

According to estimates by POPPI the number of people predicted to be unable to manage activities is likely to grow in the future as shown in the table below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to manage a mobility activity on own</td>
<td>5,477</td>
<td>6,062</td>
<td>6,737</td>
<td>7,561</td>
<td>38%</td>
</tr>
<tr>
<td>Unable to manage a self-care activity on own</td>
<td>10,121</td>
<td>11,225</td>
<td>12,338</td>
<td>13,714</td>
<td>36%</td>
</tr>
<tr>
<td>Unable to manage a domestic task on own</td>
<td>12,349</td>
<td>13,690</td>
<td>15,102</td>
<td>16,775</td>
<td>36%</td>
</tr>
</tbody>
</table>

Figure 76: Estimates of Older People unable to manage activities
Source: POPPI

**Flu Vaccination**

Flu is caused by a group of viruses that are highly contagious and can cause significant morbidity and mortality in older populations. Each year those aged over 65 or with one of a number of chronic conditions are eligible to receive a free flu vaccination via their GP. High uptake of the annual flu vaccine is crucial to keeping older people healthy through the winter months and reducing the burden on health services during the winter surge. The graph below outlines flu vaccination uptake rates per GP practice in St Helens.

![Flu uptake 2011/12 (%) aged 65+](image)

Figure 77: Influenza Vaccine uptake for 2011/12 in the 65 and overs by General Practice
General practices uptake of flu vaccine is between 70-80% for many practices in the area, with a few notable exceptions who through concerted efforts of practice staff have been able to achieve uptake rates of between 80-90%.

**Excess Winter Deaths**

People are more likely to die in conditions of extreme temperature. In England, there are more deaths in winter than in summer. Cold weather and being cold through living in a home with persistently low temperatures impacts on physical health and causes death from circulatory and lung diseases that would not have occurred in warmer temperatures and warmer homes. Less mobile people on low incomes are particularly affected, with most deaths occurring in older people and in people with debilitating conditions.

The excess number of deaths that result from winter conditions is calculated as the deaths that occur between December and March less the average monthly number of deaths during the other months of the year. The elderly are more vulnerable than others during the winter. Although excess winter mortality is associated with low temperatures, deaths are mainly not due to direct causes such as hypothermia but due to the impact on underlying conditions such as cerebrovascular disease, ischaemic heart disease and respiratory disease.

In St.Helens the rate of excess winter deaths is significantly higher than national and regional averages, between 2007 and 2010 there have been an average of 149 excess winter deaths per year.

![Figure 78: Excess Winter Deaths 2007-2010](image)
Carers

Due to an ageing population both locally and nationally, it is important to anticipate the growing support required for unpaid carers. The tables below show there is projected to be a steady increase in the numbers of older carers in the near and distant future, including those carers aged over 85. Furthermore, the numbers of older carers with poor health is forecast to rise. These trends are likely to impact upon services, with growing need and demand for support services to carers.

There is a national indicator measuring engagement with, and support to, carers. In 2010/11 in St.Helens the number of carers whose needs were assessed or reviewed by the council in a year who received a specific carer's service, or advice and information in the same year as a percentage of people receiving a community based service in the year was 45%, much higher than the national average of 28.7%. During 2010/11, 2420 carers received support from social care.

Older people are less likely to define themselves as carers, especially when caring for their spouse or partner. Older people are also less likely to define themselves as disabled than younger people with the same impairments, therefore it is possible that there remain hidden carers across the borough.

Figures from the Projecting Older People's Population Information system (POPPI) suggest that by the year 2030 there will be over 4,900 people aged 65 and over in the borough providing unpaid care to a partner, family member or other person. This is an increase of almost 1,000 carers aged 65 and over, a rise of over 27%.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2012</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 65-74 providing unpaid care to a partner, family member or other person</td>
<td>2,802</td>
<td>3,015</td>
<td>3,137</td>
<td>3,046</td>
<td>3,320</td>
</tr>
<tr>
<td>People aged 75-84 providing unpaid care to a partner, family member or other person</td>
<td>954</td>
<td>1,016</td>
<td>1,123</td>
<td>1,337</td>
<td>1,390</td>
</tr>
<tr>
<td>People aged 85 and over providing unpaid care to a partner, family member or other person</td>
<td>103</td>
<td>109</td>
<td>133</td>
<td>163</td>
<td>196</td>
</tr>
<tr>
<td>Total population aged 65 and over providing unpaid care to a partner, family member or other person</td>
<td>3,859</td>
<td>4,140</td>
<td>4,393</td>
<td>4,546</td>
<td>4,907</td>
</tr>
</tbody>
</table>

Figure 79: Predictions of unpaid care (POPPI)

Being a carer can have a major impact on people's lives and place them at a greater risk of suffering from ill health. National research suggests that Carers who provide high levels of unpaid care for sick or disabled relatives and friends are more than twice as likely to suffer from poor health compared to people without caring responsibilities.

Using data from POPPI almost a quarter of all people providing unpaid care in St.Helens are in poor health. Additionally the number of people with caring responsibilities aged 65 and over who are in poor health is projected to grow by almost 30% by 2030 to over 1200 people.
Military Veterans – older people

As outlined in the previous chapter, the term veteran refers to anyone who has experienced military service, or who is an ex-military personnel, the Ministry of Defence definition of a veteran is:

“anyone who has served in HM Armed Forces at any time, irrespective of length of service... including National Servicemen and Reservists.”

Estimating the current and future size of the veteran population is important to enable effective planning and allocation of veteran health and support services. At the present time there is no definitive data about the total number of veterans in the UK although estimates were produced by ONS in conjunction with the Royal British Legion in 2007. Data from the 2007 Adult Psychiatric Morbidity Survey of England were extrapolated to the whole population to estimate the number of veterans currently residing in private households in England. It was estimated that in 2007 there were 3.77m veterans living in residential households in England.

As the table shows, there are estimated to be over half a million veterans in the North West and more than half of these are aged over 65. This reflects the fact that the estimates include the cohort of men who were obliged to complete National Service which was compulsory until 1960.

Using this data it can be estimated that the veteran population for St.Helens at 2007 was likely to be approximately 13,000 people, 11,500 men and 1,500 women. 60% (7,900) of veterans in St.Helens in 2007 were likely to be aged 65 and over.
National projections suggest that the total veteran population is projected to decline by around 50% between 2007 and 2027. This is due to a number of factors including re-organisation within the Armed Services and the decline in the number of people falling into the National Service cohort. Within St. Helens it is projected that there will be approximately 9,000 veterans living in the borough by 2017 and 6,500 veterans by 2027.

In June 2012, St. Helens has adopted an Armed Forces Community Covenant, a voluntary statement of mutual support between a civilian community and the local armed forces community. The covenant aims to boost support for the armed forces community working and living in St Helens and to recognise and remember the sacrifices made by members of this armed forces community. This includes in-service and ex-service personnel, their families and widow(er)s in St Helens. The local covenant complements the commitment of the government to end any disadvantage military service imposes on people.

Military service often involves both physical risks and risks to mental health and wellbeing. Physical risks include being wounded in action, including loss of limbs. According to the DASA, medical discharges account for 11% of people who leave the Services each year, mostly due to injuries & musculoskeletal disorders, for example knee and back pain. The commonest mental health problems in veterans are depression & anxiety. Post Traumatic Stress Disorder (PTSD) is often a concern, but a recent study by Fear NT et al suggests the prevalence among Iraq & Afghanistan veterans is only slightly higher at 4% than the rate in the general population 3%. However, nationally the rate of alcohol misuse among veterans is much higher at 13% compared with 4% in the general population. World War II & National Service veterans generally have similar health and care needs to others of their generation. Veterans are entitled to priority access to treatment for any conditions which are considered likely to be service related, subject to the clinical needs of all patients.

There are other sources of data available which can be used to indicate potential health need amongst veterans, this includes Armed Forces Pension Data supplied by DASA (Defence Analytical Services Agency). However, this data is likely to under-estimate the total number of veterans, as only those who complete at least 2 years of reckonable service are eligible to receive the AFPS. Pensions can be paid to Armed Forces personnel upon leaving the services depending upon the time they have served therefore pension recipients are not necessarily older people.

The DASA have also provided numbers of people in receipt of War Service Pensions(WSP) and the Armed Forces Compensation Scheme (AFCS). These two payments are made to veterans injured during service (WPS is paid to people who injured prior to 2005, AFCS to those who injured post 2005). Given the fact that these pensions are dependent on the person having sustained an injury of some sort, it is likely that these will be the veterans with particularly high health and social care needs.

In July 2011, there were 940 Armed Forces Pension Scheme recipients in Halton and St. Helens and 1030 recipients of WSP or AFCS. This indicates the number of veterans receiving compensation for injuries sustained during service, but does not include all veterans with disabilities or injuries.

Many health needs of armed forces personnel and veterans are similar to those experienced by the general population. However, some of these needs are compounded by the peculiarities of active service and service family life. Some key concerns include the risk of traumatic injuries and death, pressures exerted on relationships and parenting and the
frequent changes of location impacting on employment, childcare, schooling, healthcare and the proximity to other family members. NHS Merseyside have identified a number of needs and issues facing military veterans within the area. These include:

- Rehabilitation needs
- Audiology
- Prosthetic support
- Mental Health
- Substance Misuse
- Registration with a GP from transition
- Health services for families and children.

End of Life Care

End of life services are designed to support people who are approaching the end of life to live as well and comfortably as possible until their death, and to support their carers in that process. It can include any adult with advanced incurable and progressive disease and take place in any setting, hospice, hospital, home, or elsewhere in the community.

Palliative care tends to be offered to patients with incurable cancer, though it has been estimated that two thirds of non-cancer deaths will be proceeded by a period of chronic illness that may benefit from palliative care interventions (National Council for Palliative Care). However, potentially a third of deaths that take place in hospital might have been more appropriately managed elsewhere.

Patient surveys repeatedly show that the majority of people would prefer to die at home, yet comparatively few patients are able to do this. In St.Helens 23% of people in total die in their own home, higher than the national and regional rate. Over 50% of people in St.Helens die in Hospital. For people aged 65 and over, 43.7% people die at home compared to the regional average of 41.5%.

Figure 82: Deaths which occur at home