Knowsley Joint Strategic Needs Assessment 2011

Full Report

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Update July 2012

Since publication, the Health and Social Act became law in March 2012. Key changes required by the Act are the abolition of Primary Care Trusts (PCTs) by April 2013; the development of Clinical Commissioning Groups (CCGs) as the commissioners of local health care services; moving of Public Health into local government and the establishment of local Health and Wellbeing Boards.

Health and Wellbeing Board are now responsible for the development Joint Strategic Needs Assessment (JSNA). It is the statutory function of the Council and the CCG to ensure this is produced as members of the Board. The Board also has to prepare and publish a Joint Health and Wellbeing Strategy (JHWBS) to meet the needs of the population as set out in the JSNA.

In light of these changes, in May 2011, Knowsley established and held its first Shadow Health and Wellbeing Board. The first task of the Shadow Health and Wellbeing Board was to agree the JSNA and undertake a prioritisation exercise. Details of the prioritisation process and outcome are detailed in section one and the online Summary document.

N.B. The 2011 JSNA was designed to be published online. This document is a compilation of all of the online JSNA documents. The numbering and referencing of figures and tables are relevant to the section they are included within and are not consecutively numbered from start to end of this document.
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1. **WHAT IS A JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)?**

Joint Strategic Needs Assessment (JSNA) is the means by which Primary Care Trusts and Local Authorities describe the future health, care, and wellbeing needs of local communities.

The Joint Strategic Needs Assessment is intended to ensure that the needs of local people are met, both now and in the future. It provides an opportunity to look ahead at least three to five years in order to support and direct the change that needs to happen in local service systems so that services are shaped by local communities, inequalities are reduced, and social inclusion increased.

The Local Government and Public Involvement in Health Act 2007 (Section 116) stated that it is a statutory requirement for Local Authorities and PCTs to produce a Joint Strategic Needs Assessment of the health and wellbeing of their local community.

The Joint Strategic Needs Assessment is currently the joint responsibility of the Director of Public Health, Director of Health and Social Care and Director of Children and Family Services, however in the future it will become the responsibility of the local authority and GP consortia (now known as Clinical Commissioning Group) jointly.

The Knowsley Joint Strategic Needs Assessment builds upon, and enhances, existing reports such as the Public Health Annual Report, Area Partnership Health Profiles, and the Council’s Core Evidence Base document. It provides additional intelligence by using population projections where possible and, importantly, local views to inform the prediction of future needs. A crucial distinction between other reports and the Knowsley Joint Strategic Needs Assessment is that community involvement is integral to the process. Community insight has been used to identify needs, priorities and solutions while increasing ownership by the community through effective engagement in the process.

The Joint Strategic Needs Assessment provides the data, analysis, evidence, interpretation, and local insight required to underpin the strategic commissioning process. It also informs other key strategies such as the Health and Wellbeing Strategy and the Sustainable Communities Strategy refresh.

**Aims of the Joint Strategic Needs Assessment**

The aims of the Joint Strategic Needs Assessment are:

- To ensure the needs of local people are met.
- To enable local people and service providers to plan in partnership and shape local services.
• To provide an opportunity to look ahead 3 to 5 years to support the changes that need to happen in local service systems.

Methods

A JSNA working group was initially set up to agree the JSNA process and support the development of a JSNA template and list of suggested topics for inclusion. This resulted in an initial list of over 40 topics for consideration. This list was derived from an audit of the needs identified from the last JSNA, TCS, and other needs highlighted from alternative routes from within Children and Family Services and Wellbeing Services. The list has been refined to 34, and leads were identified to complete a framework for each topic.

Each identified lead was sent a standardised template and guidance to complete a framework on their lead area. Drafts were reviewed independently and amendments made as appropriate to the drafts.

The drafts of all of the frameworks were included on an online Joint Strategic Needs Assessment page of the Health & Wellbeing Website. In addition to the online JSNA a summary document was produced that includes all of the key needs identified. It also includes a prioritisation of the needs identified through discussions with key stakeholders. Furthermore, an additional ‘Public friendly version of the JSNA will be produced and disseminated widely.

Community Engagement and Involvement

Community involvement is integral to the production of the JSNA. Since the 2008 JSNA, community engagement and involvement has become an integral part of Knowsley Health Wellbeing’s Commissioning process and there has been strong input as part of an on-going process. Therefore, specific community events and street surveys, such as those conducted for the 2008 JSNA were not repeated. Instead, community insight is drawn from previous consultations, and the information contained on the REACT database. The REACT database stores information on all of the Health and Wellbeing consultations, surveys and focus groups conducted with the community. In addition, feedback from LINKS has revealed common issues relating to Health and Wellbeing Services that has fed into the process.

Community insight from these sources is included in all of the frameworks and has been used to identify needs, priorities and potential solutions.

2011 JSNA Improvements

The first JSNA produced in 2008 was seen as a useful, easy to use document, particularly for commissioners. Therefore, building upon its success, the overall structure of the 2011 JSNA and each of the sections was kept similar.
The purpose of the 2011 Joint Strategic Needs Assessment (JSNA) is to:

- Reflect on the progress from the Knowsley 2008 JSNA
- Incorporate learning from other JSNA’s and National best practice
- Determine the key health and wellbeing needs for Knowsley in 2011 and beyond
- Explore further the relationship between the key health and wellbeing needs, and the wider determinants of health in Knowsley
- Enhance the degree of analysis by equality and diversity groups
- Ensure strong stakeholder and partnership engagement throughout the process
- Identify high impact / high level cross cutting priorities
- Produce recommendations for commissioners reflecting the QIPP agenda

Prioritisation Process

In total 34 needs were identified during the Joint Strategic Needs Assessment process. However, although all of these are high level needs it was important to prioritise the key health and wellbeing needs across the borough further. Prioritisation took place to help inform the decisions about resource allocation and priority actions for the newly formed Shadow Health and Wellbeing Board. The Board felt that it was essential that a wide range of stakeholders were involved in this process to gain ownership and ensure that a robust decision making process was undertaken.

During March and April 2012, JSNA prioritisation events and an online survey were undertaken to prioritise and rank the 34 needs identified in the 2011 JSNA. Opportunities to participate in the prioritisation process were promoted widely through direct mail to individuals through the usual networks and communication channels. People who could not attend the events had the opportunity to complete the online survey.

At each of the six events the same process was undertaken, which entailed a presentation providing an overview of the key health and wellbeing needs, followed by each individual prioritising and ranking the needs under 4 broad themes which were Children & Young People; Lifestyles; Adults and Older People; and Wider Determinants of Health. The following 2 criteria were used to rank the health and wellbeing needs within each of the four themes;

1) What has the biggest impact (on your population)?
2) What has the biggest impact on inequality / unfairness?

In addition, individuals were given the opportunity to make comments on any areas/needs they felt were missing or not emphasised in enough detail.

Stakeholder Involvement

Four JSNA prioritisation events were conducted; three public events (including a specific children and young people event) and a GP/Professional
stakeholder event. In addition, the Shadow Health and Wellbeing Board and Health & Wellbeing Engagement Board members went through the same process. These boards included representatives from the local authority, elected members, Clinical Commissioning Group, and public networks including LINks representatives.

In total, approximately 250 stakeholders took part in the prioritisation process. At the public events, over half (57%) stated they were members of the public, 20% were voluntary/community/faith organisation representatives and 10% were LINks members. Around 10% represented other areas of concern, such as older people's groups, health forums or were carers. Fifty-four attended the GP/Professional stakeholder event and around 40 completed the online survey.

The summary document available at: www.knowsley.nhs.uk/intel/jsna identifies the priority areas. The top ten health and wellbeing priorities were as follows; alcohol, cancer, child & family poverty, children with disabilities, dementia, education, employment, heart disease & stroke, mental wellbeing of children & families and smoking & respiratory disease.

2. DESCRIPTION OF THE BOROUGH / POPULATION CHANGE

2.1 About Knowsley

Knowsley Borough in Context

Knowsley is one of five local authority districts in Merseyside (and one of six districts that form Greater Merseyside if including Halton Unitary Authority), located in the North West of England. Knowsley Metropolitan Borough was created in 1974 when the urban districts of Huyton, Kirkby and Prescot were grouped with the rural districts of Whiston and parts of West Lancashire to form a new local authority area.

Knowsley lies to the east of Liverpool covering an area of 8,619 hectares and is also situated 25 miles west of Manchester. The M62 motorway runs from east to west across the south of the Borough with the M57 motorway running from north to south. These excellent transport links provide access to the motorway network across the country which serves several industrial and business parks within the Borough.

However, although there are many opportunities due to where the Borough is situated, Knowsley residents experience relatively high levels of unemployment and social deprivation which impact on their health. For many forms of disease, local people experience significantly worse health than the rest of the country.
Figure 1.1 –Knowsley’s Electoral Wards
The latest population estimates for Knowsley (2009) show that the resident population is 149,400. Since 1981, the population has fallen by 14% in Knowsley, or by approximately 870 people per year. The steady decline in the population has occurred in each of the intervening 28 years with the exception of 1998 and 2005.

As with most areas of the country, there are more females than males living in the Borough. Indeed, there are now 110 females living in Knowsley for every 100 males. Since 1981, the gap between males and females living in the Borough has widened from 4,400 to 7,200.

Between 2008 and 2009, the population fell due to people migrating out of the Borough as net migration was -800 people even though natural change (births + deaths) was +500.
### Population Structure

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Males</th>
<th>Females</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4</td>
<td>4,900</td>
<td>4,600</td>
<td>9,500</td>
</tr>
<tr>
<td>5 – 9</td>
<td>4,500</td>
<td>4,200</td>
<td>8,700</td>
</tr>
<tr>
<td>10 – 14</td>
<td>4,900</td>
<td>4,700</td>
<td>9,600</td>
</tr>
<tr>
<td>15 – 19</td>
<td>5,400</td>
<td>5,400</td>
<td>10,800</td>
</tr>
<tr>
<td>20 – 24</td>
<td>5,600</td>
<td>5,400</td>
<td>11,000</td>
</tr>
<tr>
<td>25 – 29</td>
<td>4,500</td>
<td>4,700</td>
<td>9,200</td>
</tr>
<tr>
<td>30 – 34</td>
<td>3,600</td>
<td>4,200</td>
<td>7,800</td>
</tr>
<tr>
<td>35 – 39</td>
<td>4,600</td>
<td>5,200</td>
<td>9,800</td>
</tr>
<tr>
<td>40 – 44</td>
<td>5,400</td>
<td>6,300</td>
<td>11,700</td>
</tr>
<tr>
<td>45 – 49</td>
<td>5,300</td>
<td>6,300</td>
<td>11,600</td>
</tr>
<tr>
<td>50 – 54</td>
<td>4,700</td>
<td>5,400</td>
<td>10,100</td>
</tr>
<tr>
<td>55 – 59</td>
<td>4,100</td>
<td>4,500</td>
<td>8,600</td>
</tr>
<tr>
<td>60 - 64</td>
<td>3,700</td>
<td>4,000</td>
<td>7,700</td>
</tr>
<tr>
<td>65 – 69</td>
<td>3,000</td>
<td>3,200</td>
<td>6,200</td>
</tr>
<tr>
<td>70 – 74</td>
<td>2,800</td>
<td>3,300</td>
<td>6,200</td>
</tr>
<tr>
<td>75 – 79</td>
<td>2,100</td>
<td>3,000</td>
<td>5,100</td>
</tr>
<tr>
<td>80 – 84</td>
<td>1,300</td>
<td>2,100</td>
<td>3,400</td>
</tr>
<tr>
<td>85 &amp; over</td>
<td>700</td>
<td>1,700</td>
<td>2,400</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71,100</strong></td>
<td><strong>78,300</strong></td>
<td><strong>149,400</strong></td>
</tr>
</tbody>
</table>

Table 1.1 shows the population of Knowsley split by 5-year age group and by gender. A third of Knowsley’s population are under the age of 25 with a further 18% of the population being of retirement age. Therefore, approximately half of the population (49.6%) are aged between 25 and retirement age.

Knowsley has a relatively young population with the average age being 38.5 years. In comparison, the average age across the whole of England is 39.3 years. Although the population in Knowsley is relatively younger than elsewhere, the average age is increasing at a quicker rate than nationally.
Knowsley’s population profile can be clearly seen in Figure 1.3. It is generally representative of a population from an area in a developed country in that there is little variation in the proportion of people in each age group up to the age of 54. However, there are subtle differences between the Knowsley population and the population nationally.

The most notable difference can be seen in the population aged between 25 and 39 where there are proportionally less Knowsley residents than England (particularly for males). This age group is very mobile and are likely to have left the Borough in order to gain employment in another area.

There are also proportionally less people aged between 60 and 69 in the Borough which is the result of a greater proportion of people dying prematurely in Knowsley.

Counter intuitively, there are a greater proportion of people aged between 70 and 79 in Knowsley which is a remnant of the high propensity of new housing in the Borough to accommodate the overspill population from Liverpool after World War II.

The resident population was at 149,400 in 2009 for Knowsley, this is not to be confused with the registered population. The registered population is the number of people who are registered with a GP practice in Knowsley, so in theory then can live outside of Knowsley. The latest estimate of the registered population was 158,500 (November 2010), some 9,000 higher than the resident population. The reason for the higher number of people in the
registered population is mainly due to list inflation which occurs when people move out of an area and don’t notify their practice.

**Population Density**

Figure 1.4 shows population density across Knowsley and highlights the variation within the Borough. The map shows that there are pockets of high population density in each of the main townships of Knowsley.

The electoral ward of Shevington in Kirkby has the highest population density in Knowsley which is indicative of the large number of new housing developments in the area over the last decade or so. Within Kirkby there is a large contrast to be found in the Kirkby Central electoral ward where population density is low due to a large proportion of the area being designated to Kirkby Industrial Estate.

In Huyton, population density is relatively high within the town with most electoral wards having higher population density than the Borough as a whole. The established areas of Page Moss and Swanside electoral wards have the highest density in Huyton, whereas Roby electoral ward has the lowest population density due to a substantial area of the ward being covered by Bowring Park Golf Course.

Prescot East electoral ward has the population density within the Prescot and Whiston townships which is in stark contrast to the area covered by Prescot West electoral ward. This area has the lowest population density in the Borough due to the majority of the land being covered by Lord Derby’s estate which includes Knowsley Safari Park.

Halewood North electoral ward is also an area that is sparsely populated in comparison to the rest of the Borough. This area contains a high proportion of farmland (including the village of Tarbock) and remains sparsely populated even with the high levels of housing development in the area over recent times. In contrast, Halewood West electoral ward has relatively high levels of population density.
Dependency on the Working Population

The dependency ratio looks at the ratio of children and those of pensionable age in the population as a proportion of those who are of working age. This
The dependency ratio in Knowsley has been falling steadily since 1996, from 69.5% to 61.8% in 2009. This means that there are less dependent people as a proportion of the overall population. The decrease is due to the proportion of dependent children falling and is now at 32.3%. However, there has been a steady increase in the proportion of people who are of pensionable age.

However, the overall dependency ratio is due to increase markedly in the next 20 years and is expected to be at 80.6% by 2030. The main reason for this is the expected increase in the elderly dependency ratio which is due to rise from 29.5% in 2009 to 45.0%. By 2019, it is anticipated that the elderly dependency ratio will be larger than the child dependency ratio. Although the child dependency ratio has been falling it is anticipated that it will increase marginally to a peak of 35.8% in 2025, falling gradually thereafter.

**Ethnicity**

The GP Survey was commissioned by the Department of Health and has been run since April 2009. It is sent to a different sample of patients within each GP practice every quarter and assesses patients’ experiences of local NHS services.
This analysis will focus on the demographic section of the results taken from the survey during 2009/10. In particular it focuses on ethnicity, sexual orientation and religion.

Table 1.2 – Respondents to GP Survey by Ethnic Group, 2009/10

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Persons</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>6,523</td>
<td>97.7%</td>
</tr>
<tr>
<td>Mixed</td>
<td>29</td>
<td>0.4%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>43</td>
<td>0.6%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>21</td>
<td>0.3%</td>
</tr>
<tr>
<td>Chinese or Other</td>
<td>63</td>
<td>0.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,679</td>
<td></td>
</tr>
</tbody>
</table>

Source: GP Survey Results 2009/10, Department of Health

Table 1.2 shows that of the 6,679 adults that responded to the GP Survey during 2009/10, nearly 98% were white meaning just over 2% of the Knowsley population are from a minority ethnic group. The highest proportion of people from a minority ethnic group came from the Chinese or Other group, 0.9% of people in the sample.

Sexual Orientation

Table 1.3 – Respondents to GP Survey by Sexual Orientation, 2009/10

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Persons</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual / Straight</td>
<td>5,727</td>
<td>95.2%</td>
</tr>
<tr>
<td>Gay or Lesbian</td>
<td>27</td>
<td>0.4%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>16</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other</td>
<td>39</td>
<td>0.6%</td>
</tr>
<tr>
<td>Prefer Not to Say</td>
<td>204</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,013</td>
<td></td>
</tr>
</tbody>
</table>

Source: GP Survey Results 2009/10, Department of Health

More than 95% of people responding to the GP Survey during 2009/10 said that their sexual orientation was heterosexual (straight). Of the remaining 5%, 27 said that they were gay or lesbian and 16 said they were bisexual.

Religion

Table 1.4 – Respondents to GP Survey by Religion, 2009/10

<table>
<thead>
<tr>
<th>Religion</th>
<th>Persons</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>639</td>
<td>10.0%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>17</td>
<td>0.3%</td>
</tr>
<tr>
<td>Christian</td>
<td>5,581</td>
<td>87.1%</td>
</tr>
<tr>
<td>Hindu</td>
<td>17</td>
<td>0.3%</td>
</tr>
<tr>
<td>Jewish</td>
<td>8</td>
<td>0.1%</td>
</tr>
<tr>
<td>Muslim</td>
<td>19</td>
<td>0.3%</td>
</tr>
<tr>
<td>Sikh</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>0.4%</td>
</tr>
<tr>
<td>Prefer Not to Say</td>
<td>99</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,407</td>
<td></td>
</tr>
</tbody>
</table>

Source: GP Survey Results 2009/10, Department of Health
During 2009/10, 5,581 respondents said that their religion was Christian. This corresponded to 87.1% of the sample surveyed. One-tenth of the people surveyed said that they had no religion at all. Of the remaining religions, there were 19 who are Muslim responding to the survey, 17 people who are Buddhist and 17 who are Hindu.

2.2 The Future

Population Projections

![Graph showing projected population change in Knowsley, 2009-2019.](image)

**Figure 1.6 – Projected Population Change in Knowsley, 2009-2019**

*Source: 2008-Based Sub-National Population Projections, ONS*

The population of Knowsley is expected to increase by 1.7% between 2009 and 2019, 3.2% by 2029. Although this increase seems relatively small, it is anticipated that there will be major impacts for various age groups within Knowsley.

The number of people aged over 50 residing in the Borough is expected to increase by 15.1% over the 10-year period that is an additional 7,500 people by 2019. The greatest proportional increase is anticipated to occur in the 85 and over age group where an additional 1,200 people are expected to be residing in the Borough (a 51.5% increase). In the 85 and over age group, the proportion of males is set to increase by 85% (600 men) and 38% for females (600 women).

Conversely, it is anticipated that there will be a decrease in the number of people residing in Knowsley aged between 10 and 24, and between 40 and 49.
Impact on Health

In the longer term, an aging population will mean that there will be a rise in demand for health services and long term care, possibly combined with tightened government spending, creating a challenge for the funding of public services and pensions and increasing pressure on families and friends to support retirees.

The long battle against deaths from heart disease and cancer is steadily being won, with continued falls in the number of early deaths. More people are living longer and surviving with chronic diseases. This demographic change requires a different approach to longer term care and a better structure to programmes of chronic disease management. This is particularly true for older people, who can enjoy an unprecedented life expectancy, but for some their quality of life may be limited by one or more chronic diseases. The rapid growth of the Knowsley population in retirement will increasingly pose major challenges to health and social care. Meeting the changing needs will require innovative approaches as well as resources.

A particular issue will be dealing with the rising rates of dementia. During the later stages of ageing the problems of dementia increase rapidly. The future expansion of services for dementia sufferers and their carers will present special challenges to the health and social care system, particularly where a greater proportion of the population are choosing to live alone. Newer treatments for dementia are making an important - and sometimes controversial - contribution to care. A cure remains elusive, however, and the social and emotional impacts of the condition remain as devastating as ever. Better support for carers is essential.

Another aspect of the increasing number of older people in Knowsley will be a growing demand for some types of elective surgery. Many procedures are primarily carried out on those over 60, notably joint replacements, cataract surgery and some cardiac procedures.

Knowsley Hospital Episode Statistics for 2009/10 show the percentage of older patients undergoing elective surgery.

<table>
<thead>
<tr>
<th>Elective Procedures 2009/10</th>
<th>Mean Age for Surgery</th>
<th>% of Patients 60-74 Years</th>
<th>% of Patients Over 75 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Replacement</td>
<td>69-70</td>
<td>51.6</td>
<td>26.1</td>
</tr>
<tr>
<td>Ophthalmic</td>
<td>73-75</td>
<td>34.4</td>
<td>55.9</td>
</tr>
<tr>
<td>Cardiac</td>
<td>62-64</td>
<td>30.1</td>
<td>46.0</td>
</tr>
</tbody>
</table>

Source: Knowsley Policy and Performance team

In addition, the age at which surgery will become possible is likely to increase as techniques become less invasive and the fitness of elderly people improves, reducing the risks of surgery for those over 70.
Increasing the volume of elective surgery for Knowsley people fits with the overall aim to increase proactive planned care whilst reducing the level of emergency admissions. The increase in surgery will need to be estimated to ensure plans are in place for the necessary capacity and resources.

**Impact on Social Care**

The forecast increase in the adult population, particularly for older people will have a significant financial impact on adult social care.

The increase in the population is a significant trend for Council services but particularly for adult social care as an analysis of current Knowsley age-related homecare demand shows the following:

- Aged 18 - 64 1 in 261 people are likely to require home care
- Aged 65 - 74 1 in 55 people are likely to require home care
- Aged 75 - 84 1 in 18 people are likely to require home care
- Aged 85 + 1 in 6 people are likely to require home care

Figures amended in line with new ONS 2009 Mid-year figures. Figures are based on services users as at April 2010 and exclude supported accommodation.

Or put another way **people over 85 are 37 times more likely to need services** than people aged 18-64.

The concern expressed nationally in the report Audit Commission and Care Quality Commission report “**Under Pressure – Tackling the financial challenges of an ageing population**”, which criticises Councils generally for failing to plan for the impact of demographic change, predicts

- The biggest single financial impact for Councils will be on social care spending and
- estimating a 3-4% growth per annum if services continue to be delivered in the same way

**The impact in Knowsley** is likely to be greater as areas with previously poor health are characterised by an effect described as ‘adding years to life but not life to years’, pointing out the effect of people growing old with the impact of long-term limiting conditions. Life is prolonged but without health improvement with an associated demand for all health and social care services. Significantly high rates of respiratory disease, cardiovascular disease linked to a high prevalence of smoking underpin demand for services.

Knowsley’s population also exhibits a marked trend to use crisis and emergency services as seen in the high rate of admissions to hospital in emergency with relatively low uptake until recently of preventative/screening services. The impact of ill health on carers is well evidenced but not apparent
in Knowsley with relatively low numbers of carers asking for help although we outperform all of our statistical neighbours.

Residential care for older people represents the highest percentage spend of the older people social care budget. John Bolton’s report “Use of Resources in Adult Social Care” identifies that no more than 50% of social care budgets should be spent on residential care for older people. The Knowsley figure is 52.8%, significantly better than many of our comparators and a decrease on the previous year at 55.7%. Admission rates for older people typically at around 200 per year, much less than 10% of the relevant population which, together with few admissions directly from hospital to residential, are features of well-balanced services and positive outcomes with low costs.

The service demand for both health and social care in places such as Knowsley is likely to become a greater financial issue if services continue, at least in the short term, to provide the same options and the population behaves in the same way. For example, between 2010 to 2015 the following predicted increase in expenditure are predicted:

- **Homecare** 101 people more will receive care - £0.603m (126 people - £0.759m SWIFT projections)
- **Supported accommodation** 1 person more will receive care - £0.033m (14 people - £0.520m SWIFT predictions).
- **Residential/Nursing expenditure** – 214 more people will receive care - £5.3m (99 people - £2.6m SWIFT projections)
- **Day Care** 27 people more will receive care – £0.058m (41 fewer people - £0.045m SWIFT projection)
- **Direct Payments** 609 people more will receive care - £5.1m (SWIFT projection only)
- **Carers demand** - reducing the potential unmet demand by 90% and applying the average yearly net cost of a critical home care package (£4500 or £85/week) still produces a potential cost increase in the near future of up to £1.80m

(Calculations based on POPPI/PANSI and SWIFT projections)

Failing to change service responses and demand through behaviour change and modernisation of services will produce an unsustainable financial position by 2015.

**Wider Impact in the Borough**

The changing demographic in the Borough potentially is going to have an impact on the wider influences of health.

Reduction in the working age population in the Borough may mean less people who are economically active and less informal carers providing support (i.e. less younger people to support older people). In addition, issues may arise due to a growing need for informal caring responsibilities at a time when the working age is being extended causing work life balance concerns.
In the longer term, an aging population will mean that there will be a rise in demand for health services and long term care, possibly combined with tightened government spending, creating a challenge for the funding of public services and pensions and increasing pressure on families and friends to support retirees.

This burden is likely to increase the proportion of the population in poverty. Individuals will be expected to cover more of their own care and health costs. And without changes to pensions and retirement, pensioner poverty will increase.

There will also be a requirement for a higher proportion of housing that needs to be adapted to support the needs of an aging population. This may include the need for a greater provision of supported accommodation.

Evidence suggests that an ageing population will impact on charitable giving as different age cohorts have different values, as well as attitudes towards giving in general and towards particular causes. This could potentially impact on charitable organisations that support people within the community, such as age concern.

Alongside the aging population projections, people are expected to work for longer and thus retire at an older age. The implications of this is ensuring that employment opportunities are appropriate.

In relation to access to services and transport issues it is unlikely that this will deteriorate. However, if free public transport travel was discontinued problems would arise.
3. KNOWSLEY NEEDS

3.1 CHILDREN AND YOUNG PEOPLE

3.1.1 CHILDREN WITH DISABILITIES

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<tbody>
<tr>
<td>Lead Author</td>
<td>Pauline Coulter / Jill Colbert</td>
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<tr>
<td>Approved by</td>
<td>Jill Colbert</td>
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**Key Needs**

- The level, degree and prevalence of childhood disability in Knowsley is not comprehensively understood as data collected is not co-ordinated or consistently gathered.
- Between October 2006 and July 2010 the multi-disciplinary Autistic Spectrum Disorder assessment pathway diagnosed 147 children with ASD in Knowsley and this figure continues to rise; over 250 children have been referred for assessment to date.
- Insight feedback from parents of children with complex needs tells us that their view is that Knowsley lacks a range of flexible and diverse short breaks that they have confidence in.
- In 2010-11 there has been a measurable increase in the number of young people requiring specialist in-patient mental health provision.
- National estimates of prevalence of childhood disabilities varies as between 3 to 5%, with 1 to 2% having complex needs. For Knowsley that is an estimate of between 1,113 to 2003.
- In November 2010 there were 30 children and young people known to the Community Nursing team with complex disabilities. Those children may not be well known to their GP as their medical care is generally sought from their Consultant.
- There is a need for a range of age appropriate short breaks at times and in places families need them including at home and out of hours with a level of continuity and consistency with a professional carer/support worker.
- Need for information on services and pathways for children and young people with disabilities to be clear and accessible to families.
- ONS 2004 reported 30% Autistic children have a recognised mental disorder.

**Description of Where / Who the Issue Affects**

The National Service Framework for Children, Young People and Maternity Services (2004) clearly established the significance of improving health services for children and young people with disabilities and introduced the imperative to improve pathways through models like Early Support. The
Aiming High for Disabled Children programme, rolled out in 2008, built on this foundation and firmly established disabled children as a priority in Knowsley. These important developments have influenced our progress and there is evidence that much has been improved through Aiming High to drive forward inclusive practice.

It is widely recognised however that disabled children and their families are amongst the most vulnerable family groups in the borough and national projections suggest that there will be a continuing rise in the numbers of children with disabilities due to advancing medical technology and prematurity survival rates.

In 2010 the Department of Health launched the National Framework for Children and Young People’s Continuing Care which contains a clear set of frameworks against which to assess children’s complex needs and allocate resources appropriately. We are implementing the guidance in Knowsley and monitoring the extent to which partners in the acute trust are using the tools to guide their decisions around discharge to ensure equitable decision making.

There are particular points of transition for children with disabilities where we know we need to improve our process, systems and service offer:

- As neo-nates/infants from hospital care to the community particularly in relation to the provision of specialist equipment
- In monitoring the provision of health services to children and young people as they transition in and out of out of area placements
- For young people aged 14+ who transition to young adulthood and to adult services. Parents/carers along with children and young people express specific concern about support available at this time. Additionally as more disabled children survive into adulthood due to medical advances, adult health staff are being faced with conditions they have not experienced before.
- Transition between hospital/Consultant led care with the young person’s GP

In order to address the information/data deficit the Local Authority has launched the ‘Count Us In’ survey which is a voluntary questionnaire designed to capture the range of children’s needs and family circumstances. Uptake will be monitored and it is fully supported by the parent engagement forum.

The initial AHDC programme evaluation due December 2010 and the PSS insight report will inform a future comprehensive needs assessment in relation to short breaks, including activities, leisure, short breaks, outreach and overnight stays.

The development of a borough wide Carers strategy is underway and parents and carers have been engaged in the early work on the strategy to direct and shape it.
A specific service is currently delivered to siblings of disabled children, who are not always recognised as carers, whose health can be detrimentally affected by their family circumstances. They will also be a key group addressed through the Carers Strategy.

**Equality and Diversity**

Disabled children are a disadvantaged group with restricted access to mainstream services and activities, employment opportunities, and are more likely to live in poverty. For disabled children who are members of BME communities, there are often multiple layers to their experience of oppressive practices and policies. There is limited information in the Borough relating to disabled children and young people with regard to all of the groups recognised in equality legislation which makes it difficult to ensure services are planned to meet their needs.

The new Centre for Independent Living has been commissioned through the use of Aiming High monies to meet children’s needs effectively and parents/carers will be part of the User Led Organisation which manages the centre.

Many parents of disabled children who work report that they struggle to find appropriate childcare to enable them to access education/employment.

Parents in the Borough have also indicated that they experience negative attitudes in their local communities towards them and their children.

Nationally it is estimated that disabled children are more likely to experience significant harm than the non-disabled child population.

**Links to Other Issues / Topics**

Family poverty is a particular area of concern, and specifically fuel poverty is a very real issue for families with children who rely on energy dependent equipment.

Given the increased risk of significant harm disabled children are not reflected in the numbers of children requiring a child protection plan.

Many disabled children do not access leisure, sport, the arts, healthy lifestyle activities as a matter of course. Equal access to information, transport, housing, education and employment is restricted for them for a variety of reasons.

Many disabled children are isolated and those in special schools often find it difficult to see friends outside of school as they do not live near to their school.
There is a significant number of children with complex disabilities who are obese. The voice of disabled children, young people and their family’s needs to be stronger.

**Links to Existing Strategies**

There are links to the following strategies in particular:

- Parenting Strategy
- Mental Health Prevention Strategy
- Emotional Health and Well-being and Mental Health Strategy
- Healthy Child Programme 0 - 19
- Children and Young Peoples Plan Refresh (in which disabled children are a priority)
- Housing Strategy
- Draft Child Health Strategy
- Sustainable Community Strategy

A number of pathways have been developed including an ASD assessment and diagnosis pathway and an ADHD assessment and diagnosis pathway.

A comprehensive equipment pathway will be developed as the Centre for Independent Living opens, which will operate as part of the Continuing Care Pathway.

**Future Implications**

It is predicted that the disabled child population nationally will increase by 23%-40% by 2022. This equates to 256 to 1083 extra children in the Borough. The transformational aspects of the Aiming High for Disabled Children programme set out in the Full Service Offer relating to short break provision will need to be sustained to ensure equality of access to provision. Further work is underway through the Transforming Outcomes for Disabled Children and Young People Programme which will transform service design and delivery.

As a consequence of providing clear support to grassroots groups there is a stronger parental voice in the Borough through Parents Support Groups and it is anticipated these will continue to lobby for greater equality of access to activities and services.

**Evidence of What Works**

The initial evaluation of the Aiming High Disabled Children programme due before the end of the programme in March 2011, will provide some evidence of what works in relation to short breaks which will inform future service design.
There is some early evidence that Aiming High for Disabled Children has prevented at least 4 disabled children from being accommodated by Children’s Social Care and thereby remaining in their families and in the Borough.

**Gaps**

- Lack of data and intelligence
- Lack of stepped service models which offer a range of interventions between universal and specialist and targeted services
- Lack of clear and accessible information about provision and pathways for parents/carers, children and young people
- A mainstreamed and consistent strategic approach to provision for this group

**Recommendations for Commissioners**

- Ensure that the provision of available baseline data and intelligence is coordinated by end of March 2011 and informed by parent information
- Complete the Transition Health Prompt by January 2011 to inform improved transition between child and adult health services.
- Monitor achievement of the Full Service Offer by March 2011.
- Deliver the initial outcomes of the Transforming Outcomes for Disabled Children Project by March 2011.
- Implement Children’s Continuing Care guidance by the end March 2011.
3.1.2 PREGNANT TEENAGERS AND TEENAGE PARENTS

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**Key Needs**

- Evidence shows that having children at a young age can negatively affect a young woman’s health and wellbeing and severely limit her education and career prospects.
- Children born to teenagers are more likely to experience a range of negative outcomes in both early and later life, and are up to three times more likely to become a teenage parent themselves.
- Despite the teenage conception rate in Knowsley being slightly lower than the North West average (45.8), rates remain higher than the national rate for under 18 conceptions at 43.5 per 1000 in 2008 compared to 39.8 per 1000 nationally.
- Although the number of conceptions has fallen by 21% since 1998, over 50% of these conceptions end in abortion, suggesting that these are unplanned pregnancies.
- Due to targeted work the number of conceptions in ‘hot spot areas’ of the borough has reduced dramatically year on year, but inequalities remain with parts of North Kirkby having conception rates of above 60 per 1000 under 18 year old young women.
- Vulnerable young men and young fathers require additional support to access specialised sexual health and relationships advice and signposting to support services.

**Description of Where / Who the Issue Affects**

In Knowsley, inequalities exist in the distribution of teenage pregnancies throughout the Borough, for example the highest rates are found in North Kirkby and North Huyton, with a conception rate in North Kirkby of 57.7% compared to 33.7 % per 1000 in Prescot, Whiston and Cronton (2005-7 ONS). Areas of highest conception rates are very much linked to high rates of deprivation and unemployment. To tackle this contraceptive services are based in ‘hot spot’ areas such as Kirkby and Huyton. Outreach services such as the Sexual Health Specialist Nurse and the THinK (Teenage Health in Knowsley) service target these areas.

Teenage Pregnancy rates amongst the under 16’s are lower than the national average and equated to only 74 conceptions in 2005-7 or an average of 25 per year. In terms of live births the abortion rate is above 50% and therefore there are very few under 16 year olds that are teenage mothers.
The Family Nurse Partnership pilot scheme which began in January 2010, is currently supporting 60 teenage parents (under 20 years old first time parents), out of a total capacity of 100. The scheme offers intensive support to teenage parents and their families and help to build confidence and skills in parenting and resilience.

The Teenage Pregnancy Reintegration Service had 98 referrals (under 19s) last year and 33 teenage mothers attended ‘Healthy Start Healthy Futures’ parenting course, which is based in North Huyton.

YWCA in Kirkby supported 10 teenage mothers attending ‘Parents with Prospects’ and ‘Young Mums to be’ courses in 2010.

Connexions report back to the Teenage Pregnancy Board on numbers of teenage mothers that are not in education training and employment (NEET). Although these numbers fluctuate monthly, currently there are 109 teenage mothers registered with Connexions, 23% of whom are in education, training or employment.

**Equality and Diversity**

National data on mothers giving birth under age 19, identified from the 2001 census, show rates of teenage motherhood are significantly higher among mothers of ‘Mixed White and Black Caribbean’, ‘Other Black’ and ‘Black Caribbean’ ethnicity. ‘White British’ mothers are also over-represented among teenage mothers, while all Asian ethnic groups are under-represented.

Less than 2% of the Knowsley population are from the Black and Minority Ethnic (BME) groups. Ethnicity data is collected on teenage mothers known to services, and there is no apparent disproportionality across different ethnic groups in Knowsley. Looked after children in Knowsley are supported by dedicated health workers, who are trained to deliver contraceptive advice and the ThinK in a Box service.

A number of national studies have suggested a link between mental health problems and teenage pregnancy. A study of young women with conduct disorders showed that a third became pregnant before the age of 17. There are additional implications for young mothers (Teenage Pregnancy: Next Steps). Once they have given birth they are more likely to suffer from post-natal depression and these higher rates continue for up to three years.

The Teenage Pregnancy consultation paper: Teenage Pregnancy Strategy; Beyond 2010 reinforces the importance of engaging and supporting young fathers. Research demonstrates that young fathers are as likely as young mothers to have poor educational achievement, display risk-taking behaviour and disengage from school.

Young women with learning disabilities are at a higher risk of teenage pregnancy, according to national data. This may reflect the limited sexual
heath education opportunities that are available to people with learning disabilities.

**Links to Other Issues / Topics**

Areas of high teenage conception rates tend to be the same as those with high levels of social deprivation. Other risk factors include low educational attainment and school attendance, young people who are at risk of offending and who are or have been children looked after.

Teenage pregnancy is more common in young girls who have experienced mental health problems, sexual abuse in childhood, sex before the age of 16, violence and bullying at school, poor parental support, involvement in crime, use of alcohol and substance misuse and in those who have low aspirations. Young fathers are more likely to live in deprived areas, to be unemployed and to be in receipt of benefits and have similar characteristics to teenage mothers.

In Knowsley, the majority of teenage mothers are lone parents (79%), with 19% co-habiting and 2% part of a married couple. Lone parents are more likely to be on benefits or be working for low pay and lack qualifications.

**Links to Existing Strategies**

There is an overarching Sexual Health Modernisation Programme for Knowsley and a specific Teenage Pregnancy Strategy. These are also linked to the Children and Young People’s Plan and are aligned to Children and Family Services’ Integrated and Targeted Youth Support Strategies.

Teenage Pregnancy, in terms of reducing the under 18 conception rate, supporting teenage parents and reducing the numbers of young parents that are not in education training or employment, is linked to the following Strategies;

- NEET Strategy
- Maternal Health Strategy
- Sexual Health Strategy
- Parenting Strategy
- Children’s and Young Peoples Health Strategy

**Future Implications**

By 2008, Knowsley had reduced its teenage conception rate by 21% from the 1998 baseline, this compares to a reduction of 12.5% in the North West and 13.3% in England.

If rates continue to be higher in particular areas of Knowsley, inequalities in health will remain. It is important that prevention of teenage conceptions is a priority in the areas highlighted to help to reduce the inequalities in those wards and across the Borough as a whole.
Improving outcomes for teenage parents is important because it will, in turn, reduce the chances that their children become teenage parents. More immediately, supporting teenage mothers to access and use contraception effectively after the birth of their first child will also help prevent second and subsequent unplanned pregnancies. In addition, it is important to provide continued education support with parenting and lifestyle advice.

In August 2010 the Audit Commission produced a report “Against the Odds”, which found that young parents were up to 3 times more likely to be NEET for over 6 months than young people (under 18) that were not parents. The costs in terms of benefits to support both parents and children will now vary across authorities and be capped, but this cost greatly exceeds that of providing contraception including Long Acting Contraception and for unwanted pregnancy abortion services.

**The Costs of Teenage Pregnancy (GONW 2009)**

Government Office North West estimated the following average costs for Teenage Pregnancy, not taking into account the costs of benefits and welfare post birth.

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<td>Repeat termination</td>
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<tr>
<td>termination</td>
<td>£500</td>
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<tr>
<td>Under 18 conception (including and up to delivery)</td>
<td>£2,500</td>
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<tr>
<td>LARC (long acting reversible contraception)</td>
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<tr>
<td>IUD (intra uterine device)</td>
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<tr>
<td>Injection</td>
<td>£15</td>
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<tr>
<td>Contraceptive Pill</td>
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**Evidence of What Works**

International evidence shows that the two combined measures with the strongest impact to reduce teenage conceptions are comprehensive information advice and support about sex and relationships, from parents, schools and other professionals, and accessible ‘young people friendly’ sexual health and contraception services.

NICE Public Health intervention guidance has been produced on preventing sexually transmitted infections and reducing under-18 conceptions. This includes guidelines on the provision of sexual health services that meet the population’s needs, such as specialist sexual health youth workers and training for key staff including GPs and school nurses and staff working with vulnerable groups.

In Knowsley young parents are referred to the Reintegration Officers and specialised Teenage Pregnancy Midwives and Family Nurses. Young parents are supported to stay in formal or informal education, and are able to access specialised antenatal classes and clinics. Recent evaluations of support services are very positive.
Gaps

A recent Knowsley local authority Scrutiny Committee review of Teenage Pregnancy found that although there were examples of excellent work being done by the Local Authority and NHS Knowsley and partner agencies, there still remained some gaps which could lead to inequalities in outcomes for young people. The Scrutiny Committee requested that the Teenage Pregnancy data sub group investigated these inequalities and a report has subsequently been published by Public Health Intelligence.

In terms of services, more work is needed with parents, especially fathers, to encourage them to talk to their children about sexual health. Speakeasy, a programme designed by the Family Planning Association, is delivered to parents across the Borough, and needs to be evaluated in terms of further opportunities to deliver the course in different ways and locations.

In common with national findings, the Young Peoples Parliament and Advisors in Knowsley found that the delivery of Sex and Relationships Education (SRE) across Knowsley schools was patchy and not meeting required need. It was recognised that PSHE was not integral to teacher training and that not all schools had specialist teachers that felt confident to deliver PSHE.

Young peoples’ contraceptive services in Knowsley have been branded THinK (Teenage Health in Knowsley), and within secondary schools provision THinK in a Box has been provided by the school nursing service and Youth workers. However since the new Centres for Learning have replaced previous secondary provision, there has been a period of reorganisation of services due to both the ‘bedding in’ of the new secondary provision and a restructure of school health services.

Recommendations for Commissioners

The following recommendations are drawn from the Scrutiny Committee March 2010, which are to be project managed and reported back on by March 2011.

These recommendations are being project managed within the Local Authority, and monitored by Teenage Pregnancy Strategy Board on a quarterly basis, with updates on relevant progress to the Sexual Health Modernisation Board and Maternal Health Board. The final report on progress to the Scrutiny Committee is on 30th March 2011.

Scrubtny Recommendations

1. Effective delivery of Sex and Relationship Education (SRE) by schools
   • It is recommended that there are designated teachers in each Centre for Learning, Pupil Referral Unit, Work Based Learning and College
who have been trained to deliver SRE and have appropriate skills, knowledge and approaches.

- It is recommended that there is consistent, high quality delivery of SRE across all educational settings in line with government guidelines.
- It is recommended that the involvement of trained peer mentors and outside agencies should be further integrated as part of SRE delivery.
- It is recommended that, where appropriate and possible, SRE should be delivered in a single-sex context.

2. Provision of ‘THinK in a Box’ Service
- It is recommended that there is increased access to the THinK in a Box service within Centres for Learning, Pupil Referral Units, Work-Based Learning and Colleges.
- It is recommended that the THinK in a Box service is promoted more widely to parents and carers through Centres for Learning, Pupil Referral Units, Work Based Learning and Colleges.

3. Engaging with young men including young fathers
- It is recommended that targeted and specialist services working with young men promote key messages around sexual health, contraception and relationships.
- It is recommended that support for young fathers is accessible and equitable across the Borough.

4. Responding to unequal distribution of teenage conceptions in the Borough
- It is recommended that mapping of current provision in areas with high rates of under-18 conceptions is undertaken, engaging actively with the relevant Area Partnership Boards, with a view to setting local targets and adapting and prioritising service delivery.

5. Work with parents on talking to their children about sex and relationships
- It is recommended that the Speakeasy course is evaluated with a view to having different models of delivery that enhance parental attendance.
- It is recommended that all parenting workers in the Borough are trained to work with parents around talking to their children about sex and relationships.

6. Reviewing progress
- It is recommended the Children, Young People and Families Scrutiny Committee be provided with an update on the progress of implementing the review’s recommendations and their impact in March 2011.
3.1.3 EMOTIONAL HEALTH AND WELLBEING AND MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE IN KNOWSLEY

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**Key Needs**

- It is believed that 1 in 10 C&YP have a mental health disorder. Using 2008 ONS mid-year population estimates we can estimate that there are 3,930 C&YP aged 0 – 19 in Knowsley that have an emotional health disorder.
- This overall prevalence rate is higher amongst children with autism (30%), children from more deprived communities, children looked after (CLA), children residing in a lone-parent household, refugee and asylum seekers, young offenders, children with epilepsy and disabled children.
- Significant emotional ill health is more common amongst CLA, with an estimate that 45% have some sort of mental health problem. Currently there are 303 CLA in Knowsley (April 2010), by using national prevalence rates it can be estimated that 136 of these 303 will have a mental health disorder.
- Children who have an SEN statement are particularly vulnerable to mental health disorders, with it being estimated nationally that 43% are likely to suffer from any type of disorder. In particular SEN statemented children are most likely to suffer from conduct disorders (24%). At present there are 743 pupils in Knowsley LA maintained education who are identified as having an SEN statement, by using this national prevalence rate it would suggest that 319 of these may have some sort of clinically diagnosed mental health disorder and 174 of the 743 may have a conduct disorder.
- Nationally, it has been estimated that 0.9% of children have an autism spectrum disorder – which if applied to the estimated number of young people in Knowsley would mean that approximately 20 young people in Knowsley aged between 5 and 16 have an ASD.
- Between October 2006 and July 2010 the multi-disciplinary Autistic Spectrum Disorder assessment pathway diagnosed 147 children with ASD in Knowsley and this figure continues to rise; over 250 children have been referred for assessment to date.

**Description of Where / Who the Issue Affects**

Knowsley children report a higher level of emotional health and wellbeing against the NI 50 definition than children from any other local authority in the country. Locally, we are aware that younger children report a higher level of emotional health and wellbeing than older children (Y10) and females report...
higher levels than males. Although this definition does not take into account all the factors shown to contribute to a good or content childhood – it does reflect the higher likelihood that younger children and females are to discuss their worries with parents and adults.

Older children (12 – 15+) locally are known to typically prefer discussing their worries with their peers rather than parents. Given that this age-group of young people are known to be the most likely to experience peer pressure, cyber-bullying, mental health disorders and are the most likely to self-harm, it is imperative that young people by this age are tooled to respond appropriately to hearing and appropriately helping peers dealing with the serious issues that may hinder their emotional health, wellbeing and mental health.

Children Looked After can have a particularly different experience of childhood and the support they require for a good / content childhood, to build resilience and to lessen the chances of mental health problems differ to those of other children. Key factors for these children oscillate around their experience before, during and after care. Although every CLA’s needs and experience differ, some of the factors more typical of enabling these children to lead a good childhood and build resilience are their relationship with their caregiver, the stability of their placements and the distance they are from home. These will all have an influence on their relationships with friends, experience of education and learning as well as their access to leisure activities.

Maternal and paternal influences are known to have a key influence on both whether the child has a good / content childhood, their levels of resilience and whether they suffer from a mental health problem. The ‘serve and return’ interactions between carer and child are key to the social, emotional and cognitive developments essential for the child’s emotional health and wellbeing. Where the parent has an emotional health problem or is unable to engage in this ‘serve and return’ process there can be severe implications for the child, in the immediate term as well as in shaping their longer term social interactions – which may in effect create a self sustaining cycle of negative influence on the child’s emotional health and wellbeing. The large increase in the number of safeguarding referrals for children relating to ‘Family Dysfunction’ also infers a local increase in the number of children who may be struggling to benefit from the parent – child interactions key to a good or content childhood.

Where a parent has a mental health problem, the impact on the child can be somewhat lessened by the interaction with the other parent. Given that in Knowsley there is a known high number of lone parent households, and that lone parents are also known to be more likely to suffer from mental health problems – these children can be particularly vulnerable as they do not have the ‘buffer’ of the other parent. In addition to this, children in lone parent households are also more likely to be living in poverty and are therefore less likely to have the financial capacity to participate in leisure activities – which are known to be highly important to a good or content childhood, being more
likely to be in environments perceived as ‘safe’ as well as having more opportunities to engage in peer-to-peer interactions.

Locally, young males are more likely to suffer from conduct disorders whereas young females are more likely to suffer from emotional disorders. Young females are most likely to suffer from an emotional health disorder between the ages of 13 and 15. One of the main causes of offending for persistent young female offenders in Knowsley is seen as their emotional health and wellbeing. Knowing that research indicates that a high number of young perpetrators of crime are often in environments where they are likely to also be a victim of crime, it indicates that these young people are likely to be in environments where they may be or feel unsafe – further hindering their emotional health and wellbeing.

Key themes that were discussed by young people as part of the consultation for the Emotional Health and Wellbeing and Mental Health Strategy included stigma, dealing with problems when young, prevention and early intervention, information and awareness raising.

From the discussions and consultation that was carried out with children and young people they identified their own priorities as being:

- A vision should focus on key areas such as training, communication, promotion and awareness
- Awareness is crucial - young people need to know what is out there to help and support them and what is the difference between for example a Tier1 and Tier3 service.
- To support young people dealing with problems practical examples should be shared of different things other young people have done or used to cope in difficult situations.

**Equality and Diversity**

**Children with Autism Spectrum Disorders (ASD)**

It is estimated that children with an ASD have a 30% chance of having a clinically recognisable mental disorder – most typically these have been seen in research to relate to anxiety or depression\(^1\). Not only is the prevalence of anxiety and depression higher amongst children with an ASD as these young people often struggle to communicate feelings and emotions – it is believed that there is high potential for these disorders to go undiagnosed.

**Young Offenders**

It is believed that 31% of young offenders have mental health needs, most commonly these needs are due to depression (18%) and anxiety (10%)\(^2\).

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For Prolific Young Offenders, lifestyle factors become more of an issue as well as the buildup of a larger number of issues suggesting young people with a number of issues and difficulties in their lives are those most likely to become prolific young offenders. Females are more likely to have emotional and mental health issues seen as a key driver behind their offending – once again this being most common in the PYO cohort.

**Young Carers**

Research has found that young carers can experience substantial physical, emotional or social problems and encounter difficulties in school and elsewhere. It is estimated that there are between 19,000 and 51,000 young carers in the UK – with 30% providing care for a parent with a mental health disorder. It is also estimated that 114,000 5–15 year olds nationally are providing some form of informal care (approximately 1.4%). In Knowsley this would equate to 284 children, with 18 of these believed to be providing 20 hours or more a week and 9 providing more than 50 hours of informal care per week.

Teenage mothers are also more likely to have significantly lower emotional health in the three years following the birth of their child than older mothers or teenage non mothers.

**Children with Special Educational Needs (SEN)**

Children with identified SEN are also known to be a group more vulnerable to mental health disorders. The children who have an SEN statement are particularly vulnerable to mental health disorders, with it being estimated nationally that 43% are likely to suffer from any type of disorder. In particular SEN statemented children are most likely to suffer from conduct disorders (24%).

**Children Looked After**

Significant emotional ill health is more common amongst Children Looked After (CLA), with an estimate that 45% have some sort of mental health problem. Currently there are 303 CLA in Knowsley (April 2010), by using national prevalence rates it can be estimated that 136 of these 303 will have a mental health disorder. This rate is also believed to be higher amongst CLA who are aged 5–17, as well as CLA who are resident in residential settings.

In households where neither parent is working 1 in 5 children have a mental health disorder (approximately 990 children locally – based on ONS population estimates), and almost 1 in 4 children who are in receipt of

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disability benefit (24%) are believed to have a mental health disorder\(^6\) (approximately 238 children locally, again based on ONS population estimates).

Low-income parents are also known to be substantially more likely to have low emotional health and wellbeing as well as being more susceptible to a mental health disorder\(^7\). In particular, this is more of an issue amongst females rather than males suggesting that the high number of female lone-parent households in Knowsley may represent a particularly significant vulnerable cohort.

Research does show that the experience of being lesbian, gay or bisexual often impacts on the experience of school had by these young people. Lesbian, gay and bisexual children report an experience of being bullied more often than other children\(^8\) with 2 / 3 lesbian, gay or bisexual pupils nationally claiming to have experienced homophobic bullying and 7 out of 10 feeling this affected their school work. Although Bullying is known to be the main issue from KOOTH.com, amongst those who identify themselves as from a BME minority, bullying is less a less prominent issue (although the sample size is very small).

**Links to Other Issues / Topics**

The central importance of emotional health is recognised as providing a platform for improving aspirations, ambition and better adult mental health outcomes as well as providing resilience in improving overall health outcomes for children and young people.

An emphasis has been placed on preventative and early interventions with the identification of the key elements that provide for good emotional health and development for children.

Parenting models and building resilience have been highlighted as essential in delivering better emotional health and wellbeing. This approach is a whole systems approach and recognises the link between health outcomes, behaviour and lifestyle choices of children, parents/carers and the wider community.

**Links to Existing Strategies**

Improving emotional and health and wellbeing in Knowsley links with the following strategies:

- Knowsley Children and Young People’s Plan (2008 - 2011) and Annual Review and Refresh (2009-2011)

\(^6\) ONS (2004) ‘Mental Health of Children and Young People in Britain
\(^7\) http://www.poverty.org.uk/62/index.shtml
• Emotional Health and Wellbeing and Mental Health Strategy 2010 – 2013 (currently in development)
• Mental Health Promotion Strategy (2006 – 2009)
• Knowsley Child Health Strategy (Currently in development)
• Knowsley Maternal Health Strategy (2010 – 2013)
• Knowsley Substance Misuse Treatment Plan (2010 – 2011)
• Knowsley Corporate Parenting Strategy (2007 – 2010)
• Supporting Parents and Families in Knowsley (currently under revision)
• Implementation of the Healthy Child Programme

Future Implications

The emotional health and wellbeing strategy will help to put in place integrated systems, strengthen partnerships and co-ordinate evidence based services which will support a sense of wellbeing, build resilience in children and young people (0-19 years) and help them to cope with problems they experience as they grow up.

The benefits of good mental health go far beyond childhood, getting it right at this vital time of their lives will help them throughout their lives, helping them to enjoy life and contribute to the society in which they live.

In Knowsley the traditional understanding of the term CAMHS has related in the main to Tier 3 – Specialist CAMHS or Tier 4 – Highly Specialist CAMHS. Our vision is to promote a whole system approach to emotional health and wellbeing and mental health in Knowsley and our mechanism for achieving this is through the Knowsley model of Children in Need. In order to get there we need to build a more cohesive CAMHS model at Tier 2 (Targeted), one which provides training and consultation to universal services to support promotion, early intervention and prevention of mental ill health; delivery of clinical interventions where appropriate and in conjunction with universal services and finally a filtering and gate-keeping function in relation to specialist (Tier 3) services.

Evidence of What Works

The following NICE guidance currently exists in relation to mental health. Service providers are required to implement the evidence based practice contained within the guidance:

• Antenatal and postnatal mental health, February 2007
• Attention deficit hyperactivity disorder (ADHD), September 2008
• Bipolar disorder, July 2006
• Depression in children and young people, September 2005
• Depression with a chronic physical health Problem, October 2009
• Eating disorders, January 2004
• Self-harm, July 2004
The emotional health and wellbeing strategy sets out a service model of promotion, early intervention and specialist support for emotional health and wellbeing and mental health, based on the best available evidence as outlined within the Government Guidance: Promoting the Emotional Health of Children and Young People.

Gaps

Gaps exist in relation to data availability for some equality and diversity groups. The provision of more robust data will allow for a greater understanding of need, trends and targeting of provision.

At present only 2 years of electronic CAMHS referrals records are available. As this dataset grows, analysis of whether this is a growing number of referrals in specific localities and for particular age groups will be possible.

The lack of detailed information on the number of children with disabilities and specific local information about these children’s experience relative to their emotional health, wellbeing and mental health needs is a significant intelligence gap locally.

The focus on Child and Adolescent Mental Health Services (CAMHS) in Knowsley has largely been on the provision of specialist services. Some of the challenges within specialist services are the number of children and young people being referred to the service and the length of time that some children and young people have to wait to receive a service.

Targeted services are currently focussed upon vulnerable groups resulting in a lack of generic (targeted) services for the greater population of children and young people in Knowsley.

Recommendations for Commissioners

- To train and develop universal staff to recognise specific areas of risk and behaviour, including self harm and challenging behaviour in addition to the promotion of mental wellbeing.
- Develop clearly defined pathways and an appropriate service model for targeted services with sustainable funding by March 2011.
- To ensure that Specialist CAMHS provision is offering effective, appropriate cost effective interventions that improve outcomes for children, young people and families by November 2011.
- To explore community based treatment models to prevent in-patient admissions and ensure sufficiency of in-patient beds during 2011.
- To improve the involvement and engagement of children and young people and parents/carers in service planning and delivery by November 2011.
3.1.4 CHILDREN LOOKED AFTER

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Key Needs

- At year end 295 children and young people were looked after compared to 306 at the end of 2009 – this equates to 84 per 10,000 population compared to 88 per 10,000 last year and is our lowest CLA population since the end of 2007.
- Between 2008 and 2009 the national population rose by 2.5%, the increase in the North West was 3% whereas we bucked the trend reducing our population by 4%. Although our rate per 10,000 is similar to our Statistical Neighbours we are still much higher than the 2009 national and regional averages of 55 and 74 per 10000 population.
- Placement stability is an essential building block for delivering positive care outcomes and it is essential we have a sufficient range of local placements to cater for individual needs and ensure all CLA have stability for the duration of their care episode. This will ensure that the trauma of care entry is minimised, will facilitate contact with friends and family and avoid disruption in terms of schooling and access to the full range of universal services.

Description of Where / Who the Issue Affects

Nationally 60,000 children are looked after and it is well documented that they have significant and complex needs. They underachieve educationally and are highly represented in social exclusionary factors such as teenage pregnancy, unemployment, youth offending, poor mental health, drug and alcohol abuse and homelessness.

Care needs are linked to overall deprivation – approximately 70% of our CLA population come from the most deprived areas. 44% originate from 4 wards – Page Moss, Northwood, Stockbridge and Prescot East - Page Moss alone accounts for almost 16%. These same 4 wards also account for 50% of all 10-15 year olds looked after. Halewood West whilst accounting for just 6% of the total population provides.

The age distribution of CLA has also remained fairly constant with the 10-15 age groups accounting for 40% of the total. 27% were aged 0-4 and 13% aged 16+ in contrast to the respective national figures of 21% for both age
The highest number of 1-4 year olds (11) equating to 16% of this age group.

The length of time children and young people remain in our care varies considerably and not surprisingly is related to age – the younger the child the shorter their care episode. Overall almost 28% of our current population have been in care for less than 6 months and 26% for longer than 3 years.

During 2010, 73 children entered our care – a 7% reduction from the previous year. The largest proportion of care entrants over the last 2 years has been younger children in particular the 1-4 age group. Compared to national averages we look after a significantly higher % of younger children. In 2009 22% of our care entrants were in the 10-15 age group compared to 36% nationally. In 2010 this number increased slightly to 26%.

Equality and Diversity

A full needs assessment is carried out prior to any child or young person becoming looked after or, in the case of an emergency admission to care, immediately following care entry. This multi-agency core assessment takes full account of individual holistic needs and ensures placements are matched to individual needs. Wherever practicable children and young people are placed locally to minimise disruption and ensure continuity of access to universal services, family and friends.

Representatives of CLA contribute to service design, development and delivery through their membership of the Children in Care Council, their involvement in recruitment panels and their active role as Young Inspectors of services.

Of our total looked after population 89% were cared for in local family settings including all children aged under 10. The remaining 11% were placed in residential settings - much lower than the national average of 16% (2009).

Links to Other Issues / Topics

Children in public care are amongst the most vulnerable - it is widely accepted that children who come into care have significant and complex needs including low self-esteem and resilience, poor parenting and peer relationships and an often chaotic lifestyle. It is also well documented that once in care they underachieve educationally and are highly represented in social exclusionary factors such as teenage pregnancy, unemployment, youth offending, poor mental health, drug and alcohol abuse and homelessness.

However Knowsley looked after children do better than national and other comparators.
Links to Existing Strategies

The following strategies are linked to the Children Looked After:

- The Children and Young People’s Strategic Plan 2009-11
- The Corporate Parenting Strategy 2010-11
- The 14-19 Implementation Strategy 2008-11
- The NEET Reduction Strategy 2010-11
- The Transition Strategy 2010-11
- The Care2Work Programme 2010-11
- The Special Guardianship Order Policy 2009-11
- Knowsley’s Children in Care Council
- Emotional Well-being and Mental Health Strategy 2010

Future Implications

CLA services are highly resource intensive and vary according to both age and placement type. The ADCS has recently calculated the annual average cost of a children’s home placement at £125,000 and a foster placement at £25,000. Loughborough University (June 2010) reported that In 2008-09 the weekly unit cost of local authority foster care has increased by 64% to £383, but the weekly unit cost of independently provided foster care had increased by 13% to £864. Given the significant financial pressures we face, we need to ensure minimal use of external/independent provision and reduce the size of our CLA population. These concerns are exacerbated by the ONS population projection which indicates that by 2021 the number of Knowsley young people aged under 15 will increase by 1,500 from the 2006 baseline figure of 36,415.

Evidence of What Works

Recent evidence (In Loco Parentis, Demos 2010) combined with our local experience indicates clearly that the following actions are essential to delivering good outcomes:

- High quality multi–agency assessments to ensure only those who need care are looked after.
- Decisions on taking children into care are made as early and decisively as possible and that poorly planned or unsupported reunification attempts are minimised.
- To compensate for many children’s pre-care exposure to abuse and neglect, and to reduce the psychological impact of these experiences, the care system must seek to build looked-after children’s and young people’s resilience by maximising the number of protective factors in children’s lives, such as a stable base, a secure attachment to a carer and positive school experiences and peer relationships.
- To reduce the risk of placement disruption for children with challenging behaviour or significant needs, it is essential that their carers are well trained and supported to help them understand and respond to the children’s emotional and behavioural needs.
Greater involvement of children and young people in decision-making on matters pertaining to their care needs and taking time to listen to them.

A local, high quality and stable range of placements matched to individual need to minimise disruption and assist in those who are looked after maintain local links with services, family and friends. Placement stability has a strong association with educational attainment, mental health and emotional well being.

Secure attachments and a carer’s ability to impose consistent rules are fundamental to children’s socialisation and wellbeing.

Swift and equitable access to local universal, targeted and specialist services.

A seamless transition to adulthood

Gaps

Limited information in respect of the 0-18 population forecasts.

The need to embed the systematic usage of end of service questionnaires and undertake a bi-annual evaluation to ensure services reflect user needs.

We are not currently commissioning from local providers – we need to understand the reasons for this.

60% of those leaving care in the last 2 years spent less than 12 months in our care. However of those experiencing less than 12 months in care almost 25% of this total for each of the last 2 years spent less than 1 month being looked after. This raises the issue of access to care – are all those we look after in need of our care.

Recommendations for Commissioners

Develop a clear commissioning strategy to define priority areas of investment for looked after children.

Lead in the quality assurance of all family support services, including that commissioned from the third sector, to ensure that interventions focus on enabling children to remain at home where appropriate.

Facilitate user feedback to ensure services reflect user needs.

Encourage the use of alternative orders including Special Guardianship and Residence Orders.

Ensure that the Sufficiency Strategy in development delivers a sufficient range of high quality local placements to meet the range of children’s needs.

Engage with local providers both internal and external, to develop services which reduce the need for external placements.

Explore collaborative commissioning with neighbouring Local Authorities to pool demand for residential providers and achieve efficiencies.

Strengthen the gate keeping role to ensure only those in need of care enter our care.
3.1.5 SAFEGUARDING CHILDREN AND CHILD PROTECTION

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**Key Needs**

At year end March 2010 167 children and young people were the subject of Child Protection Plans - this equates to 48 per 10000 population aged under 18 compared to the 2009 national, regional and statistical neighbour averages of 31, 35 and 44. Our 2010 cohort represents a 24% increase in the number of CP plans from March 2009. Further analysis shows that:

- 9% of plans were categorised as sexual abuse compared to the 2009 national, regional and statistical neighbour (SN) averages of 6%, 6% and 5%.
- More than 80% resulted from emotional abuse or neglect compared to the low/mid 70% recorded for the SN, regional and national averages.
- Plans made under the category of sexual abuse were low at 9% of the total which reflects regional, national and SN averages.
- In terms of duration of plan 70% had been in force for less than 12 months at year end and 4% or 7 plans had been in force for more than 2 years.
- In regard to age groups 70% of plans relate to children less than 10 years of age.
- 8% of those who became the subject of a Child Protection plan during the year had previously been the subject of a plan – this compares with the 2009 national and regional averages of 13%.
- During the year 137 new plans were implemented – the highest number (43 or 31.4%) were made in respect of children in the 1-4 age group and the gender split was almost identical.
- 98 plans were completed during the year and almost 2/3 of these related to boys – children in the 1-4 age group accounted for 33% of completed plans.

**Description of Where / Who the Issue Affects**

For a relatively small percentage of children and young people the need for protection from neglect and abuse in all its forms necessitates formal and timely interventions based on a multi-agency assessment of their needs, presenting risks and how best these can be addressed and managed. Interventions can vary dependent on individual circumstances but where it is deemed the risk is too great to be managed on a voluntary basis it is necessary to for the child’s
need for protection to be managed via a Child Protection Plan (CPP). The Child Protection Plan sets out clear aims and objectives within defined timescales. At the point the presenting risk is deemed manageable without a Child Protection Plan it is practice within Knowsley that Children’s Social Care provide the lead professional role for a time limited period to ensure continuity and reduce escalation of future concerns/issues which may lead to a further Child Protection Plan being required.

The current number of children subject to a Child Protection Plan is 214 at the end of September 2010. This equates to 62 per 10000 and represents an increase of 28% in the total number of new CP plans in the 1st 2 quarters of the current year. Research is currently being undertaken to understand this sudden rise in the number of children being subject to CP Plans.

Almost half the total number of CP plans relate to children and young people living in just 4 of 21 wards - Northwood, Longview, Page Moss and Prescot East.

Northwood accounted for 15.6% of the total in contrast to 11 other wards each accounting for 3% or less of all plans.

35% of CP plans relate to young children in the 1-4 age group with boys accounting for more than 2/3 of this cohort - in all other age groups the gender balance is much closer.

**Equality and Diversity**

Detailed multi-agency assessments are undertaken prior to any decision to implement a CP plan – such assessments are holistic and take full account of the child’s specific needs arising from their gender, age, religious, cultural, linguistic and racial origins.

Statutory CP reviews are chaired by Independent Reviewing Officers. A critical role of the Independent Reviewing Officer is to ensure all information is shared, an assessment of risk is undertaken, professionals attending the Child Protection Conference make a decision as to whether a child is at risk of significant harm, what that harm is and ensures a child protection plan is formulated to ensure the identified risk is managed and the child’s welfare protected and promoted. In addition they have a role in ensuring the needs and wishes of the child/young person and their family.

All children and young people have access to an independent commissioned advocacy service to ensure their views are heard

**Links to Other Issues / Topics**

The safeguarding and protection of children and their needs are linked to deprivation, domestic abuse, parental substance misuse, mental health and learning difficulties.
Of those cases attributable to emotional abuse, domestic violence features in the vast majority and is compounded in a smaller number of cases by substance abuse and/or mental health issues.

**Links to Existing Strategies**

The following strategies are in place for safeguarding and child protection:

- The Children and Young People’s Strategic Plan 2009 -11.
- The Parenting Strategy
- The Safeguarding Children’s Board Business Plan
- The Domestic Abuse Reduction Strategy
- The Corporate Parenting Strategy 2010-11

**Future Implications**

The following future implications have been identified in relation to safeguarding and child protection:

- Significant pressures on Local Authority resources
- CP services are resource intensive and the number of CP plans has increased substantially over the last 9 months
- Children at risk depend on the ability of staff in all agencies to identify and respond to signs of abuse, and of those with child protection responsibilities to make difficult judgements. This requires a thorough understanding of roles, responsibilities, thresholds and referral procedures across all agencies.
- CP work demands specialist skills and knowledge, an ability to engage with often less than willing family members and co-ordinate a range of services to deliver agreed objectives within agreed timescales.
- Need to ensure workforce development and training
- A national Review (The Munro Review of Child Protection) has been commissioned by the secretary of state and will report in April 2011.

**Evidence of What Works**

National and local evidence indicates that the following is approaches are effective:

- An inter-agency approach to early identification/ intervention and prevention.
- A common agency understanding of local referral procedures, assessment, information sharing and decision making.
- Timely and multi-agency assessments with a focus on risk and how this can be managed.
- Integrated support to deliver clear, realistic and attainable CP Plans within reasonable timescales.
• Provision of a good blend of universal and targeted services to safeguard vulnerable children and young people.
• Early access to effective local services and support.
• Management oversight of front line practice and robust staff supervision.

Recommendations for Commissioners

• Data collection systems need updating to improve the accuracy of analysis.
• There are on-going challenges associated with education and awareness raising across the range of all professionals who come into contact with children, parents and carers.
• Research the over representation of CP cases in Northwood, Page Moss and Longview.
• Ensure CP awareness raising, training and inter-agency responsibilities are thoroughly understood.
• Improve the systems for the engagement of children, young people and families in all decision making processes.
• Ensure that all specifications address expected safeguarding standards.
• Implement an area based, multi agency, proactive and preventative Family Support model.
• Review and monitor information sharing protocols/systems.
• Improve the understanding of thresholds for tier 2 and 3 services as determined by the Knowsley Model of Need to ensure a common understanding and application by all agencies, appropriate responses and referrals according to assessment of need.
• Findings from local and national Serious Case Reviews are reviewed and incorporated in service design and delivery where applicable.
• Continue to engage with GPs/Primary and Acute settings to reinforce their duty to safeguard and promote the welfare of children and young people.
3.2 LIFESTYLES

3.2.1 ALCOHOL

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**Key Needs**

- The Alcohol Learning Centre Ready Reckoner estimates that Knowsley has 24,988 increasing risk /hazardous drinkers; 8,684 higher risk / harmful drinkers and 4,776 dependent drinkers.
- Alcohol attributable mortality in Knowsley is lower than the North West as a whole (although not significantly so), however deaths related to alcohol are on the increase.
- Males from Knowsley have significantly lower levels of alcohol specific mortality and deaths from chronic liver disease than the North West as a whole, however for females the rates are slightly higher.
- Knowsley has significantly higher rates of hospital admissions for alcohol related harm than the North West and England.
- Males and females from Knowsley have significantly higher rates of alcohol attributable and specific hospital admissions than their counterparts from the North West.
- In the 2006 Adult Health & Lifestyle Survey a higher proportion of males than females stated that they drink alcohol on a weekly basis.
- Those from Knowsley living in the least deprived quintile were more likely to drink on a weekly basis, however those from the most deprived quintile were more likely to binge drink. NB Researchers refer to drinking more than eight units of alcohol for men and more than six for women in one go or on one day as binge drinking.

The Children and Young People’s Partnership needs assessment, together with consultation with young people and stakeholders and practitioners have identified that:

- Alcohol use is an issue in primary schools which increases during secondary school. TellUs survey (2008) indicates an increase from year 8 to year 10, particularly alcohol use among females.
- Binge drinking in the 16-24 age group is a cause for concern.
- Most alcohol use centres around friendship and social practices with a clear 82% of young people drinking in public spaces.
- Over 70% of referrals to specialist services are for 14-16 year olds 33% of referrals for alcohol.
Alcohol is the most widely used mood-altering substance in the UK and consuming alcohol gives pleasure to people and economic benefit to economies. However, when used irresponsibly it can cause immense harm to users, their families, friends and communities. Indeed, alcohol’s harms are so varied that it is impossible to determine whether alcohol is primarily an issue of health, social care or community safety. Alcohol misuse can cause injury and illness. In addition to short term injuries (trips, falls etc), the long term health of drinkers can also suffer. Excessive drinking increases the risk of heart disease and cancers, such as breast cancer. Cirrhosis of the liver is a serious consequence of over drinking. At its most serious, alcohol can cause premature death.

Alcohol is also closely linked to mental wellbeing and behavioural problems, and people who have both mental health and alcohol problems are more likely to experience problems with employment, housing and relationships.

Alcohol consumption is also associated with teenage pregnancy and the spread of sexually transmitted diseases, challenges to parenting capacity and there are health issues for women and foetus who drink during pregnancy

Excessive drinking is related to certain behaviours. Domestic abuse, sexual violence, town-centre violence and anti-social behaviour are all associated in varying degrees with people who are intoxicated on alcohol.

Though some crime and disorder is strongly associated with young people (e.g. anti-social behaviour and town-centre violence), a large proportion of alcohol-related violence and abuse is committed by adults. Young people are often also the victims of alcohol-related violence and abuse.

The cost to the taxpayer of dealing with alcohol-related crime and disorder is considerable, as is the extent to which this behaviour negatively impacts upon the quality of life of others.

**The Cost of Alcohol in Knowsley and the North West:**

- Knowsley has had higher rates of hospital admissions for alcohol related harm than the North West and England since 2002/03. The rate for alcohol related harm has increased by 59% since this point in time where it is now at it highest point of 2570.9 per 100,000 population in 2009/10.
- 10 people a day in the North West die due to alcohol related illnesses.
- North West has the highest rate of hospital admissions relating to alcohol of any region – 1 person admitted every 7 minutes.
- More than 73,000 recorded crimes across the North West last year (2009) were alcohol related, 50,000 were violent
- 33% of men and 25% of women in the North West consume alcohol at harmful or hazardous levels.
Alcohol Needs Assessment 2009

- Adults living in the least deprived areas of the borough are significantly more likely to drink alcohol on a weekly basis than Knowsley as a whole. This is consistent with national patterns.
- More than half of Knowsley males drink alcohol weekly (50.8%) compared with 31.0% of females – a statistically significant difference.
- The proportion of adults drinking ‘unsafe’ levels of alcohol in Knowsley has increased from 13.1% to 14.7% between 2001 and 2006.
- A significantly higher proportion of males (21.4%) drink ‘unsafe’ levels of alcohol in Knowsley compared with females (8.9%).
- 5.5% of Knowsley male adults recognise that they have a problem with alcohol, a significantly higher proportion than females (2.4%).

National Facts and Figures:

- Alcohol misuse costs Britain in the region of £3.3 billion a year.
- Of the total bill, some £2.8 billion is being lost by British industry in terms of sickness absence, unemployment and premature deaths.
- The cost to the National Health Service is reckoned to be in the region of £200 million.
- Alcohol-related road accidents account for a further £189 million and criminal activity £68 million.

Equality and Diversity

The 2009 Knowsley alcohol needs assessment looked at diverse communities and particular groups: Overall, there was no evidence that black and minority ethnic communities represent an area of unmet need. The borough has a very small BME population. In addition no evidence was found to either prove or disprove the existence of above average levels of alcohol problems in the lesbian, gay, bisexual, and trans-sexual community.

The first 2 quarters’ data from the P1E records (homeless records) submitted to Communities and Local Government (Jan–June 2009) for those accepted as homeless show that in Knowsley 4 people were accepted as homeless on the primary ground of vulnerability due to drug dependency, and 4 on the primary ground of alcohol dependency. Over the course of the last 2 years, (07-09), a total of 12 people were accepted because of drug or alcohol problems (6 for each), with 1 of the 12 recorded as having both problems.

The totals for the North West as a whole are only 16 and 20 respectively in the first 6 months of 2009, and 30 each year for drug dependency, and 36 and 49 for alcohol dependency, for the two years 07-08 and 08-09. Only a few authorities regularly record anyone with a reason for priority status being drug or alcohol dependency, with Liverpool and Manchester always having larger cohorts. Other authorities, including Knowsley, Wigan, and Warrington, regularly report one or two each quarter.
It is hard to know whether there are more single people with significant vulnerabilities as a result of drug or alcohol dependencies in those areas, or whether the authorities listed take a more defined approach to deciding whether someone is vulnerable as a result of a dependency.

Clearly, the main reason for the acceptance of homelessness duty is that the household contains dependent children. P1E records show only the reason for awarding priority need status, and it is quite likely that other households who were accepted as homeless had a drug or alcohol problem, but were not accepted as homeless as a result of a vulnerability linked to that problem.

**Links to Other Issues / Topics**

Alcohol misuse is linked to a wide range of issues within Knowsley. Excessive alcohol consumption is a cross-cutting priority for Knowsley’s Local Strategic Partnership and it can impact on the areas below.

- Blood borne viruses
- Sexual health
- Workforce/sickness and absence
- Policing and Criminal Justice
- Domestic violence
- Trading standards/Licensing
- Community safety
- Safeguarding/Children and young people
- Fire service
- Older People’s services
- Long Term Conditions
- Community Cohesion
- Housing and Resettlement

**Links to Existing Strategies (incl. Policies / Services)**

Alcohol impacts on the following service development areas in Knowsley:

- Drugs Strategy
- Safeguarding
- Alcohol Strategy
- Bradley Report (Mentally Disordered Offenders)
- Equitable Access to Primary Medical Care
- Safer Knowsley Partnership Strategic Assessment 2010
- Knowsley Substance Misuse Treatment Plan
- Knowsley alcohol harm reduction plan
- Children and Young People’s Plan
- Knowsley Parenting Strategy
- Mental Health strategy
- Children & Young People Emotional Health & Wellbeing Strategy
- Sustainable communities strategy
• Young People’s Substance Misuse plan.
• Crime and Disorder Reduction Strategy
• Healthy Schools Strategy

**National Drivers Include:**

• Safe, Sensible, Social: The next steps in the National Alcohol Strategy (2007)
• Youth Alcohol Action Plan, Department of Health (2008)
• Youth Crime Action Plan (2008)
• Tackling Violent Crime Action Plan (2008)
• Working with Alcohol Misusing Offenders: Strategy for Delivery (NOMS, 2006)

**Future Implications (Modelling / Projections)**

If excessive alcohol consumption and binge drinking continue, levels of alcohol-related diseases and hospital visits or admissions are likely to increase. This would have implications for services and potentially divert resources from other treatments.

**Key Objectives:**

• Supporting the reduction of alcohol consumption and alcohol dependence
• To support the reduction in the incidence of alcohol related crime and disorder, domestic violence & anti social behaviour.
• Amelioration of alcohol–related health problems e.g. liver disease, malnutrition, psychological problems
• General improvement in health and social functioning
• To support a reduction in the risks associated with safeguarding/hidden harm
• Signposting for individuals that have been identified as being at risk from their alcohol use to relevant specialist services
• Increasing the number successfully completing treatment programmes back into training & employment

**Evidence of What Works**

There is a wide range of guidance and documentation on effective evidence based interventions around alcohol, covering both prevention and treatment activity. These are used to inform local action.
The National Alcohol Strategy ‘Safe. Sensible. Social.’ (2007) includes a toolkit to support local programmes. A range of good practice guides and evidence briefings from the National Treatment Agency and other agencies are also used.

NICE have provided the following guidance related to alcohol:

- NICE Guidance Alcohol: Diagnosis and clinical management of alcohol-related physical complications (2010)
- NICE Guidance Alcohol: preventing the development of hazardous and harmful drinking (2010)

Encouraging healthy behaviour in relation to diet, physical activity, smoking, drinking, drugs, and sexual health has the potential to improve people’s health and quality of life.

Current policy guidance identifies a key role for fully trained frontline staff, through everyday contact with service users, in helping people to adopt and sustain healthier lifestyles through the use of behaviour change interventions. At a local level, building capacity and capability amongst public health practitioners and the wider workforce to deliver behaviour change interventions has been identified as key to achieving government health targets, particularly in relation to tackling health inequalities.

From a children and young people’s perspective all services offer a package of interventions which combine all or several of the following elements:

- Motivational Interviewing/Counselling
- Reduction programmes
- Educational programmes
- Relapse prevention including complementary therapy.
- Harm minimisation advice

Gaps

- There is currently under diagnosis and low identification of alcohol misuse.
- Earlier and higher detection rates will improve the quality of interventions for those affected by alcohol related issues. However, this is predicated on there being sufficient specialist alcohol services available for referral.
- Data intelligence and analysis including predictive modelling relating to alcohol needs to be refined.
- Low level criminal justice base interventions e.g. conditional cautioning.

Recommendations for Commissioners

- Ensure robust plans in place for 2010-11 to communicate to individuals and their families/carers about the harms associated with alcohol misuse.
• Ensure that frontline staff have the appropriate level of training to be able to respond to patients and clients experiencing alcohol problems, including being able to refer people to appropriate support services and undertake alcohol screening and brief interventions.

• Enable people who live and work in Knowsley to understand and act on the health and social impacts and risks associated with alcohol misuse in themselves and their families.

• Ensure that targeted information is designed to raise awareness and communicate with people who live and work in Knowsley the key messages relating to alcohol misuse, such as unit alcohol content and the relationship between alcohol misuse and ill health.

• Enable those who suffer as a result of alcohol misuse to be aware of and have timely access to appropriate alcohol treatment services.

• Ensure timely access to and benefit from appropriate and effective local services and interventions.

• Need to prioritise work with vulnerable groups including young people at risk of ‘hidden harm’.

• There is a need for an identity/brand and marketing for young people’s health services (including alcohol), and local health promotion campaigns to amplify the messages from national social marketing.

• Develop swift easy access and clear referral pathways through Tier 1-4 and across adult services for young people through co-ordinated relevant service delivery.

• Ensure that transition arrangements between young people and adult treatment services are robust.

3.2.2 BREASTFEEDING

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**Key Needs**

• Significant improvements have been made in breastfeeding initiation rates in Knowsley since 2008.

• From a baseline of 32 in 2007/08, 40 out of 100 women are now choosing to initiate breastfeeding in Knowsley. This is compared to 56 in the Northwest and 70 in England.

• Statistical neighbours average 62 babies out of 100 initiating breastfeeding.

• As few as 15 out of 100 babies are still breastfeeding at 6-8 weeks in Knowsley.

• Breastfeeding rates are lower in younger women and in the more deprived areas such as Kirkby and North Huyton.

• Breastfeeding initiation varies according to place of delivery.
Description of Where / Who the Issue Affects

National Surveys carried out in 2000 and 2005, both showed a clear association between breastfeeding and socioeconomic status. The 2005 survey found that, across the United Kingdom, 88% of mothers in managerial and professional occupations breastfed initially, compared with 77% of mothers in intermediate occupations, and 65% of mothers in routine and manual occupations. Breastfeeding rates among mothers who had never worked were the same as those found among mothers in routine and manual occupations (65%).

Local evidence supports this assertion, with babies born in areas of highest deprivation within the Borough further disadvantaged by being less likely to be breastfed. For example, only 8 out of 100 babies born in North Kirkby are still being breastfed at 6-8 weeks compared with 22 out of 100 babies in South Huyton. In addition, only 5 out of 100 babies born to teenage patents are still being breastfed at 6-8 weeks compared with 30 babies out of 100 to women aged 35-40.

Recent insight into breastfeeding attitudes and behaviour across North Mersey suggests that there exists a group of approximately 40 out of 100 women living in Knowsley’s who would like to breastfeed but do not live in a social context which supports this choice. A further 25 out of 100 women who would like to breastfeed reported that they have access to appropriate experience and practical help within their extended family and social group to support successful breastfeeding.

This issue of culture and normality of breastfeeding within Knowsley presents a significant challenge and has informed the commissioning of a Peer Support Service for Breastfeeding within the Borough. The service aims to facilitate a shift in local culture through the recruitment of local women who will support communities in making informed choices regarding infant feeding. The service will also offer intensive, ongoing support to women who choose to breastfeed, prioritising those who are less likely to succeed. The Family Nurse Partnership pilot which is currently being tested in the Borough will also provide intensive support to first time teenage parents, promoting breastfeeding as a feasible choice and supporting breastfeeding continuation.

Equality and Diversity

Breastfeeding rates by ethnicity are currently not available at a local level; however, information on ethnicity forms part of the national Infant Feeding Survey 2005. As in the 2000 survey, mothers from all minority ethnic groups were more likely to breastfeed compared with white mothers. Thus more than nine in ten mothers who classified themselves as Asian, Black, or Chinese or other ethnic origin initially breastfed compared with around three-quarters of white mothers (74%). Between 2000 and 2005 incidence of breastfeeding increased among both white mothers (68% to 74%) and Asian mothers (87% to 94%).
Further consideration must be given to the range of equality groups which exist within Knowsley communities and whose members may not experience equal access to services and information which supports successful breastfeeding. Groups such as those defined by race, faith, religion or belief groups, Knowsley’s Lesbian, Gay, Bi-sexual and Trans (LGBT) community and adults and young people with disabilities may be disadvantaged in respect of breastfeeding support. Currently, no data is available nationally or locally for analysis within these groups and this is identified as a key area for local development for the future.

**Links to Other Issues / Topics**

The first two years of life are identified as critical in ensuring appropriate lifelong growth and development and central to this is the availability of optimal nutrition provided through human breast milk (World Bank 2006). As well as its nutritional value, breast milk plays an important role in protecting infants and young children from a range of infections, such as gastroenteritis, otitis media, respiratory and urinary tract infections (Quigley et al 2007). Breastfeeding also protects against some chronic long term conditions, such as juvenile onset diabetes, raised blood pressure and obesity (Ip et al 2007, Horta et al 2007).

Breastfeeding also benefits women by reducing the risk of ovarian and breast cancer, both pre and post menopausal (World Cancer Research Fund 2007). As such, exclusive breastfeeding for the first six months of life is recommended by the World Cancer Research Fund, WHO and the UK Department of Health.

In 2009, the National Support Team for Infant Mortality recognised the important contribution breastfeeding has to make towards reducing infant mortality. Further evidence to support this assertion is found in a recent systematic review of the evidence relating to developed countries which found a clear association between breastfeeding and reduced risk of childhood leukaemia, sudden infant death syndrome and necrotising enterocolitis (Horta et al 2007).

**Links to Existing Strategies**

Improving infant and maternal health links with the following Knowsley strategies:

- Knowsley’s Infant Feeding Strategy 2008 - 2011
- Children and Young People’s Plan 2008 – 2011
- Energise Knowsley 2009/12 – Healthy Weight Strategy
- Knowsley’s Child Health Strategy 2011 – 2014
Future Implications

In addition to the health benefits discussed, breastfeeding contributes significantly to the economic and environmental health of the population. Costs attributed to the treatment of gastroenteritis alone in bottle fed babies in the UK in 1995 amounted to £35 million. It is estimated that a 1% increase in breastfeeding at 13 weeks would save the NHS £500,000 in treatment costs for gastroenteritis (North West Regional Public Health Group 2008).

Breastfeeding rates in Knowsley have improved significantly over the past few years, breastfeeding initiation rates increasing by 8% between 2007/8 to 2009/10. Further improvements will release longer term savings as fewer women will experience breast and cervical cancer. Furthermore, the incidence of long term conditions, such as hypertension and diabetes in women who have breastfed will be reduced, a critical consideration due to the inequalities that currently exist in relation to gender related health and wellbeing in the Borough. If further improvements are not realised, the converse will occur, further disadvantaging women and increasing the health inequalities gap.

Consideration must also be given to the environmental consequences associated with buying formula, manufacturing and disposing of packaging and equipment. The impact of this is significant and would be greatly reduced if breastfeeding rates increased (North West Regional Public Health Group 2008).

Evidence of What Works

There exists a plethora of evidence pertaining to effective interventions to increase breastfeeding rates. NICE (2006, 2008) recommend that commissioners:

- Adopt a multifaceted approach across different settings to increase breastfeeding rates. This should include training for health professionals, peer support programmes and education for pregnant women, followed by proactive support during the postnatal period.
- Implement a structured programme, using the UNICEF Baby Friendly Initiative (BFI) as a minimum standard, to encourage breastfeeding.
- Ensure there is a written, audited and well publicised breastfeeding policy that includes training and support for staff who may be breastfeeding. Identify a health professional responsible for implementation.
- Ensure all staff in maternity and children’s services understand the importance of breastfeeding and help promote a supportive environment.
- Provide local, easily accessible breastfeeding peer-support programmes. Ensure peer supporters:
  - Are part of a multidisciplinary team
  - Receive training and have child protection clearance
  - Contact new mothers within 48 hours of their transfer home (or within 48 hours of a home birth)
  - Offer on-going support according to the mother’s needs – face-to-face, by telephone or through groups
- Can consult a health professional for support
- Monitor the Family Nurse Partnership pilot as dedicated support to young mothers

**Gaps**

Recent commissioning of a Peer Support Service for breastfeeding within the Borough has ensured that all recommended interventions are now available to women living in Knowsley. However, discrepancies exist between breastfeeding initiation rates according to the place of birth.

Gaps also exist in relation to data availability for certain equality and diversity groups. More detailed analysis of local trends relating to these groups will enable a more informed targeting of service provision. In addition, the effectiveness of new services has not yet been assessed as they are still in the early stages of implementation.

**Recommendations for Commissioners**

**Data / Intelligence Requirements:**

- To ensure that breastfeeding rates are collected by equality dimensions by April 2011
- To review quality of breastfeeding data submitted by all providers on a quarterly basis
- To undertake a updated breastfeeding health equity audit in January 2012

**Service Improvements:**

- To review Knowsley’s Infant Feeding Strategy 2008–2011 by April 2011
- To ensure that Knowsley’s Breastfeeding Strategy Group continue to performance manage the implementation of the Infant Feeding Strategy through quarterly meetings of the multi agency group
- To ensure that quarterly breastfeeding performance reports are produced and reported to the Early Years and Maternal Health Board and Breastfeeding Strategy Group, particularly paying attention to variation in initiation rates according to place of birth.
- To produce an annual breastfeeding inequality report for the Early Years and Maternal Health Board and Breastfeeding Strategy Group
### 3.2.3 CHILDHOOD IMMUNISATIONS

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#### Key Needs

- The trend of Childhood Immunisation uptake has increased significantly over time; however national targets set for local uptake continue to be a challenge and are not fully being met.
- During 2009/10, 92 out of 100 babies born in Knowsley completed immunisations for DTaP/IPV/HIB before 1 year of age. In 2008/09, 89 out of 100 babies completed the course.
- In 2009/10, 89 out of 100 children aged 2 completed immunisation for MMR compared to 86 in 2008/09.
- By the age of 5, 85 out of 100 children in Knowsley completed immunisation for DTaP/IPV by the end of 2009/10 compared to 81 in 2008/09.
- This year, 84 out of 100 5 year olds completed immunisation for MMR (2 doses) compared to 78 last year.

#### Description of Where / Who the Issue Affects

The Childhood Immunisation Programme is one of the most important public health programmes available to children and young people, preventing a range of infectious illnesses and improving the experience of childhood in England. In line with current World Health Organisation (WHO) recommendations, at least 95% of children should receive three primary doses of diphtheria, tetanus, polio and pertussis in the first year of life; and at least 95% should receive a first dose of a Measles, Mumps and Rubella containing vaccine by two years of age. In line with the WHO target, at least 90% should receive a booster of dose of tetanus, diphtheria and polio between 13 to 18 years of age; and, as of September 2008, at least 90% of girls aged 12 to 13 years should receive a complete course of human papillomavirus vaccine.

Knowsley is not currently meeting these public health targets, which are in place to end the transmission of these vaccine-preventable life-threatening infectious diseases and variations in uptake of childhood vaccinations continue to exist within the Borough. Consideration is given to the range of factors which have the potential to impact on the uptake of the Childhood Immunisation programme in the Knowsley Childhood Immunisation Health
Equity Audit, through which available data is systematically appraised and categorised by age.

Emerging trends within the data suggest an association between uptake and levels of deprivation, with more deprived areas within the Borough exhibiting lower uptake rates at key ages. An example of this is that 8% more babies born in South Huyton are fully immunised at 1 year compared with babies born in South Kirkby. At 2 years this differential still exists, however, by the age of 5 years, rates for booster immunisations across the Borough fall well below expected levels, with Prescot, Whiston and Cronton recording the lowest rate of MMR booster at 81%.

Uptake rates vary across the UK, with the England average for the uptake of MMR by 24 months in 2008/09 being 84.5%. Comparatively, the North West Average for this cohort was 87.2% in 2008/09 with Knowsley also achieving 87.2%. During 2009/10, Knowsley’s MMR uptake increased to 89.5%, however, no comparative data is yet available for 2009/10 for England or the North West.

**Equality and Diversity**

Local data illustrates a disparity in the rate of uptake of the programme by ethnic group, with 65 out of 100 babies born to Asian or Asian British families and 75 out of 100 babies born to Mixed White and Black Caribbean families completing the immunisation programme in the first year of life. 91 out of 100 White British born babies attended for the full course compared to 90 out of 100 Asian British Pakistani infants. Caution must be paid to the interpretation of this data due to the small number of babies included in the cohort; however, it raises questions relating to equity of access to services for families who experience a different ethnic heritage.

Out of a cohort of 240 looked after children and young people, currently 217 are fully immunised, with a further 23 who are partially immunised. The majority of young people who are not fully immunised fall within the age category of 5-18 years.

There is currently a paucity of evidence pertaining to the impact of disability on access to the childhood immunisation programme locally and nationally and, as such, insight into this issue is limited. In addition uptake rates in other minority groups, such as asylum seekers and the travelling communities are unknown and this is identified as an area for development in the future.

**Links to Other Issues / Topics**

Childhood immunisation is integral to the Healthy Child Programme and represents the health protection element of the programme. The ethos of the Healthy Child Programme is a holistic approach to optimising child health in the context of the family and community through a model of progressive universalism in partnership with a wide range of stakeholders.
Childhood immunisation has the potential to sustain child health within communities or conversely, may pose a significant threat if uptake rates fall below expected levels. It is essential; therefore, that consideration is given to factors which influence uptake. Evidence exists to support the hypothesis that poverty and deprivation have a detrimental impact on the uptake of childhood immunisations and, as such, consideration of issues such as the impact of poverty, literacy and educational attainment and poor housing must be applied to any strategy developed to increase childhood immunisation rates.

In-depth insight work regarding uptake of Childhood Immunisation in Knowsley was undertaken in 2008. The process provided insight into the journey which families travel in Knowsley when faced with the decision whether to immunise their children or not. Some common barriers and enablers to accessing the programme were identified and are valuable in informing improvements within the system.

**Links to Existing Strategies (incl. Policies / Services)**

Improving childhood immunisation uptake in Knowsley links with the following Knowsley strategies:

- Children and Young People’s Plan 2008 – 2011
- Parenting Strategy
- Knowsley’s Child Health Strategy 2011 – 2014
- Knowsley Healthy Child Programme

**Future Implications (Modeling / Projections)**

If the uptake of childhood immunisation within Knowsley continues to fall below rates required to achieve herd immunity, there is real risk of outbreaks of particular diseases within the community such as measles or meningitis. This would produce significant increased costs in relation to treatment and containment of the spread of disease.

**Evidence of What Works**

NICE published guidance entitled, ‘Reducing the Difference in the Uptake if Immunisations’ in September 2009. The guidance incorporates the following recommendations:

- Adopt a multifaceted, coordinated programme across different settings to increase timely immunisation among groups with low or partial uptake. This recommendation includes ensuring that there is an identified healthcare professional in the PCT and in every GP practice who is responsible – and provides leadership – for the local childhood immunisation programme.
- Improve access to the childhood immunisation programme through extended clinic times, ensuring children and young people are seen promptly in child and young people friendly venues.
• Ensure PCTs and GP practices have a structured, systematic method for recording, maintaining and transferring accurate information on the vaccination status of all children and young people. Vaccination information should be recorded in patient records, the personal child health record and the child health information system. The same data should be used when reporting vaccinations to the child health department and when submitting returns to the PCT for GP and practice payments. This will ensure records in both systems are reconciled and consistent.
• The Healthy Child Team and School Health teams should proactively check the immunisation status of children at set times through the Healthy Child programme, and facilitate families to access childhood immunisation clinics or organise outreached immunisations according to need, specifically targeting groups at risk of not being fully immunised.
• PCTs should have an identified person responsible for coordinating the local hepatitis B vaccination programme for babies at risk of hepatitis B infection. The person should also be responsible for scheduling and follow-up to ensure babies at risk are vaccinated at the right time.

Gaps

Current gaps exist in relation to:

• A systematic and proactive approach to following up children at risk of not being fully immunised.
• Leadership within the Healthy Child Team and Primary Care in driving improvements in Childhood Immunisation.
• Knowsley’s Immunisation Team capacity to proactively follow up children at risk of not being fully immunised. The team’s current remit includes the provision of a universal service to families who could be offered the programme through primary care.
• The current data pathway requires review as two separate systems presently manage the process and delays in reporting potentially impact on nationally submitted uptake rates.
• Quality of data relating to certain equality and diversity groups

Recommendations for Commissioners

Data / Intelligence Requirements:

• To ensure that Knowsley’s Childhood Immunisation Committee continues to monitor uptake rates within the Borough on a quarterly basis and lead improvements in local service provision.
• To complete a Health Equity Audit relating to Childhood Immunisation within Knowsley by December 2010 and make recommendations regarding reducing inequalities in uptake rates within the Borough.
• To ensure that all childhood immunisation data is collected according to equality dimensions by April 2011.
Service Issues:

- To review current processes in relation to Childhood Immunisation within Knowsley by December 2010, this will include both the clinical pathway and data flow processes.
- Review current model on service delivery giving consideration to putting GP’s central to delivery of the Childhood Immunisation Programme by December 2011.
- Review service specification of NHS Knowsley’s Immunisation Team by April 2011, giving consideration to developing a more targeted offer by the team, enabling the proactive follow up and engagement of families who do not attend for the universal offer.
- To ensure full compliance with NICE Guidance by April 2011.

3.2.4 HEALTHY WEIGHT

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**Key Needs**

- Adult Obesity prevalence in Knowsley is lower that both North West and National figures (respectively at 24.5% & 23.5) and is predicted to be at 23.4% (2010). However combined overweight and obesity rates for adults are suspected to be around 60% prevalence in the adult population of Knowsley.
- Childhood Obesity in Knowsley continues to be a priority area for Knowsley. Rates of Reception year children are around 13%, but by Year 6 increases to 23%.
- Children are at increased risk of obesity if: their parent(s) are obese, they are “children looked after” or have a physical/learning disability.
- Adults are at increased risk as age increases, are of ethnic minority, are ex-smokers, those with hypertension, or have a disability. Men are at higher risk of obesity as income increases, whereas women are at higher risk of obesity when income is low. Women are at greater risk of obesity post-pregnancy.
- Adherence to the healthy weight services pathway varies across the borough, and there is a need to ensure standardised access to the appropriate services for all adults.
- There is a need to continue to prevent the onset of childhood obesity, through the promotion of healthy lifestyle services and interventions.
Description of Where / Who the Issue Affects

The recent Public Health White Paper Adult and childhood obesity remains a priority issue in Knowsley and mirrors the national prevalence of obesity. Levels of adult obesity in Knowsley were recorded at 20% during 2006\(^9\), and over half (56%) of the Knowsley adult population were recorded as overweight or obese, which equates to 68,768 Knowsley residents. The national prevalence data has shown an increase in adult obesity, over the last few years\(^10\), the national prevalence is now 24.5%, and overweight is 36.9%. Assuming that Knowsley has followed this trend, we estimate the 2010 average adult obesity rate to be 22% (27,016 people)\(^11\).

Whilst approximately two thirds of children in Knowsley are a healthy weight, childhood obesity in Knowsley is significantly above the national and regional average. Approximately 33% of Knowsley children are clinically overweight or obese, which equates to around 10,000 children. Evidence shows that 70% of these children will remain overweight or obese into adulthood, which would create a further 7,000 residents in Knowsley becoming overweight/obese adults in the next 5-10 years.

The Foresight Report (2007)\(^12\) predicted that if current trends continue, 60% of men, 50% of women and 25% of children in the UK will be obese by 2050 (and a further proportion of the population would be classed as overweight). Knowsley would be likely to follow a similar trend, with a resulting severe impact on the health of the population and Knowsley’s subsequent economy. The rise in childhood obesity has the potential to reverse the trend in life expectancy. Reducing obesity and overweight rates for children and young people in the Borough would provide improved personal and public bodies’ (NHS Knowsley and Knowsley Council) outcomes in relation to health, educational and financial improvements (individuals would be healthier, do better in education, more likely to seek employment, and less likely to develop diseases which reduce quality of life). It would also help break the cycle of obesity; the children would be less likely to become obese adults and in turn they would be less likely to become parents of children who become obese, with the attendant health problems.

Parental Obesity and Child Obesity

Having a parent who is obese increases the risk of child obesity. Having the same sex parent who is obese appears to be an important factor, if a mother is obese it is more likely that her daughter will become obese, and similarly if a father is obese, his son will be at increased risk. The risk of obesity at age eight years old has been found to be ten times greater for girls and six times greater for boys if the same-sex parent was obese. It has been found that only three percent of overweight or obese children have parents who are not overweight or obese.

\(^9\) Knowsley Adult Lifestyle Survey 2006, NHS Knowsley Public Health intelligence
\(^12\) Foresight Tackling Obesities: Future choices (2007). government Office for Science
Independent predictors for obesity: Incidence is higher in certain sub-groups.

Adults: For both men and women, being ‘most at risk of obesity’ has been found to be positively associated with:

- Age
- Being an ex-cigarette smoker
- Self perceptions of not eating healthily
- Not being physically active
- Hypertension
- Income is also associated with being ‘most at risk’, with a positive association for men and a negative association for women. Additionally, among women only, moderate alcohol consumption was negatively associated with being at risk.

Childhood: survivors of childhood cancers, some ethnic minority groups (e.g. southern Asian populations), children or young persons who have one or more obese parent, looked after children, and young persons who experience learning difficulties.

Obesity and Disability

Obesity is associated with the four most prevalent disabling conditions in the UK (arthritis, mental health disorders, learning disabilities and back ailments). Amongst the obese adult population the odds of having disability is increased compared with the healthy weight population. There is twice the risk of having a physical disability, 84% increased risk of musculoskeletal illness, 35% increased risk of back problems, 3.5 times the risk of developing osteoarthritis and 4 times the risk of other arthritis and 2.5 times the risk of having a disability requiring personal care.

Health and Obesity

Preventing and treating obesity and the direct and indirect consequences of being obese are complex. For example, it is estimated that 9% of CHD could be avoided if all those who are sedentary and lightly active became more moderately active, 5% of hypertension is linked to people who are overweight, Coronary artery disease (CAD) and stroke has an increased risk 2.4 fold in obese women and two-fold in obese men under the age of 50 years, and 10% of all cancer deaths among non-smokers are related to obesity.\(^{13,14}\)

Obesity reduces life expectancy by, on average, 9 years\(^{15}\). It has been stated that over half of the increase in diabetes prevalence 2005-2010 has been attributed to overweight and obesity. Obesity contributes to a vast range of health illness, which makes it difficult to separate out cost-effectiveness of

\(^{13}\) DoH 2008: Healthy Weight, Healthy Lives, A Cross Government Strategy for England
\(^{15}\) DoH 2001: Obesity: defusing a health time bomb
obesity treatments compared to specific illness treatments, and we must also acknowledge that interventions targeted at prevention and treatment of obesity in children, rather than the whole population, take longer to show a cost benefit as the avoidance of disease only becomes visible when they reach middle and older age.

**Prescribing of Obesity Medication**

As with surgery, the use of pharmacological interventions is becoming an increasingly common treatment for obesity. The Nice Guidelines for Obesity (NICE, 2006) specify that the prescription of Orlistat for adults should only be considered after dietary, exercise and behavioural approaches have commenced and are being evaluated. Prescription is applicable for individuals of ≥30 BMI (≥28 with physical co-morbidities). Orlistat is not advocated as a stand alone treatment, and NICE guidance sets out that information, support and counselling on diet, activity and behavioural strategies should also be provided by appropriate health care professionals. Prescription should continue past three months, only if a weight loss of 5% of baseline weight has been lost. Medicines management monitors prescribing rates on a quarterly basis at practice and PBC level. During 2009-10, NHS Knowsley spent £190,557 on anti-obesity medication, this is an increase 7% from the pervious 2007/08 costs, and higher than both the regional and national average spends in 2009-10. Whilst the rates of adult obesity vary across Knowsley borough, there appears to be significant variation in prescribing behaviours between individual practices and clusters.

**Obesity Costs to Health**

Estimated annual costs to NHS Knowsley of disease related to overweight and obesity is £57.1 million during 2010, and is estimated to rise to £61 million by 2015. Worryingly, more recent cost calculations have suggested that obesity costs are conservatively estimated at £2,715 Per Person, so for NHS Knowsley the current local cost may actually be as high as £73,348,440 per year.

**Equality and Diversity**

Healthy weight services within the care pathways are available to residents of Knowsley or those registered with a Knowsley GP. Using profile mapping of obesity prevalence, deprivation and insight segmentation on family cluster groups, services are targeted towards areas most in need, and respond/adapt to the needs of these specific groups. Services offer advice and information as appropriate for race or religious beliefs (for example healthy eating guidance), and services are required to complete Equality Impact Assessments to demonstrate assessing and complying to need, for example ensuring that advice and services are suitable for individuals with learning or physical disabilities. Specific services which target groups of individuals are also supported to promote healthy lifestyles and make refers to weight management services, this is evident for example with Knowsley’s Options service, who conduct lifestyle

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16 Foresight Tackling Obesities: Future choices (20207). government Office for Science
assessments with offenders and encourage them to make sustainable lifestyle changes.

**Issues of Inequality**

**Sex**

Whilst synthetic estimates of obesity prevalence suggest deprivation is an important factor in a predicted higher prevalence of obesity in Knowsley compared with the England average. Health Survey for England\(^{18}\) findings suggest a link with deprivation (and income) is much greater in women than men. This may suggest an inequality in obesity prevalence amongst men and women in the borough. Further analysis on Knowsley data may help determine this if this is a cause for concern.

**Disability**

It is likely that people with disability (learning and intellectual disability) have a higher prevalence of obesity. This requires further investigation using local data to determine if this is an issue in Knowsley.

**Obesity Surgery**

North West England, Morbid Obesity Service is monitored via specialist commissioning contract. Bariatric surgery is provided by SPIRE, an external service provider. Each client is assessed for surgery on an individual basis in line with referral and pathway criteria. A deviation from NICE guidance (43), has been agreed across North West Directors of Finance, and Directors of Commissioning which has raised the criteria threshold to BMI 50, or 45 plus co-morbidities, this differs from the recommendations given from NICE (2006). Between 01/01/08 and 31/12/09, 22 Knowsley residents received Bariatric surgical procedures, to treat their obesity. This is a significantly lower figure than other areas within Cheshire and Merseyside.

An Equality Impact Assessment of the Energise Knowsley- Healthy Weight Strategy was conducted in 2009.

**Links to Other Issues / Topics**

- The life chances of children can be affected by obesity. For example, it is linked to poor educational attainment. This can impact on employment opportunities and income levels in adult life.
- Adult obesity causes a reduced life expectancy of 8 to 10 years, mainly through early deaths as a result of heart disease, stroke, cancer, liver disease or complications of diabetes. People with obesity are more likely to suffer from sleep disturbances and from arthritis in the hips and legs.
- Obesity is also associated with poor mental health, depression and low self esteem.

• Obese adults are less likely to be promoted at work. Obesity can also impact on social integration and the levels of independent living for Older People.
• In poorer areas, access to healthy food can be a problem and cooking skills and facilities may be limited. This can make it harder to eat well, particularly on a low budget.
• Obesogenic Environment- promoting and providing healthy environments to enable individuals to travel in a safe and active way, and improve community cohesion by increasing acceptability of seeking healthy weight advice and support is a priority for Knowsley.

Links to Existing Strategies (incl. Policies / Services)

Obesity links to the following local strategies:
• Energise Knowsley- Healthy Weight Strategy 2009-2010
• Infant Feeding Strategy
• Maternal health strategy
• Children & Young People emotional wellbeing strategy
• Alcohol Harm Reduction Strategy
• Children & Young People Plan
• Sport and Physical Activity Alliance Action Plan
• Healthy Schools Strategy
• Workforce Health Strategy
• TCS Citizenship;
• Play strategy,
• Green Spaces,
• Sustainable Community Strategy
• Community Cohesion Strategy

Future Implications (Modelling / Projections)

Response Plan

Long-Term Strategy: Target Year 2014/15

Aim: Reduce adult obesity by 5%; reduce childhood obesity by 3%
Activity: Prevention and treatment (secondary prevention) of childhood obesity via Family Futures and (primary prevention) by Carnegie Community Clubs. Long-term and planned support for treatment of adult obesity (CHANGES weight management, orlistat, bariatric surgery)

Short Term Strategy- Annual

Aim: Reduce adult obesity prevalence by 1% per annum; reduce level of childhood obesity 0.6% per year.
Activity: Targeted population who will most benefit:
Key Target Populations:

1. **Children - prevent onset of clinical obesity**: continuing with our borough wide National Weighing and Measuring Programme to identify children most in need of support and advice and working with interventions (Family Futures and Carnegie Clubs), to achieve the 2010-11 target of year 6 prevalence of obesity being reduced to 20%, and reception year children’s prevalence of 13%.

2. **Maternal obesity**: as highlighted in the recent white paper maternal obesity is a priority area. We aim to support women planning second pregnancies to reduce obesity. Targeted via midwifery and health visiting services into CHANGES. Evidence shows obesity in pregnancy contributes to increased morbidity and mortality for both the mother baby during and after child birth. Obese women stay longer in hospital and overall represent a five times increased in the cost of antenatal care. Maternal obesity can lead to the need for additional healthcare due to complications associated with the pregnancy. Resource implications relating to maternal obesity have been identified as: increases in caesarean and operative deliveries/ admission to hospital for complications/ length of hospital stay (obesity women spend between 4-5 days increase in days, minimum additional cost of £800-1000 extra ) requirements for neonatal intensive care/ a need for appropriate equipment to manage safely the care of obese mothers.

3. **Adults who are attending stop smoking services**: Adults who attend stop smoking services are highly likely to increase weight as a result. It is important that weight management services target these individuals to prevent direct correlation between decreasing smoking in Knowsley and increasing obesity.

4. **Improve treatment services efficiencies**: CHANGES weight management service have assessed cost-efficiency and through a service remodel (April 2010) the cost per client has been reduced from £417.33 to £284.55, this has been achieved by increasing activity within the service to reach an additional 350 clients per year, in total this service will treat 1100 obese adults in Knowsley (targeting 4% of the obese population per year).

Evidence of What Works (referring to NICE 2006)

**Prevention of Obesity (Primary and Secondary)**

Knowsley have developed a childhood health weight care pathway (completed Nov 2009) which aims to work specifically with overweight and obesity children in a bid to 1) prevent further development and 2) reduce current rate of obesity. These services over the next three years will target nearly 1500 children and

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therefore, if successful outcomes can be reached (as commissioned) then the level of obesity in Knowsley will fall within national trend and specified LAA targets.

Knowsley have focused the healthy weight agenda to ensure that effective and quality care pathway services are in place. These services include increasing access to support and information within local community venues, and services are now using technology such as text messaging and website forums to engage children and their families in a new and innovative way. Focusing on childhood obesity prevention and treatment aims to ensure that in the future of Knowsley will reduce the obesity levels, rather than seeing a 2-fold increase in the levels of adult obesity in Knowsley.

Investing in the treatment (secondary prevention) and prevention of obesity in children; brings about a positive return on investment. These services will prevent an increase in subsequent adult obesity, thus reducing long-term costs. Investing in the treatment of childhood obesity will bring about a net saving of £210,900 (this figure does not include any additional savings made through reduction in healthcare costs through childhood). Moreover, investing in the prevention of obesity in a targeted overweight population will create a net saving of £1,132,855.

**Adults**

Non-surgical interventions are the cornerstone of overweight and obesity treatment. The intensity of management for overweight and obesity will depend on the level of risk of health problems and the potential to gain benefit from weight loss. If weight loss relative to trend remains constant for 5 years post-intervention before returning to baseline, the cost per Quality Adjusted Life Years (QALY) in the best-performing non-pharmacological studies ranges from £174 to £9971. At the current, within the investment of obesity, the largest cost is accountable to bariatric surgery. However interventions and treatments together are working to reduce the prevalence of obesity in Knowsley. A 1% reduction in prevalence of obesity in Knowsley would bring significant overall savings. However if the rate of reductions of 1% was maintained for 5 years, then an overall 5% reduction in adult obesity would give rise to a substantial £16.9 million saving per year, for NHS Knowsley (based on current cost of obesity to NHS Knowsley (includes health care costs attributed to obesity linked to other diseases such as diabetes, heart disease etc) at £73.4m per year, this would reduce to £56.0m)

**Gaps**

Over the past 12 months Knowsley have participated in a National Support Team visit (NST, Feb 2010), and a local KMBC scrutiny review on childhood obesity (Nov-Dec 2009). Following these reviews, a series of recommendations were proposed on how Knowsley could move the agenda forward and improve the childhood obesity prevalence in Knowsley.
Recommendations for Commissioners

Key Areas for Action are:

- There is a need to further understand how data and intelligence interlinks across this agenda, and how this data can be used to target specific groups. Carry out further data collation and analysis to understand the trends and patterns of obesity and also to understand the uptake of services in relation to need with a particular focus on children. Conduct mapping analysis on links between adult obesity, diabetes, CVD, smokers (ex-smokers); and mortality rates across Knowsley.
- Investigate if there is a link between disability (physical, learning and intellectual) and obesity rates in Knowsley. Investigate inequality trends and obesity trends of adults across Knowsley and if there are own sex variations on prevalence.
- Audit medication prescription rates in primary care and understand the variation in prescribing behaviour in differing GP practices (with the aim to improve quality of care and reduce costs).
- Reduce the onset of childhood obesity, through targeted evidence based interventions. Encourage universal services to offer more support and encouragement to increase physical activity and adopt healthy eating practices.
- Develop and implement an outcome specific maternal health pathway.

3.2.5 ORAL HEALTH

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**Key Needs**

- Dental decay affects around 64% of young children in Knowsley by the time they reach their 5th birthday – children in Knowsley have one of the poorest records for dental health in the England.
- Inequalities in child dental health across the borough – with a threefold difference in decay levels for 5 year old children living in Stockbridge and Northwood compared to Roby.
- More older people retaining their natural teeth present new challenges for prevention and dental treatment services.
- Vulnerable groups with poorer dental health, more untreated dental disease and difficulties in accessing dental care.
- Uptake of regular dental care in Knowsley is low compared to other parts of the North West. Recent DH statistics have shown that over a 2 year period, 53% of Knowsley residents access dental care. This is amongst the lowest dental attendance rates in the North West region and the PCT has agreed a target of 63% attendance by 2013.
Description of Who the Issue Affects

Young Children

Child dental health in Knowsley is amongst the poorest in England. Some key facts are:

- The 2005-6 survey of 5 year olds ranked Knowsley 305 out of 311 PCTs for dental health.
- Over 64% are affected by dental decay by 5 years old
- There are significant variations in child dental health across the borough with Roby having the best child dental health and Northwood and Stockbridge having the worst child dental health.
- In 2005-6 approximately 2000 north Merseyside children had decayed teeth extracted under general anaesthetic in local hospitals.
- Research has shown that once a child has developed dental decay in a single tooth, there is a 75% chance that they will go on to develop decay in other teeth. It has also been shown that 1 in 10 children with tooth decay will have an acute episode of dental pain in a 12 month period and 1 in 20 will require dental extractions.
- Dental attendance amongst young children is low – the vital signs for Knowsley showed that in the 2 year period prior to March 2010, just fewer than 40% of 5 year olds had seen a dentist – i.e. around young 7000 children have not attended a dentist in the last 2 years. The uptake is particularly low amongst very young children: less than 30% of 0-2 year olds had attended a dentist.
- Health visitors distribute dental care packs to all families with young children on two occasions in the preschool years. Currently community based fluoride toothpaste programmes are available to all children who attend day care provision up to 3 years old in Knowsley. However significant numbers of children do not attend child care before 3 years old – and they consequently do not have the benefit of being part of the supervised brushing programme. Once children move into state funded nursery provision they are able to be included in the fluoride milk programme – but not a fluoride toothpaste programme.

Older People

The older population in Knowsley is set to increase over the next 20 years and the adult dental health survey, 2010, is likely to show that over 90% of older people have some natural teeth. Access to dental care - including effective preventive care - for frail older people is poor. In general dental services are reactive for this group of patients when they develop dental problems rather than being pro-active.

A bigger proportion of the older population with extensively restored teeth is set to be a key challenge in dentistry for the future. Over 90% of older adults now have some natural teeth though many are heavily restored. The problems of a ‘failing dentition’, high incidence of gum disease coupled with
medical, mental and physical incapacity in frail older people will place a significant pressure on dental care services – including specialised care which is currently mainly available in secondary care settings.

Other Vulnerable Groups

Oral Health Needs Assessment of vulnerable groups has highlighted a possible gap in dental service provision for vulnerable groups including adults with learning difficulties. Services for many of these patients are often reactive rather than pro-active.

Equality and Diversity

In Knowsley, there are approaching eight hundred adults with learning disabilities, over two hundred young children with learning disabilities and approximately one thousand elderly patients in care and adults with serious mental illnesses. In addition, there are three hundred Looked after Children in the Borough.

The annual health assessment for adults with learning disabilities does include some questions about oral health but these may not always be included and are aimed at highlighting those with dental problems rather than promoting dental attendance pro-actively. Similarly for children with complex needs, adults with severe mental illness and for socially excluded groups (including substance mis-users) the dental service provision is mainly responsive to problems rather than pro-active or linked in to other health programmes such as the ‘Options’ scheme.

Recent data suggests that the proportion of BME groups in Knowsley are small. Where the local community does include those from BME groups, language and cultural barriers, lack of clarity around entitlement to free dental care and different expectations of dental services can be significant barriers to dental health and accessing care.

Links to Other Issues

Healthy Eating

A major risk factor for the development of dental decay is frequent consumption of sugar. Children who consume frequent sugary snacks and drinks are far more likely to develop dental decay. Clearly diet is also a key risk factor for other significant health issues such as obesity, diabetes. Although diet is a common risk factor, no direct link has been established between dental decay and obesity – i.e. children with high levels of dental decay are not necessarily the children who are overweight and vice versa. Nevertheless it is important that programmes aimed at healthy eating should encompass the key dietary messages for all conditions with a diet risk factor.
Smoking

Smoking is a risk factor for mouth cancer and periodontal disease. Over 7000 new cases of mouth, throat and head and neck cancers are detected in the UK each year with a mortality rate of around 50% - the main issue being late detection of cases. Smoking, chewing tobacco and high levels of alcohol consumption are all recognised as significant risk factors. It is therefore important that health improvement programmes include information about mouth cancers and also that we ensure there are sufficient awareness of the issues amongst primary care practitioners.

Link between Dental Health and Deprivation

Dental health surveys have consistently demonstrated a link between poor dental health and higher levels of deprivation. Children in areas with higher levels of deprivation will have poorer dental health (unless they have access to fluoridated water supplies). However, recently published research has also demonstrated that it is difficult to fully predict which children will develop dental decay – although more children from deprived localities will develop dental decay, some children from less deprived localities will also develop dental decay. Consequently current guidelines recommend that preventive measures should target all children though additional measures may be required for some groups.

Links to Other Strategies

The main strategies linked to oral health are:

- Oral health improvement strategy
- Dental commissioning strategy
- Child health promotion strategy
- Healthy weight strategy
- Anti tobacco strategies
- Children and young persons plan

Future Implications

5-10 years with No Change: Impact of Current Strategies:

Child Dental Health

Currently all pre-school children are targeted with the ‘Brushing for Life’ toothpaste scheme operated by health visitors and a postal distribution scheme targets 12-18 month old children. All children attending day care prior to moving into state funded care (at 3-4 years) are targeted with a supervised toothbrushing scheme and once in school and nursery attached to school parents are offered the option of receiving fluoride milk. Running alongside the fluoride schemes are ongoing oral health promotion programmes which focus on raising the awareness of the dental health and developing ‘healthy
policy’ (particularly around diet) in community settings such as Childrens’ Centres.

There is good evidence that the current fluoride toothpaste programmes will improve the dental health of the children who take part. The effectiveness at a population level could be increased if toothpaste schemes were extended to include children who do not attend nursery or day care before 3 years of age, (this is currently around 4500 children in Knowsley) and to children beyond 3.5 years (i.e. once they have moved into state nursery provision and school).

Although those taking part will benefit, the risk of increasing inequality in dental health between those in the programmes and those not included (in particular children who do not attend day care provision before 3 years old), remains.

Primary dental care has traditionally focussed on treatment of established disease rather than prevention. The current primary care dental care contract – which is a national contract – continues to reward and monitor activity for dentists in terms of treating dental disease – rather than prevention of disease. The national contract is currently under review and there may be scope to include prevention amongst key performance indicators in the future.

Vulnerable Groups

Recent needs assessment work has demonstrated problems with access to dental care for some and patchy coverage with oral health improvement programmes. In particular the changing pattern of oral health for older people is a key challenge. With no change to current provision, there will be:

- Increased incidence of high decay rates and dental treatment needs amongst older people with a retained natural dentition
- Increased morbidity linked to poorer dental health amongst vulnerable patients – particularly frail older people.
- Increased reliance on secondary care based specialist services for these groups of patients with complex needs

Evidence of What Works

Programmes which focus on the increased exposure of teeth to fluoride have the strongest evidence base around effectiveness. NHS Knowsley has previously supported an SHA North West led approach to increasing water fluoridation schemes across the region. At the present time there are no plans to pursue this further and so alternative fluoride programmes will be needed for the foreseeable future.

Community oral health programmes focussing on increasing the use of fluoride toothpaste and fluoride milk operate in all early years settings and primary schools. Although the evidence around the effectiveness of fluoride milk in caries reduction at a population level is inconclusive, it is generally agreed that a well managed fluoride milk scheme can improve dental health.
for target groups and therefore could be considered as part of a basket of measures aimed at improving dental health amongst children. The Knowsley fluoride milk scheme is offered in all nurseries and primary schools across the borough with an average of 80% of children taking fluoride milk. A small number of schools scattered across the borough have scope to increase uptake.

Published research has demonstrated that fluoride toothpaste distribution programmes have achieved a 16% reduction in dental decay levels between test and control groups. Supervised tooth brushing schemes have been shown to bring around reductions in dental decay of around 30%. The supervised tooth brushing / fluoride toothpaste scheme covers all children’s centres and private nurseries and includes around 1700 children aged 1-3 years – this is 93% of children attending day care provision.

In 2007 the Department of Health published a prevention toolkit for primary care dentists – ‘Delivering Better Oral Health’ which provides clear guidance for general dental practitioners around the most effective preventive care for all groups of patients. There is significant potential for general dental practitioners and their staff to make a difference to the dental health of their patients by following the guidance particularly through the increased use of fluoride varnish treatments which are effective in reducing dental decay. Future commissioning of dental services should support the adoption of a more preventive focussed approach.

**Additional Interventions:**

In Northern Ireland, a comprehensive programme of fluoride toothpaste schemes: including supervised brushing programmes, distribution via health child health practitioners and toothpaste by post schemes achieved a 35% in the number of child dental general anaesthetics over a 3 year period.

The addition of ‘fluoride toothpaste by post’ scheme for young children in Knowsley, would reach children who do not attend day care in the very early years and who may miss out on supervised tooth brushing programmes. The addition of 2 postal drops of toothpaste packs to families with young children would cost approximately £18000 per year. Based on the Northern Ireland work, this, together with the current community fluoride programmes, could lead to a reduction in the numbers of child dental general anaesthetics significantly.

Through outreach and social marketing the numbers of local residents accessing primary dental care including vulnerable groups could be increased. Pilot work in Stockbridge Village and in Liverpool has demonstrated that outreach sessions into early years settings can be an effective way of increasing the numbers of young children receiving fluoride treatments in areas of high need.

Re-focussing the work of dental practitioners on delivery of preventive care would lead to further improvements in dental health – however this would
need to be supported by changes to the current dental contract and the introduction of key performance indicators. The preventive approach will benefit all groups of patients – not just children. In particular, older adults and vulnerable groups of patients can benefit significantly from the preventive measures recommended in ‘Delivering Better Oral Health’.

**Gaps**

There are around 4500 children who do not access any formal day care before 3 years old who are not included in the current supervised fluoride toothpaste / brushing schemes. Fluoride toothpaste schemes do not currently target children once the move into state funded nursery places (although they may receive fluoride milk).

A significant proportion of the Knowsley population do not readily access dental care. There is a need to increase uptake of primary dental care – through social marketing and outreach, and to ensure that primary dental care services have an appropriate emphasis on prevention, supported by the commissioning process.

Gaps in service provision for vulnerable groups of patients have been identified with dental services through needs assessment. This includes the 1100 residents of nursing and residential homes in Knowsley being mainly reactive to dental problems rather than pro-active.

**Recommendations for Commissioners**

- The current range of oral health promotion programmes should be reviewed in order to provide resource to further develop the fluoride toothpaste programmes to include all children in the early years. Fluoride toothpaste by post schemes have been shown to be effective in reaching families and reducing dental decay levels.
- There is need for ongoing work with primary care dentists to ensure that all patients receive an appropriate package of preventive dental care (as set out in the DH guidance, Delivering Better Oral Health) as part of their dental care and to shift the emphasis of care from a restorative approach to treatment towards a preventive approach. Inclusion of preventive care amongst key performance indicators would support this change in emphasis. A care pathway approach based on patients need and monitoring improvements in oral health has been trialled in other areas. It is expected that this approach will be incorporated into changes to the new national dental contract.
- The use of outreach programmes into community settings such as children’s centres, community pharmacies may be useful in promoting dental attendance and reaching those who do not readily access dental care with effective prevention.
- Commissioning of dental services to meet the needs of vulnerable groups, including frail older patients is required. This should include:
  - refocusing existing services towards pro – active planning of dental care including preventive care,
• development of specialised skills to ensure there is clinical leadership locally available in order to minimise the need for hospital based care
• Integration of oral health into general health assessments for vulnerable groups.

3.2.6 SEXUAL HEALTH

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Key Needs

- Young people need easily accessible services to support their contraceptive and sexual health needs, as they are high risk groups for unintended pregnancy and sexually transmitted infections.
- Women where possible are to be supported in accessing contraception that meets their needs and encourages uptake of Long Acting Reversible Contraception (LARC).
- Higher prevalence groups for HIV, including BME communities, asylum seekers, men who have sex with men and intravenous drug users need access to awareness information and safer sex materials.
- Service users who may be at risk need to be encouraged to attend routine screening in community or primary care settings

Description of Where / Who the Issue Affects

Sexual Health issues affect the sexually active population of Knowsley including adults and young people. Younger people aged 15-24 have a higher prevalence of most Sexually Transmitted Infections (STIs), except for HIV which in Knowsley is mostly 20-39 years. Overall fewer men are accessing sexual health services than women, but represent a slightly higher prevalence of STIs, especially among 20-24 year olds.

There is a very low relative prevalence of HIV, although there are a small number of new infections each year adding to prevalence.

Women aged 20-24 years are the main group accessing contraceptive services in the community. However, they also have the highest rate of terminations and pregnancy in Knowsley (165 in 2006). This indicates there is still room for improvement.

There are high levels of the STIs Chlamydia and gonorrhoea throughout the PCT, and specifically in women between 15-29 years. Chlamydia screening rates have been increasing, but not in line with expectations of National
Chlamydia Screening programme and associated vital signs targets (25% in 2009/10 and 35% in 2010/11). There are particularly low levels of male chlamydia diagnoses in community settings, with the exception of teenage services.

There are high levels of the key five STIs in the areas of Prescot, Page Moss, Kirkby, and Halewood. STI prevalence is highest amongst ‘Disadvantaged Households’ and ‘Urban Challenge’ areas. 62% of youth service users are male which represents a reversal in service use trend when compared to the KT31 data.

Until the opening of the integrated sexual health service, the Arch, there had been no sexual health provision which included testing for all STIs and management in Knowsley PCT, and service users have had to be signposted to acute Genito-Urinary Medicine (GUM) services in Royal Liverpool or St. Helens GUM services for more comprehensive sexual health intervention.

Local insight and national research indicates links between sexual health, alcohol and mental health and wellbeing. A local programme to identify people at risk of alcohol related problems alongside the provision of brief interventions and signposting has been rolled out. LINKS have been made aware of young people’s services and sexual health services to offer screening and brief advice at local events.

Terminations are higher in Knowsley than surrounding areas, especially among women aged 20-29. Repeat abortions are higher than the national and regional averages.

High risk groups for HIV transmission include MSM (Men-who-have-sex-with-men) and asylum seekers. There is limited resources and provision dedicated to lesbian, gay, bisexual and transsexual people in Knowsley and residents present at specialist services in surrounding areas such as Liverpool.

Teenage pregnancy and STI prevalence is higher in particular Area Partnership Boards including North Kirkby, North Huyton, and to a lesser extent South Kirkby and Halewood.

**Equality and Diversity**

In Knowsley, services are being contracted to deliver against requirements of the Single Equality Scheme. This has presented conflicts, especially with regard to recording of sexuality or religious belief, in relation to gathering this data.

There is a similar uptake in services by ethnicity, compared to the demographic breakdown in Knowsley. There is no identified higher prevalence of HIV in BME populations in Knowsley compared to national data. This may reflect our current low overall HIV prevalence.
People living with physical disabilities have attended clinics and reported access issues (which have since been resolved). A need has been identified to support and enable vulnerable adults, or those with learning difficulties, and their carers around their sexual health. They are overrepresented in Safe Place experiencing sexual assault or rape.

There is a higher uptake by women than men of sexual health services, as explained earlier. Trans men and women will often present at sexual health services in the initial instance, according to national data, and have few formal support services available across the region, none in Knowsley.

Limited data is now being collected about sexuality from services, although there are a significant number of refusals to the question. Gay and bisexual men are identified as high risk for HIV and other STIs, and according to Cheshire and Merseyside Sexual Health Network guidelines would be signposted to Level 2 or 3 sexual health services outside of Knowsley as there is currently none available.

Sexual health issues are often focussed on young people, with the sexual health needs of older people potentially ignored.

Other key groups – National data identifies high risk groups to include migrant workers, people with learning disabilities, sex workers, and offenders. Data is not available locally around their needs but sexual health interventions need to reflect these needs as appropriate.

**Links to Other Issues / Topics**

Areas of poor sexual health outcomes tend to be the same as those with high levels of social deprivation. Other indicators include low educational attainment and school attendance, young people who are at risk of offending and who are or have been children looked after. Teenage pregnancy is more common in young girls who have experienced mental health problems, sexual abuse in childhood, sex before the age of 16, violence and bullying at school, poor parental support, involvement in crime, use of alcohol and substance misuse and in those who have low aspirations. Young fathers are more likely to live in deprived areas, to be unemployed and to be in receipt of benefits and have similar characteristics to teenage mothers.

In Knowsley, the majority of teenage mothers are lone parents (79%), with 19% co-habiting and 2% part of a married couple. Lone parents are more likely to be on benefits or be working for low pay and lack qualifications.

Sexual Health behaviours is often associated with other lifestyle factors especially in the younger age group. There is significant evidence for sexual risk-taking behaviour with substance misuse, especially alcohol. There are also strong links with risk-taking and self-esteem and mental well-being, smoking, self-harm, body image and eating disorders. The link with substance misuse also is a key factor with regard to incidents of sexual assault and rape for Knowsley residents.
Young people, especially those described as not in education, employment or training (NEET), are being engaged through various health services, over their specialist needs and anecdotal insight supports national strategies that indicate a joined-up approach provides better value, less duplication and a better experience for the service user. Where services and interventions are more generic, or opportunistic (such as outreach) feedback suggests that it is less stigmatising, especially for young people.

Sexual Violence also has a significant impact on survivors, who can have significant effects on their long-term mental health and well-being. Survivors are also at greater risk of developing problems around alcohol and substance misuse.

**Links to Existing Strategies (incl. Policies / Services)**

There is an overarching Sexual Health Modernisation Board for Knowsley and a specific Teenage Pregnancy Strategy. These are also linked to the Children and Young People’s Plan and are aligned to Children and Family Services’ Integrated and Targeted Youth Support Strategies.

There is also an Increasing Chlamydia Screening Project which has supported achievement of the increasing targets in 2009/10 and 2010/11. Chlamydia Screening requirements are being included where appropriate in provider contracts and specifications for various community services, including Options (GP services), Knowsley Sexual Health Services, Armistead and teenage services.

A Sexual Health Locally Enhanced Service Specification has been introduced, offering Knowsley GPs incentives to provide long acting reversible contraception and Chlamydia screening. Community Sexual Health Services are due to be tendered in September 2010, as the existing contract (which had been extended by a year) expires in March 2011, leading to the development of a suitable specification.

**Future implications (Modelling / Projections)**

The implications of teenage pregnancy and links to health outcomes are described in more detail in a specific section on teenage pregnancy.

The implications of increased sexually transmitted infections impact on wider determinants of health. Some infections, such as HIV and Chlamydia have an attributable cost to the health economy.

The impact of reduced chlamydia transmission would be less treatment of complications caused by pelvic inflammatory disease, such as infertility and ectopic pregnancy. Approximately 1 in 10 of young people screened test positive for chlamydia. According to the HFEA (Human Fertility and Embryology Association), each IVF cycle costs approximately £2.5k, with a success rate of 28.2% for women under 35.
Every avoided HIV transmission would save approximately £200k in treatment costs from diagnosis to death\(^1\). There is a much greater implication with increased inputs from disability living allowance, and inputs from community nursing and social care. We also contract Sahir House to deliver ongoing support for HIV positive individuals from Knowsley, which is based on numbers of clients.

HIV prevalence is increasing currently in Knowsley, where there has been a historical low pool of infection. As treatments improve, and fewer people die from HIV related illness, the prevalence increases with new infections, thus increasing the potential rate of infection.

**Evidence of What Works**

NICE Public Health intervention guidance has been produced on preventing sexually transmitted infections and reducing under 18 conceptions. This includes guidelines on the provision of sexual health services that meet the population’s needs, such as specialist sexual health youth workers and training for key staff including GPs and school nurses and staff working with vulnerable groups.

Links with the Cheshire and Merseyside Sexual Health Network provides shared best practice across a larger footprint, and joint commissioning of specific elements of sexual health support (such as HIV services, gay men’s health promotion, Safe place Merseyside).

There is a growing body of evidence to encourage joined up working around lifestyle issues, such as links to alcohol, substance misuse, mental health and well-being, especially targeting similar groups such as young people, NEET and deprived areas.

**Gaps**

There are data collection gaps with respect to whether or not hard-to-reach groups are accessing fixed site and outreach services. There is limited data about sex work and public sex environments in the Knowsley area, however anecdotal evidence suggests there is activity NHS Knowsley are not aware of.

There needs to be a co-ordinated vision around the whole scope of sexual health services in the Knowsley area in order to support better outcomes across the patch.

Significantly many Knowsley people are going out of the area to access sexual health services, as they have not been available locally, such as GUM clinics, HIV services, gay men’s health, community sexual health, abortions services and Brook Advisory clinics.
Recommendations for Commissioners

Follow the detailed recommendations of the Teenage Pregnancy Scrutiny Panel 2010, more information is included in the teenage pregnancy section.

Data / Intelligence Requirements

- Uptake of developing sexual health services needs to be monitored in 2010/11, to inform future specifications.
- Overall LARC uptake and Chlamydia Screening rates need to be monitored to measure impact of current interventions.
- Monitoring for sensitive information with respect to sexual orientation, trans status and religious background should be collected where agreed with providers.
- Needs assessment work for hard-to-reach (especially higher risk groups for HIV transmission) groups should be conducted ahead of any tendering in 2011.

Service improvements

- Sexual health service specifications need to be developed in the light of information gathered from local market research and access surveys to meet a procurement of services from 2011/12.
- Sexual health services need to be accessible and flexible to the needs of young people.
- Services should be commissioned over wider footprints where possible to derive best value and avoid duplication.
- Sexual health services should be provided as part of a wider package of preventative and community lifestyle services to encourage attendance and support opportunistic screening.
3.2.7 SMOKING

READER INFORMATION

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<tr>
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<tr>
<td>Lead Author</td>
<td>Chris Owens</td>
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<td>Approved by</td>
<td>Julie Tierney</td>
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<td>Date completed</td>
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Key Needs

- Smoking prevalence in Knowsley is 23.7% compared to 21% nationally and 25% regionally.
- Prevalence varies from 8.3% in Halewood North to 32% in Stockbridge.
- Prevalence in young people is 7%. However, 17% of girls in year 10 were found to be smokers.
- Research shows that almost half of the young people who smoke purchase their tobacco from the informal economy (illicit tobacco).
- The number of women smoking at time of delivery is 25.5%. Only 34% of pregnant smokers are currently referred for stop smoking support.
- More men than women access the stop smoking services.
- The number of under 18 year olds accessing the stop smoking services is low.
- Intensive long term support is required in the communities where prevalence is highest and quit rates are currently the lowest.
- Smokers told us that the biggest reason for relapse is weight gain or fear of weight gain.

Description of Where / Who the Issue Affects

The current smoking prevalence in Knowsley is 23.7%. The prevalence varies from 8.3% in Halewood North to 32% in Stockbridge. Northwood has a prevalence of 31.2% and Kirkby Central has a prevalence of 29.5%. Overall, in areas of high deprivation the quit rates are lower and these people find sustaining a quit attempt more difficult. It is therefore important that we provide a targeted service to support these clients most effectively. National smoking prevalence is currently 21%. Therefore to reduce inequalities between Knowsley and the rest of England and within the borough, there is a lot of work to be done.

The Knowsley Tobacco Control Strategy aims to ‘reduce uptake of smoking in young people’. The locally agreed target for this is a 1% reduction in prevalence year on year from a baseline of 13% in 2006 in order to meet the national requirement of 9% by 2010.

Nationally in 2008, 11% of girls and 8% of boys aged 11-15 yrs had smoked a cigarette during the last week.

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The Health Related Behaviour in Knowsley 2009 shows an overall prevalence for all young people in years 8 and 10 of 7%. With Year 8 figures being 4% boys and 2% girls and year 10 boys 7% and females 17%. Knowsley progress has been excellent in relation to the target to reduce smoking prevalence in young people to 9% by 2010. However the number of young girls smoking in year 10 is a cause for concern.

Research conducted amongst fifteen and sixteen year olds found that in Knowsley 13% smoked regularly with females more likely to smoke than males. This survey also found that almost half of the tobacco purchased by young persons is from the informal economy. This includes street sellers, neighbours, private houses and vans with the likelihood that the products are counterfeit or smuggled.

The number of women in Knowsley smoking at time of delivery (2008/09) was 25.5%. In order to reduce the number of women smoking at time of delivery to 20% a total of 142 women would need to successfully quit smoking during their pregnancy and remain quit. In 2008/09 a total of 97 women set a quit date and 35 of these women went on to successful achieve a 4 week quit which equates to a 36% quit rate. Using this quit rate baseline it would mean that in order to reduce smoking in pregnancy to a prevalence of 20% 394 women would need to set a quit date to ensure that 142 of them (36%) successfully quit. For this to be achieved there needs to be significant increase in the number of pregnant smokers that are referred to the stop smoking service for support.

Equality and Diversity

Smoking disproportionately affects those people living in the most deprived areas and in the most deprived groups, with those being economically inactive being most likely to smoke.

Smoking rates are known to be highest in the routine and manual group. The desire to quit is known to be the same across all socio economic groups, however the success of quit attempts is not equal, with those from the most disadvantaged groups being less likely to sustain their quit attempt.

Young people in lower socio-economic groups take up smoking in greater numbers than those in higher social classes.

It is known that as many as 78% of sentenced prisoners and 88% of remand prisoners smoke. It can therefore be presumed that smoking rates amongst offenders will be considerably higher than those of the general population.

More women than men access the stop smoking services. However men have better success rates than women.

The stop smoking services are accessed relatively evenly across the age groups for people aged 18-59 years, with those aged 45-59 being the group with the largest number. There are significantly less people aged 60+
accessing the services and very few under 18s access support to quit smoking.

On average 1.6% of people accessing the stop smoking services who declare their ethnic background are not white British this is similar to the proportion of BME population in Knowsley.

Previously information about faith, religion, disability, or sexual orientation has not been collected. This is now addressed through the single equity scheme.

**Links to Other Issues / Topics**

Smoking more than any other identifiable factor contributes to the gap in healthy life expectancy between those most advantaged and those most disadvantaged. In Knowsley there is a clear association between rates of smoking and social deprivation, with smoking related diseases contributing significantly to reduced life expectancy in the poorest parts of the Borough. Reducing the high rates of smoking will reduce rates of lung cancer, heart disease, stroke and respiratory disease and will close the health gap between the poorest and the more affluent parts of the Borough.

Those people with the lowest incomes spend a higher proportion of their disposable income on smoking thus further contributing to their disadvantage. The availability of illicit tobacco has reduced the impact of price controls to reduce prevalence and is known to be more likely to be available in the most deprived areas within the community.

Smoking rates are known to be high amongst vulnerable groups such as those suffering from mental health problems, the homeless and unemployed. Nationally prevalence is highest amongst the economically inactive aged 16-59, with prevalence highest amongst those economically inactive people whose last job was a routine or manual one.

It is also known that disadvantaged groups who have higher rates of smoking often also exhibit other unhealthy behaviours.

**Links to Existing Strategies (incl. Policies / Services)**

Smoking prevention and cessation initiatives are covered in the following Knowsley strategies:

- Tobacco Control Strategy
- Cardio-vascular Disease Prevention Programme
- Infant Feeding Strategy
- Healthy Workforce Strategy
- Children and Young People’s Plan
- Maternal Health Strategy
- Cancer Prevention Strategy
- Long Term Conditions Strategy
- Healthy Schools Strategy
Future Implications (Modelling / Projections)

Smoking prevalence in Knowsley remains high when compared to national levels. However, continued investment in a range of stop smoking services locally for children and adults combined with improved quality of service provision, should result in a gradual decline in the level of smoking in the Borough over the next 3 years.

Currently the Knowsley stop smoking services aim to support a total of 1850 adults to stop smoking per year. Whilst the service have previously managed to achieve a high quit rate, it is of concern that the success rate has been falling over the last two years reaching a low point of 35% in quarter one 2009/10. The quit rate has increased each subsequent quarter to above the minimum specification of 45% during quarter two 2010/11.

In order to prevent a further reduction, as part of contract extension negotiations, public health commissioning has introduced a target minimum quit rate of 45%. The intention is that services will work harder to ensure that clients are successful in their quit attempts and so in future years this minimum quit rate will be increased to align the results with our statistical neighbours. If we are able to increase the success rate to match that of our statistical neighbour group (51.3%), we would achieve 2,387 quitters a year (based on the throughput during 2008/09). With the same number of people entering the service as 2008/09, this would result an additional 500 quitters over the 1868 achieved in 2008/09.

The current contracts require a minimum quit rate of 45%. This will produce an additional 225 four week quitters. Four week quitters is used nationally as a measure for stop smoking services. Gathering longer term quit data becomes problematic as people are no longer in contact with services. There is a move to use prevalence as an indicator of success across tobacco control in addition to four week quit rates.

Increasing the number of people accessing the services will also increase the numbers setting quit dates. Working closely with marketing, using the results of insight work undertaken in 2009, a plan for increasing the numbers accessing the service has been developed.

Following the findings from the insight work, there has been a focus on improving the quality of services delivered across Knowsley by the provision of additional training and resources. This has shown an impact with the quit rate increasing through the year 2009/10 and continuing into 2010/11. This quality improvement will be a focus for the coming year.

It is important that the number of pregnant women receiving support to quit during their pregnancy is increased. Increasing quit rate in this client group by improving the quality of support delivered and by imposing a minimum quit rate in the contract for the commissioned service is how this needs to be addressed. implementing the recommendations contained in the NICE guidance PH26 how
to stop smoking in pregnancy and following childbirth. In particular this should include

- The introduction of an opt-out pathway with routine CO monitoring for all pregnant women.
- Redesign of pregnancy stop smoking service to ensure smooth referral pathway and efficient use of resources.
- Brief intervention training for midwives and associated staff.

During 2011/12 the stop smoking services in Knowsley will be re-specified and re-tendered. Alternative ways of delivering a quality service to pregnant smokers will also be explored.

Evidence of What Works

There is a range of guidance and documentation on interventions designed to assist people to stop smoking.

Nice Guidance

- PH1 (March 2006) Brief interventions and referral for smoking cessation in primary care and other settings
- PH5 (April 2007) Workplace interventions to promote smoking cessation
- PH10 (February 2008) Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities
- PH 14 (July 2008) Guidance on preventing the uptake of smoking by children and young people
- PH23 (February 2010) School based interventions to prevent the uptake of smoking among children
- PH26 (June 2010) How to stop smoking in pregnancy and following childbirth
- TA123 (July 2007) Varenclaire for smoking cessation

Other Guidance

Department of Health ~ (30/11/09) NHS Stop Smoking Services: service and monitoring guidance 2010/11


Gaps

Additional intensive long-term support is needed in the most disadvantaged communities, where quit rates are currently the lowest.
The evidence base of interventions designed to prevent and delay the uptake of smoking in young people is weak. Following an external review of the current service an action plan for service development needs to be produced.

Many women who try to stop smoking during pregnancy will relapse either before or just after delivery. Further evidence is needed of effective activities to help prevent relapse.

At present stop smoking services attract more women than men. There may need to be some revamping of the services to encourage more men to use them.

Data regarding cost effectiveness of stop smoking interventions locally and the impact of quitting smoking on NHS costs would be useful in planning services, however this is currently not available

**Recommendations for Commissioners**

**Service Improvements**

- During 2010/11 continue to invest in a comprehensive approach to providing stop smoking services (including social marketing, insight and communication initiatives) to meet the targets for quitters.
- Ensure that there is a focus on increasing the success of those quitters in the most deprived areas, through quality improvements and specification of a minimum quit rate (45%) in contracts as they are reviewed in 2010/11 and ensure that this is monitored via the regular service reviews with each of the services.
- Ensure that during 2010/11 clear pathways for referral to other lifestyle services e.g. weight management are in place. Develop an action plan for developing a comprehensive smoking prevention and stop smoking programme for young people. This should use effective local approaches to engage with young people on tobacco issues and smoking cessation using the NICE guidance and the findings from the external review of the young person’s service and should be completed by April 2011.
- Develop an opt out referral pathway including CO monitoring for all pregnant women and implement by March 2011.
- Develop training to increase awareness and skills of community and service staff in contact with pregnant women.

**Data / Intelligence Improvements**

- Implement the regional data collection system for all specialist stop smoking services by end March 2011.
- Explore possibility of modeling cost savings to the NHS locally of the provision of stop smoking service.
3.2.8 SUBSTANCE MISUSE AND OFFENDER HEALTH

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**Key Needs**

- Opiates and Crack combined remain the main problem drug in Knowsley accounting for 58% of substances used within the in effective treatment population in 2008/09. Knowsley’s percentage proportion of opiate and crack related referrals are lower when compared to regional and national data.
- Powder cocaine related referrals in Knowsley remain the highest in the North West accounting for 33.0% of the referring substances.
- The Merseyside treatment system as a whole has significant pockets of powder cocaine users which differentiates it from the rest of the North West, the reasons for this may be that Merseyside is a key entry point for smuggling cocaine and low prices reflect this. The increasing number of seizures of cocaine by the police would also support the view that powder cocaine is the emerging drug of choice of for people in Knowsley.

**Description of Where / Who the Issue Affects**

An estimated 3.76 million people in England and Wales use at least one illicit drug each year (British Crime Survey), and around one million people use at least one of the most dangerous drugs (such as heroin and crack). While the numbers of people with serious drug problems may be small, drug misuse affects us all. The British Crime Survey in 2009/10, reported that 5.5% (367,000 young adults) of 16-24 year olds in the UK have used powder cocaine within the last year. Powder cocaine can be linked to particular lifestyle patterns; in particular with the night-time economy and alcohol consumption in pubs, clubs and wine bars.

In Knowsley the latest National Drug Treatment Monitoring System (NDTMS) report shows that 1056 people are in effective treatment for their drug use of whom 707 (67%) are heroin and or crack cocaine users.

Drug misuse wastes lives, destroys families and damages communities. It costs taxpayers millions to deal with the health problems caused by drugs and to tackle the crimes such as burglary, car theft, mugging and robbery which are committed by some users to fund their habit. The drug trade is linked to
serious organised crime, including prostitution and the trafficking of people and firearms.

Providing drug misusers with well-managed, effective treatment is the most successful way of tackling all of these harms.

Injecting drug use amongst Opiate and or Crack users in effective drug treatment in Knowsley remains low 9%. Compared to 25% for the North West. Whilst this relatively low rate of prevalence of injecting is obviously desirable there is still a need to plan activity around the prevention and treatment of Blood Borne Viruses.

Currently 33% (n=10) pharmacies in Knowsley which provide needle exchange and this level of provision is more than adequate when compared to the injecting population.

In 2009/10 within criminal justice settings, powder cocaine users accounted for more than double those people with heroin and or crack in 2009/10. Within this cohort thirds of the heroin and or crack group were unemployed compared to nearly half of the powder cocaine group.

There were a total of 1,717 recorded drug offences in 2007/2008. The vast majority of these offences were Possession of Cannabis” offences that accounted for nearly 87% of the total. The second highest offence is for “Possession of Cocaine” (5.8% of the total or 100 actual offences). The pattern of drug offences is fairly consistent over time in Knowsley with the top 2 offences accounting for over 90% in most years.

Possession of Cannabis offences account of the vast majority of drug offences in Knowsley in 2007/08 with possession of cannabis rising by 53% between 2005/06 and 2006/07. Possession of cocaine offences have also risen significantly over the last two years.

**Equality and Diversity**

Service offers advice and information as appropriate for race or religious beliefs.

Despite potential barriers to engagement and retention in drug treatment, women enter treatment at different points in their drug use, with different needs and different problems, there is no evidence to indicate that women are under-represented in treatment services in England. These findings are supported locally in the North West and in Knowsley.

The Knowsley Housing Needs Assessment undertaken in 2009/10 identified 219 people in need of accommodation. This figure is based upon NDTMS data, which identifies the number of people in a year entering treatment and what their housing status is. The analysis showed that a total of 108 people in a year were classified as having a housing problem or an urgent housing problem. To this was added a further 10% of those entering treatment as the
definition of a “housing problem” was such that some people were excluded who should not have been e.g. those receiving a supported housing service at the time. A further 25% was added to reflect the fact that a number of people will still be known to services and still in housing need even though they had not been in treatment in that year. This figure was based on the proportion of people caught by the snapshot survey who were in housing need but had received treatment in previous years. In line with nation trends housing issues present a barrier to recovery.

**Links to Other Issues / Topics**

Substance misuse is linked to a wide range of issues within Knowsley. Excessive alcohol consumption is a cross-cutting priority for Knowsley’s Local Strategic Partnership and it can impact on the areas below.

- Blood borne viruses
- Criminal Justice
- Alcohol
- Safeguarding/Children and young people
- Long Term Conditions
- Community Cohesion
- Housing & Resettlement

**Links to Existing Strategies (incl. Policies / Services)**

The following strategies and policies are related to substance misuse and offender health:

- National Drugs Strategy
- Safeguarding
- Bradley Report
- Equitable Access to Primary Medical Care
- Safer Knowsley Partnership Strategic Assessment 2010
- Knowsley Substance Misuse Treatment Plan

**Future Implications (Modelling / Projections)**

There are no under 18 heroin/crack users in Knowsley and this changing epidemiology is reflected in the 18-24 and 25-30 year olds and in consequence Problematic Drug Users (PDUs) are getting older. It is evident that powder cocaine and cannabis are becoming more prevalent amongst younger adults whilst heroin and or crack use is declining.

At the end of Quarter 4 2009/10 a total of 597 people were reported to be in receipt of a substitute script in Knowsley of whom 113 were in shared care.
This ageing PDU cohort mirrors the North West trend which has seen the number and proportion of those people in treatment aged 45 and older increase.

Analysis of the age profiles over the last four years using needs assessment data indicates an increase in PDUs in treatment who are aged 35-64 (n=178, 67%). Comparative data confirms that the treatment system in common with Merseyside has an ageing cohort of service users however South Knowsley has the highest % of service users aged 18 – 24 and the second highest % of service users aged 25 -34(mostly powder cocaine). These changing drug patterns require a treatment response which is different to that which is offered to heroin and or crack users.

**Evidence of What Works**

The following has been identified to work to support substance misusers and offenders;

- Effective treatment with clear goals supported by wraparound services.
- Recovery groups such as Narcotics Anonymous/Cocaine Anonymous/Alcohol Anonymous
- Integrated Offender Management Model
- NICE Guidance Drug misuse: psychosocial interventions
- NICE Guidance Drug misuse: opioid detoxification

**Gaps**

- Increased emphasis on recovery based outcomes
- Services for younger adults who misuse powder cocaine and alcohol

**Recommendations for Commissioners**

- Develop a recovery and abstinence orientated drug treatment system in 2011/12.
- Develop services for cocaine users offering brief interventions in 2011/12.
- Stronger links between alcohol and drug treatment services including joint protocols
- Ensure that robust criminal justice liaison arrangements are in place for mentally disordered offenders.
- Conduct an offender health needs assessment by March 2011.
3.2.9 MENTAL WELLBEING

**READER INFORMATION**

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<td>Lead Author</td>
<td>Chris McBrien,</td>
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<tr>
<td>Approved by</td>
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<td>Date completed</td>
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**Key Needs**

- Mental Wellbeing is fundamental to achieving a healthy, resilient and thriving population.
- Mental Health problems are common and costly to the public sector, with one in six of the adult population experiencing mental ill health at any one time.
- Wellbeing levels are low in Knowsley compared to the regional average.
- Levels of wellbeing are lower in areas of deprivation and is lower in identified population groups of unemployed people, those with low educational attainment, older people experiencing disability and health problems.
- There is a growing evidence that action can be taken to improve wellbeing and this requires a multi-organisational strategy with a focus on a population approach.

**Description of Where / Who the Issue Affects**

Mental well-being is about how we think, feel, behave and function. It is fundamental to achieving a healthy, resilient and thriving population. It underpins healthy lifestyles, physical health, educational attainment, employment and productivity, relationships, community safety and cohesion and quality of life. Action to improve mental well-being will therefore contribute to a wide range of positive outcomes for individuals and communities, in addition to the prevention of mental health problems.

There is robust evidence that improved population wellbeing can result in:

- Increased quality of life and overall wellbeing
- Improved educational attainment and outcomes
- Safer communities with less crime
- Reduced health inequalities – both physical and mental health related and lower health care utilisation
- Reduced mortality
- Improved productivity and employment retention
- Reduced sickness absence from work
- Reduced levels of poor mental health and mental illness.
Mental Wellbeing in Knowsley

Analysis of the 2009 North West Mental Wellbeing Survey, which used the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), a measure of positive mental health at a population level, shows that, Knowsley adults had the third lowest mean WEMWBS score in the North West, indicating that overall levels of mental wellbeing were lower than the North West average. However, when broken down into categories of low, moderate and high levels of mental wellbeing, adults from Knowsley had the third highest proportion of people in the moderate category in the North West.

The WEMWBS data showed regionally and across Knowsley lower levels of wellbeing and living in areas of deprivation. The survey also showed levels of wellbeing become lower with age.

People who report higher levels of mental wellbeing are more likely to be in employment, have higher educational attainment, better physical health, have healthy lifestyle behaviours, report satisfaction with personal relationships, satisfaction with their local area and feelings of optimism and ability to influence.

Knowsley residents have relatively low mental wellbeing, have relatively low incomes, are generally less likely to have healthy lifestyles and are more likely to be unemployed. Residents are also less likely to join sports clubs, religious groups or educational groups. Individual wellbeing and behaviour is consistently worse in Knowsley than elsewhere in the North West.

However, the WEMWBS survey also showed that Knowsley residents report positively on many indicators used to demonstrate area or community wellbeing. Across the North West region Knowsley residents report the highest likelihood of feeling they belong to their immediate locality and the second highest level of satisfaction with the local area as a place to live. Knowsley residents reported the highest assessment of being safe in their home at night and being safe outdoors in the day. They had the highest likelihood of talking regularly with neighbours, being able to find help in a crisis and likelihood of finding help if ill. Residents also reported the highest level of agreement that they can influence decisions in their local area.

Equality and Diversity

Wellbeing affects everyone, however research shows that certain groups tend to report lower levels of wellbeing.

The WEMWBS survey shows that in Knowsley those situated in the most deprived quintile had the least proportion of people who stated they had ‘high’ levels of mental wellbeing, the lowest proportion of people in the ‘moderate’ category and the second highest proportion of people in the ‘low’ mental wellbeing category.
Lower levels of wellbeing are also more likely amongst people experiencing poorer health and or disability. Poorer health often compromises independent living which in turn affects wellbeing. Wellbeing has been recorded as decreasing with age, meaning that as people get older their emotional wellbeing gets poorer. The regional data indicates there is a dip in mental wellbeing around middle age (40 – 54 years), this is also supported by wider literature. For Knowsley the dip is shown to be in the 55 – 64 age category. This may correlate with physical health becoming poorer with age.

The WEMWBS survey found people living in assisted or supported housing (housing usually occupied by older people and or people with disabilities) were more likely to also have low levels of wellbeing. In addition, it is more likely that vulnerable groups, such as those with physical and mental disabilities and older people may have a greater fear of crime that will affect wellbeing.

Lower wellbeing scores are also more common if you are out of work (through unemployment or sickness) and it is lower amongst population groups with lower educational attainment. Knowsley data show that the majority of the Knowsley workforce have qualifications up to level 2 (57.8%), this includes people with five or more GCSEs at grades A* to C. However, Knowsley has the lowest proportion of its workforce at level 4 (15.8%), which includes workers who hold a first or higher degree. It also has the highest proportion of workers with no qualifications (24.2%) compared with 11.9% for England as a whole.

Figures from 2009 show the proportion of the working population in Knowsley claiming job seekers allowance was 6.7%, higher than the regional (4.6%) and national average (4.1%). Knowsley’s areas of higher deprivation have higher average levels of unemployment and lower levels of educational attainment compared with areas of lower deprivation. Not being able to find and or maintain suitable work can lead to risks of isolation, loss of confidence, mental health issues, de-skilling and social exclusion.

There is no local and regional data to indicate any significant difference in the levels of mental wellbeing between men and women.

The WEMWBS survey shows that there are differences by ethnicity with levels of mental wellbeing being more likely to be high among non-white adults. However, there is limited data on this, and consideration needs to be given on how effective the WEMWBS tool is in different cultural settings.

**Links to Other Issues / Topics**

Wellbeing is interplay of individual, economic, social, cultural, community and environmental factors.

Wellbeing is linked to the wider structural determinants of health which include access to education, meaningful employment, affordable housing, health and social care.
Wellbeing is also linked to people’s sense of belonging to cohesive and inclusive communities and having a valued social role. Satisfaction with a local area as a place to live is far higher for those with a high level of wellbeing than those with low levels. Attractive, safe and sustainable neighbourhoods with good transport links, housing, green spaces, amenities and leisure and cultural opportunities are all important factors in influencing wellbeing factors. They combine to influence feelings such as safety, sense of belonging and ability to connect with others. Knowsley residents report strong indicators for area wellbeing.

Capacity, capability and motivation to make positive health choices are strongly influenced by mental well-being. There is a cyclical relationship between mental wellbeing and a number of heath behaviours such as smoking, alcohol consumption and physical activity. Lifestyle behaviours all contribute to risk of health conditions and affect life expectancy. Health check data demonstrates that people need support to change multiple lifestyle behaviours. Poverty also negatively impacts on wellbeing. This is affected by employment and training but also by lifestyle choices such as the financial cost of smoking.

Supporting wellbeing needs to be an integral part of any health improvement programme and programmes need to link together to ensure a person centred and holistic approach to support lifestyle changes.

Poor wellbeing can also lead to people having less resilience to be able to deal with life’s difficulties. This can lead to wider mental health issues such as suicide, self harm, domestic violence and child protection issues.

The foundations for mental wellbeing are laid down early in life and through childhood years, for half of those with a lifetime mental illness, evidence shows symptoms where present at the age of 14. It is important to promote protective factors and resilience at an early age and the ensure promotion of whole family wellbeing.

**Links to Existing Strategies (incl. Policies / Services)**

Promoting wellbeing should be an integral component of all services and strategies.

It is linked to:

- Community Cohesion Strategy
- Mental Health Promotion Strategy
- Emotional Health and Wellbeing Strategy – Children and Young People
- Child Health Strategy (Due in early 2011)
- A Positive Age
- Sustainable Communities Strategy
- Suicide Reduction Plan
- Tobacco Control Strategy
Evidence of What Works

There is strong evidence that mental health status impacts in a broad range of health and social outcomes and there are interventions that can promote mental wellbeing and prevent poor mental health.

The National Mental Health Development Unit (NMHDU) recommends achieving positive population mental wellbeing it requires:

- A focus on populations rather than individuals, while recognising that interventions need to be proportionate to the degree of disadvantage.
- Joint action by a broad range of organisations to build resilience and tackle inequalities by addressing the social determinants of mental health and wellbeing.

The NMHDU also identifies ten commissioning areas where evidence-based interventions have been shown to make a significant contribution to improving mental wellbeing at population level.  

These are:

- Pre- and post-natal programmes to support healthy early child development and wellbeing and maternal health and wellbeing.
- Parenting skills programmes – universal as well as targeted at higher risk families.
- Whole school approaches to building the social and emotional skills and resilience of children and young people.
- Improving working lives through support for unemployed, healthy workplaces, supported work for people recovering from mental illness and early identification and treatment for working age adults with mental health problems.
- Psychosocial interventions and enhanced physical activity programmes for older people.

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20 Commissioning Mental Wellbeing for All, A Toolkit for Commissioners, Commissioned by National Mental Health Development Unit, UCLAN, 2010
• Opportunities for participation and personal development to support self-efficacy and prevent social isolation.
• Initiatives to prevent identify and respond to emotional, physical and sexual abuse.
• Universal lifestyle programmes to reduce smoking, alcohol use, substance use and obesity.
• Tackling alcohol and substance abuse.
• Community empowerment and development initiatives to encourage community action, cohesion and participation.

The Foresight Report 21 has evidenced five ways to wellbeing as specific steps individuals can take to improve their own wellbeing. These are connect, get active, take notice, keep learning and give. Building these actions into daily life it is estimated life expectancy could be extended by 7.5 years.

Future Implications (Modelling / Projections)

Mental Health problems are common and costly to the public sector, with one in six of the adult population experiencing mental ill health at any one time. Recent estimates of the annual wider costs of mental health problems is around £77 billion. 22

The WEMWBS survey shows that wellbeing levels are low in Knowsley compared to the regional average. Admission rates for mental health conditions in Knowsley have been significantly higher than England and the North West since 2005/2006. 23

The enablement and promotion of evidence based actions for wellbeing is embedded in many of Knowsley’s strategies and programmes of work. For example, an Emotional Health and Wellbeing Strategy for Children and Young People has recently been produced and a Children’s Health Strategy is under development, both of which prioritise the evidence based actions for the protection of and development of factors to promote wellbeing at an early age and within the family.

Knowsley has an older person’s health and wellbeing strategy: “A Positive Age”, this contains eight themes, which address the wide ranging factors that affect wellbeing, themes included are economic wellbeing, crime and personal safety and access to community services and learning.

A Working Well programme is in place for businesses in the borough and the Knowsley KMBC / NHS Workforce Health Strategy which will be reviewed in light of organisational change. Knowsley has an Improving Access Psychological Therapies programme, which includes support for people in the workplace. There are also several programmes in place to help people make

21 Foresight Report: Mental Capital and Wellbeing: Making the most of ourselves in the 21st century, 2008
22 New Horizons: Confident Communities Brighter Futures: A Framework for Developing Wellbeing, Department of Health, 2010
23 Internal Report Mental Health Equity Audit, Public Health Intelligence Team 2010
lifestyle changes and the current pathway of access into and between these services is being also reviewed.

During 2010/11 the five ways to wellbeing have been promoted in Knowsley. It is important going forward into the decade of wellbeing opportunities are maximised to promote these simple self help messages and the steps are embedded across sectors and into services.

Knowsley has well established boards and structures in place such as Area Partnership Boards, Knowsley Older People’s Voice and Local Involvement Networks that support communities and enable community participation in decision making.

Knowsley’s Sustainable Communities Strategy demonstrates the borough’s strong commitment to addressing the wider determinants of health which impact upon wellbeing. There are also many developments in the borough that will be completed in 2011 such as the redevelopment of Halewood Shopping Centre, Stockbridge Village Centre and the Huyton Leisure and Culture Park. Such developments will have an impact on the wellbeing through employment and training and improved access to shops, education and leisure opportunities. It is also anticipated over the next decade Knowsley will be a location for new housing and there will be further development of its business parks.

Long term population projections may bring challenges to population wellbeing. It is anticipated that there will be a reduction in the working age population and increased number of retired and older people living Knowsley. This could reduce the size of the resident workforce in Knowsley, increase pressures on services required to support older people and place potential strains on families with increased caring responsibilities.

The current economic climate and changes in the provision of public services will bring challenges that could negatively affect wellbeing with the possible withdrawal and reduction of services. Knowsley already has lower than average levels of employment, workforce education levels and health inequality which are more pronounced in its areas of deprivation.

The National Mental Health Development Unit has produced an evidence based framework checklist \(^{24}\) to enable the consideration of wellbeing when there are changes to or the development of a new policy, strategy, service or initiative. This framework should also be drawn on as part of impact assessment tools to maximise the positive and minimise the negative impacts of any structural change. To ensure a population approach the consideration of wellbeing needs to be an integral part of all decision making and embedded into health and social care improvement programmes.

There is a growing body of evidence based interventions that are shown to improve wellbeing and further direction on how to promote mental wellbeing

\(^{24}\) Mental Wellbeing Checklist, National Mental Health Development Unit, 2010
will be provide in the new National Mental Health Strategy, which is due early 2011. It is important to ensure Knowsley’s strategies and programmes draw on the National Strategy and the emerging wellbeing evidence base. The WEMWBS survey helps in identifying groups which are experiencing lower wellbeing, the learning from this survey should be used to appropriately target programmes. Drawing on all this information a new Knowsley Mental Wellbeing and Promotion Strategy will be developed in 2011.

Gaps

As previously stated above, mental wellbeing is shown to decrease with age and living in more deprived communities is strongly associated with lower levels of mental wellbeing. Further analyses of the data is required to identify if there are any particular wellbeing factors that differ between age and community area’s by deprivation such as health, relationship status or work that could help understand differences in wellbeing between different groups and within different areas of Knowsley.

It is also important to understand how the determining factors of wellbeing such as employment, education, health, social networks, and feelings of safety, change with age and are more or less prominent in population groups living in areas of deprivation.

There is limited data on wellbeing for different ethnic groups and information about faith, religion, disability, or sexual orientation have not been collected.

Recommendations for Commissioners

Data and Intelligence

- Consider repeating the Wellbeing Survey to allow for trend analysis, and consider using an enhanced sample in order to conduct lower level geographical analysis, for example on an Area Partnership level and Electoral ward.
- Conduct an evidence review on the relationship between community cohesion and health outcomes.
- Assessment of wellbeing should be included as a key part of impact assessments.
- The findings of the wellbeing survey need to be linked to other data sources including satisfaction with health and wellbeing in Knowsley and tracker surveys.

Policy and Health Promotion

- Ensure that the findings of this survey inform the development of a Joint Strategic Asset Assessment to be produced in 2011.
- Utilise the findings of the WEMWBS survey and assessment of wellbeing (using a tool such as the NMHDU Mental Wellbeing Checklist in the development of strategies, including the Community Cohesion Strategy.
• Promote the five steps to wellbeing campaign across Knowsley, and in particular target some of the specific vulnerable groups identified.
• Promote the five steps to wellbeing to key partners across Knowsley, including NHS, Council, and the voluntary and community sector.
• Promotion of wellbeing should be included as a core element of service delivery for NHS commissioned services and improved wellbeing should be considered as a primary outcome measure, particularly for lifestyle services.
• Development of Knowsley Mental Health and Wellbeing Promotion Strategy.

3.3 ADULTS & OLDER PEOPLE

3.3.1 CANCER

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**Key Needs**

• Cancer accounted for 8168 years of life lost prematurely in 2006 – 2008 within Knowsley.
• The number of new cases of cancer is increasing as the population ages, and perhaps as we detect more cancers however, mortality is decreasing.
• In males lung cancer is the most common cause of premature cancer death followed by colorectal, prostate and oesophageal cancer.
• In females, again lung cancer is the main cause of premature cancer death followed by breast and colorectal cancer.
• All cancer mortality rates are highest in Kirkby Central, with Northwood, Parts of Cherryfield, Page Moss, Longview, St Michaels, St Gabriel’s and Halewood West showing higher than the Knowsley average rates. Specifically lung cancer mortality is higher in Northwood and Kirkby Central.
• Recent work showed the uptake rates for breast cancer and cervical screening in eligible female adults with learning disabilities are low.
• Only 46% of people aged 60-69 who have been offered bowel screening have returned the test.
Description of Where / Who the Issue Affects

Cancer accounted for 8168 years of life lost prematurely in 2006 – 2008. It caused 31% of premature male deaths (i.e. deaths under 75) and 28% of premature female deaths in the same time period.

The number of new cases of cancer has increased by 15.3% since 1985-1987, however the mortality rate has decreased by 24% since 1995-1997 and this rate of decrease is greater than that seen across the North West. Despite this, cancer mortality remains above the North West and national average.

In males, lung cancer is the most common cause of cancer death, accounting for 30% of premature cancer deaths. This is followed by colorectal cancer (12% of cancer deaths) and then prostate and oesophageal cancer, both causing 8% of deaths. In females, again, lung cancer is the main cause of premature cancer death at 29%, breast cancer 13% of female cancer deaths and colorectal 8%.

Lung Cancer

Males and females from Knowsley experience significantly higher lung cancer mortality rates than their counterparts from the North West. However, there has been a 41% decrease in the lung cancer mortality rate since 1995-97 for males in Knowsley, and a 17% reduction for females. Five year survival currently stands at 14% compared to 8.1% in the North West.

Breast Cancer

Although Knowsley experiences lower rates of breast cancer than the North West, the rate has increased by 47% since 1985 -1987. Breast cancer is one of the few diseases that shows a link to affluence so the high levels of deprivation in Knowsley may contribute to our relatively low rates of breast cancer. There are many theories why breast cancer is increasing nationally such as an ageing population, the breast screening programme and links to hormone treatment.

On a more positive note mortality rates for breast cancer are lower in Knowsley than the North West and England and have fallen by a third in the last 11 years. This is likely to be due to the screening programme and improvements in treatment. A screening programme is in place for women aged 50-70 (to be extended over the next six years to 47-73), we currently screen 70% of eligible women, and this has dropped slightly over the last few years and is something we are working with women and our partners to improve.

Cervical Cancer

Cervical cancer incidence is higher in Knowsley then the North West but has decreased by a third in the last 21 years and mortality has decreased by 58% since 1995-1997. A GP-based cervical cancer programme is in place for
women aged 25-64 and has shown recent progress, for the final quarter of 2009/2010 77.1% of eligible women were screened, this is up 1.4% on 2008/2009 figures. The Human Papiloma Virus vaccination programme, in place for school-aged children will also in time lead to reductions in the incidence of cervical cancer. Around 70% of cervical cancer is caused by one of the viruses included in the vaccine.

**Prostate Cancer**

The increase in prostate cancer rates in Knowsley is similar to the picture seen regionally and nationally and is likely to be due to a number of factors including increased detection. The numbers of people diagnosed with prostate cancer has increased by 178% since 1985-1987, but mortality has fallen by 20% in the last 11 years.

**Oesophageal Cancer**

Oesophageal cancer cases have increased by 54% since 1985 -1987 and are higher than the North West. Mortality from oesophagus cancer in Knowsley remains above the North West and England’s trend and is significantly higher than England’s in some years. There has been an increase in the rate of mortality in Knowsley of 8% since baseline. It should be noted that this does represent small numbers so trends are difficult to pull out.

**Liver Cancer**

It is also important to highlight the increasing rates of liver cancer within the Borough. Since 1985-1987 there has been an increase of 50% in the number of cases locally, mortality has increased by 30% in the last 11 years. This reflects the trend across the UK and may be related to an ageing population, behaviours (e.g. increased alcohol consumption) or other factors.

**Bowel Cancer**

We have been screening people aged 60-69 for bowel cancer for two years and the age range has been extended to 75 from April 2010. The latest uptake data for Quarter 3 2009/2010 shows 47% of those eligible and offered screening took up the offer. This is low compared to the North West and the PCT aims to increase this to 60% through local campaigns and community work.

**Equality and Diversity**

All cancer mortality rates are highest in Kirkby Central, with Northwood, Parts of Cherryfield, Page Moss, Longview, St Michaels, St Gabriel’s and Halewood West showing higher than the Knowsley average rates. Specifically lung cancer mortality is higher in Northwood and Kirkby Central.

The gap between the rate of premature cancer death (the number of years of potential life lost prior to age 75), in the most deprived areas of Knowsley and
Knowsley as a whole has decreased by 12.6% between 2001-2003 and 2006-2008. However, when we separate this by gender we see the gap has decreased for women by 29.4% but has increased for men by 27.5%.

A Health Equity Audit for cervical cancer has shown variable uptake of cervical screening within GP practice populations, ranging from 65% to 88% (Quarter 3 09/10). Screening uptake in large parts of Stockbridge, Longview have lowest coverage and parts of Northwood, Kirkby Central, Cherryfield, Page Moss, St Gabriel’s, Whiston South, Halewood West and Halewood South show higher uptake. In addition, women aged 25-29 and aged 54-64 are less likely to attend cervical screening.

Whereas cervical screening uptake is less in areas of greater deprivation the proportion of women where the last smear was high grade (indicating an increased risk of cancer) is highest in areas of greatest deprivation. This means that in the areas where women are more likely to require treatment for abnormal smears they are less likely to have a smear.

The uptake figures for the breast screening programme are also available at a practice level. For the latest screening round (2005-2007), uptake ranged from 51% - 78%.

Recent work undertaken looked at the health of individuals with learning disabilities in Knowsley. This showed the uptake rates for breast cancer screening in eligible female adults with learning disabilities are low. Only 1 in 3 have ever received breast cancer screening. Only 1 in 5 have had breast cancer screening in the last 3 years.

One in three of eligible female adults with learning disabilities have received cervical cancer screening ever. Of these, only one in five have received this screening in the last 3 years. The Cancer awareness and Early Detection (CAED) Project has been set to improve the uptake of cancer screening programmes in Knowsley, working with key partners to target such groups and work towards reducing health inequalities.

Links to Other Issues / Topics

Cancer is a complex topic with many different types of cancer affecting almost every part of the body. With the most common cancers there are certain risk factors that may predispose individuals to the disease. Some are fixed by factors such as age and family history, some are more amenable to behaviour change, these include smoking, alcohol, sun exposure, poor diet and obesity. The HPV vaccine which has been introduced to schools aged children, works against viruses that are implicated in around 70% of cervical cancers.

Links to Existing Strategies (incl. Policies / Services)

The following strategies are related to cancer prevention:

- North West Cancer Plan
Future Implications (Modelling / Projections)

Cancer is predominantly a disease of ageing and there are challenges ahead with the estimated increase in the population aged over 50 of 16.3% in the next ten years.

However, the population is changing behaviour, smoking rates have fallen and this is likely to also have an impact on rates, along with the earlier detection of cancer through screening and early awareness. The picture is complex.

The proportion of people in Knowsley who smoke has fallen and in 2008 24% of people smoked (compared to 20% for Merseyside as a whole). This had fallen from 26% in 2006. This continued drop is likely to mean a continued fall in the number of new cases of lung cancer.

Local intelligence suggests that we will see increases in breast, prostate and liver cancer and decreases in lung, oesophageal, cervical and colorectal cancer. Some of the increases in cancer are due to an ageing population and increases in lifestyle related cancer, such as liver cancer. Decreases reflect the progress we have made on reducing the rates of smoking, the HPV vaccination programme and the introduction of screening programmes.

Survival rates have also increased, due to earlier detection (through screening and general awareness) and improvements in treatment. Five year survival for all cancers is currently at 44%. This is compared to the North West average of 46%.

Evidence of What Works

The Cancer Reform Strategy provides a framework for improving outcomes in cancer prevention, early detection and management. It includes actions on lifestyles and behaviours including a focus on smoking (strongly associated with lung cancer), alcohol intake, obesity and safety in the sun.

The national cancer screening programmes for Breast Cancer, Cervical Cancer and Bowel Cancer are evidence based programmes to detect cancer early and improve treatment outcomes.

Improving Outcomes Guidance national standards exist for the management of specific cancers. NICE guidance also exists for specific interventions.
Gaps

Current gaps exist around understanding which groups of people are not accepting the offers of the cancer screening programmes and why.

There is a need for more information on staging of cancers to enable us to understand at what stage in the disease process people are presenting with symptoms and the impact this is having on survival rates. Staging data has improved in Knowsley but is still patchy.

Recent work on Cancer Awareness suggests low levels of awareness of cancer warning signs despite high responses from relatives of cancer sufferers. The survey also found low levels of awareness of the bowel cancer screening programme despite high levels for cervical and breast screening.

Work done on a regional basis suggests that cancer outcomes in older people may not be as good as for younger people which may be due to a number of factors. Work is required to look at this issue and increase outcomes in this group.

Recommendations for Commissioners

- Continue to focus on reducing the prevalence of smoking within the population.
- Reducing other risk taking behaviours including alcohol and promoting better diet and more active lifestyles.
- Promotion of the HPV vaccination to young girls.
- Community focussed social marketing work to understand the barriers to cancer screening.
- Improving the expertise of cancer treatment services – balancing concentration of specialist skills with improved access.
- Conduct health equity audits on bowel cancer and breast cancer uptake.
3.3.2 CARDIOVASCULAR DISEASE (HEART DISEASE AND STROKE)

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**Key Needs**

- CVD is a leading cause of premature mortality in Knowsley, accounting for 28.9% of deaths in 2006-08. During 2008, 171 people under the age of 75 died from this condition.
- Premature mortality from CVD has almost halved in Knowsley in the 11 year period from 1995-97 to 2006-08 (48.6% reduction), and the Borough is not significantly different to its Statistical Neighbours. However, the mortality rate of 69.4 per 100,000 in 2006-08 remains significantly above both regional and national comparators.
- Hypertension is a major risk factor for CVD. There are 21,638 patients currently recorded as hypertensive across Knowsley, however the projected number of patients expected to have hypertension is 39,264 patients.
- The majority of General Practices within Knowsley have a lower recorded prevalence of coronary heart disease (CHD) than the expected level.

**Description of Where / Who the Issue Affects**

Cardiovascular disease (CVD) is the spectrum of conditions that includes coronary heart disease, stroke and transient ischaemic attack (TIA), and peripheral arterial disease.

Since 1995-97, there has been a substantial reduction in premature mortality due to CVD, both locally and nationally. Indeed, figures for 2006-08 show there has been a 40.4% reduction in the mortality rate in Knowsley, with the gap between the Borough and England closing by 22.0%.

However, while there has been a significant reduction in premature mortality from CVD in Knowsley, this has not been achieved in all areas of the Borough. Premature mortality within Knowsley ranges from 22% above national levels in South Huyton, to 89% above national levels in North Huyton.

Taking the Borough as a whole, premature mortality from CVD is 54% above levels seen in England & Wales and data suggests that further significant reductions are required if it is to achieve its 2010 (2009-11) target of 84.8 deaths per 100,000 population.
Coronary Heart Disease

Coronary heart disease (CHD) is the leading cause of CVD mortality and accounted for 17.4% of all premature deaths within Knowsley during 2006-08. Even though premature mortality from this condition has almost halved in Knowsley in the 11 year period from 1995-97 to 2006-08 (48.6% reduction) it remains significantly above both regional and national comparators.

Data for 2008-09 shows that 4.7% of the Knowsley registered population have been diagnosed with coronary heart disease. This equates to 7,433 patients. This compares to an expected prevalence of 5.7%, or 9,119 patients.

Stroke

Stroke accounted for 5.5% of all premature deaths in Knowsley during 2006-08. Indeed, 32 people under the age of 75 died from the condition during 2008. There has been an 18.4% reduction in the stroke mortality rate in Knowsley between 1995-97 and 2006-08 and although this is not significantly different to its Statistical Neighbours, the gap with England has widened substantially since 1995-97.

Data for 2008-09 shows that 1.7% of the Knowsley registered population are on the disease register for stroke and transient ischaemic attack. This equates to 2,679 patients, and compares to an expected prevalence of 2.5%, or 4,009 patients.

High Risk

Knowsley has a registered population of 158,329 people and of these around 66,191 are aged between 40-74 years. It is estimated that 45,670 individuals are eligible for a NHS Health Check and out of these around 13,200 individuals (29%) will be at high risk of developing CVD in the next ten years.

Equality and Diversity

Local data on CVD incidence and prevalence by ethnicity is currently not available; however, national evidence highlights that individuals from a BME group, particularly those from South Asian communities, have a high rate of CVD compared to the majority population.

The link between CHD and diabetes is especially strong in BME populations. The prevalence of Type 2 diabetes, for example, shows marked differences among ethnic groups. Almost one in five people of South Asian origin living in the UK develop diabetes, compared to 1 in 25 among the general population. This increased prevalence is coupled with earlier disease onset: UK South Asian people tend to develop diabetes eleven years earlier than their white counterparts (at age 46 versus age 57) and at a Body Mass Index less than their white counterparts.
Of the resident population in Knowsley, 2.8% of people are estimated to be from a black and minority ethnic (BME) group which equates to approximately around 4,300 people (ONS Resident Population by Ethnic Group, 2007). However, this figure has doubled from 2,300 in 2001.

Male CVD mortality in the most deprived areas of Knowsley has fallen by 31% between 2001-03 and 2006-08 and as a result the gap between these areas and Knowsley as a whole has narrowed. Although female mortality in the most deprived areas has also fallen, the gap between these areas and Knowsley has widened.

CVD continues to be an issue for all residents, male and female, but especially those living in the most deprived fifth of the borough. In particular, Kirkby town centre, North Huyton, Prescot, Whiston, Halewood and Longview show high prevalence and emergency admission rates for various CVD conditions.

Further consideration must be given to the range of different groups which exist within Knowsley communities and whose members may not experience equal access to CVD services (primary and secondary care) and information. Groups such as those defined by race, faith, religion or belief groups, Knowsley’s Lesbian, Gay, Bi-sexual and Trans (LGBT) community and adults and young people with disabilities may be disadvantaged in respect of CVD prevention (primary and secondary). Currently, no data is available for local analysis within these groups and this is identified as a key area for local development for the future.

**Links to Other Issues / Topics**

While there are genetic factors relating to CVD, at least 80% of cases are potentially preventable. There is substantial evidence that modifying lifestyle risk factors does cut the risk of developing CVD in the first place (primary prevention) and improves outcomes in those who already have the condition (secondary prevention).

The impact of smoking in causing arterial disease is well documented, and is known to be greater in people with diabetes, hypertension and chronic kidney disease. Stopping smoking has been shown to reduce CVD mortality in individuals with established CVD as well as those without. It is important that the efforts around smoking cessation continues and that the tobacco control strategy

**Overweight, obesity** and an increase in abdominal fat significantly increase the risk of CVD, thus weight reduction is effective at lowering risk. Overweight and obesity has a direct relationship with poor diet; in particular high intake of total and saturated fat is linked to increased mortality. It is important that efforts continue around healthy weight and physical activity, such as the Energise Knowsley Strategy.
People with diabetes, particularly Type 2, are also at significant risk of developing CVD. Approximately 23,841 people are estimated to have pre-diabetes in Knowsley which makes them up to 15 times more likely to develop diabetes. Evidence suggests that intensive lifestyle interventions (diet/exercise) and/or therapeutic interventions can delay or prevent onset of type 2 diabetes.

Individual lifestyle choices have been shown to only partly explain the social distribution of CVD; these choices are influenced by the social environment (e.g. within which people live, and may be more damaging when combined with poor working and living conditions. For example, access to healthy foods, safe open spaces for physical activity, personal economic circumstances, sense of personal security and availability of transport can all have direct or indirect effects on cardiovascular health.

Partnership working must continue with the Regeneration, Economy and Skills department in the Local Authority in providing and sustaining health promoting environments across Knowsley (in leisure, retail, housing, transport and with local businesses).

**Links to Existing Strategies**

The following Knowsley strategies, programmes and services are associated with CVD:

- Knowsley at Heart Programme
- Practice Based Commissioning Business Plans
- CVD Community of Practice
- Knowsley Stroke Strategy Implementation Board
- Long Term Conditions Local Enhanced Service
- Community CVD Service
- Long term Conditions Transforming Community Services Strategy
- Healthy Workforce Strategy
- Working Well Strategy
- Tobacco Control Strategy
- Energise Knowsley - Healthy Weight Strategy (2009 - 2012)
- Alcohol Harm Reduction Strategy

**Future Implications**

Data for 2010 suggests the prevalence of CVD in Knowsley is 8.9%, or ~10,790 patients. This figure is expected to rise to 9.3% (~11,530 patients) by 2015 and to 9.9% (~12,290 patients) by 2020. This would represent an increase of around 1,500 patients within 10 years.

However, as the estimated CVD prevalence is based solely on 2006 population projections it could be argued that future prevalence could be significantly higher when factoring in the increasing levels of obesity and diabetes alone.
Evidence of What Works

Changes in CVD risk factors can be brought about by intervening at both a population and individual level. There is substantial national evidence that interventions focused on changing an individual’s behaviour are important and are currently supported by a range of existing NICE guidance (smoking, physical activity etc).

Evidence suggests that changes at a population level could lead to even further substantial benefits and this has led to the recent NICE publication on ‘Prevention of cardiovascular disease at the population level’. To be effective, this guidance will need to be implemented collaboratively with local government, government agencies, industry and key, non-governmental organisations.

Gaps

Despite there being a number of sources that provide CVD data there remains to be gaps in current CVD knowledge. For example, there is little understanding relating to the access and uptake to services by the hard-to-reach groups.

There continues to be substantial differences between GP practices across Knowsley with regards to the recording and treatment of both primary and secondary preventative CVD indicators. For example, there is wide variation in the percentage of patients newly diagnosed with hypertension who have a face to face cardiovascular risk assessment within 3 months of diagnosis.

In addition, several major risk factors for cardiovascular disease remain undiagnosed. For example, about half of all people with high blood pressure, one third of those with diabetes and some of those with disorders in their heart rhythm (e.g. atrial fibrillation) are undiagnosed and therefore untreated. A more systematic approach is required for the identification of disease to close the gap between the reported and expected prevalence.

In terms of services, more work is needed with regards to increasing the knowledge and awareness of the relatively ‘new’ CVD community clinic to those GPs that either have high referral rates into ‘other’ secondary care CVD clinics and/or low referral rates into the local CVD community clinic. This will support the utilisation of this innovative service whilst helping to maximise clinical management, patient experience and health related outcomes.

As people with diabetes are at significant risk of developing CVD it is important to implement a diabetes prevention service; currently there is no systematic approach to the identification and management of individuals with pre-diabetes.
Recommendations for Commissioners

- Further develop the local NHS Health Check programme to provide a more systematic and targeted approach to screening to ensure that the programme identifies men and women with undiagnosed disease. This should target individuals that:
  (a) are deemed to be more at risk by virtue of their current risk factors and
  (b) do not regularly access Primary Care services.
- Further develop a programme of work to raise awareness and understanding within the Knowsley population about stroke and ‘mini-strokes’, including signs and symptoms, the urgency of early presentation and appropriate treatment.
- The CVD Community of Practice (CoP) should be used to inform (but not direct) the commissioning process bringing about improvement to clinical management, patient experience and health outcomes. In achieving this, the CoP should facilitate the implementation of clinical pathways (including chest pain, heart palpitations and murmur, and atrial fibrillation) as identified by the North Mersey CVD QIPP.
- Further develop professional education with relevant support and as part of the wider QIPP agenda.
- Develop GP profiles to support service improvement/development relating to CVD pathways/services (e.g. primary and secondary prevention, activity etc).
- Continue to invest in smoking cessation services as a high priority across Knowsley and in particular in areas of high smoking prevalence, particularly in North Kirkby, South Kirkby and North Huyton.
- In order to tackle the prevention of CVD at the population level and to create more health promoting environments, commissioners should continue to develop strong working relationships with professionals from local government, government agencies, industry and key, non-governmental organisations in implementing the NICE guidance on the ‘Prevention of Cardiovascular Disease’ (PH25).
3.3.3 CARERS

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**Key Needs**

- The vital role that carers play in supporting people to remain living at home in their own community and the financial and resource implications if they were not supported to carry on this role.

- Evidence of the negative impact of caring in terms of the carers own emotional and physical health, financial situation, work and family life.

- In Knowsley the role of carer falls primarily onto women.

- The needs of carers carries across all client groups and health issues.

- The number of carers is predicted to increase by 11%.

**Description of Where / Who the Issues Affects**

The need to care for someone can happen at any time to anybody as a result of a sudden event, such as an accident, or as a gradual process when someone’s physical or mental health slowly deteriorates. Carers give practical, physical and emotional support to vulnerable people so that they can continue to live in their own communities. They help the person they care for to deal with problems caused by illness or disability, mental distress or problems resulting from alcohol or substance misuse. Carers may supervise someone to keep them safe.

In the 2001 Census, 17,360 Knowsley residents described themselves as unpaid carers. This represents 11.5% of the Borough’s population and is slightly higher than the national average of 10%. Three out of 10 Knowsley carers reported providing more than 50 hours of unpaid care each week. The national figure is two out of 10.

A report from Carers UK analysing the 2001 Census data found that carers who provide high levels of unpaid care are more than twice as likely to suffer from poor health compared to people without caring responsibilities. Analysis of the Census shows that nearly 21% of carers providing over 50 hours of care say they are in poor health compared to nearly 11% of the non-carer population.
It was also found that carers in younger age groups – i.e. 16 and up – are significantly more likely to suffer ill-health than non-carers of the same age. And, as carers become older, the evidence suggests that they are far more likely to be caring with ill-health.

A study based on the analysis of the British Household Panel Survey, also found that carers were more likely to report high levels of psychological distress, including anxiety, depression, loss of confidence and self-esteem.

During April 2009 to March 2010 1678 carers received information/services as a result of an assessment or review. The Knowsley Health and Wellbeing Commissioning Strategic Plan sets out a commitment to increase the year on year number of carers receiving support to 2470 (or 50% of adults receiving information or a service) by 2013. Some services will be accessed and delivered through third sector partners. At the end of September 2010 3699 carers were registered with Knowsley Carers Centre accessing a range of services.

Between April 2009 and March 2010 the Knowsley Young Carers Project received 109 referrals and provided advice and support to 88 young carers and their family. It is currently providing ongoing support to 50 young carers and their families. Nationally it has been estimated that 2.1% of the child population has a caring role. In Knowsley, that equates to about 800 young people, although it could be argued that this figure may be higher given the Borough’s health profile.

Direct payments gives carers and users more control over their own lives by offering an alternative to social care services provided by councils. The payments help increase the opportunities for a break from caring and increase the potential for employment. During 2009/2010 Knowsley provided 51 carers with direct payments.

Equality and Diversity

Carers are from all genders, cultures, ethnicity, sexual orientation and age. The 2001 census and evidence gathered through The Princess Royal Trust for Carers estimates that nationally 58% of carers are women with 42% men.

The findings from a small scale local survey of carers carried out in August 2009 show that the figures for gender differ in Knowsley, with 70% of respondents being women and 30% men.

This is a reflection of those carers registered with the Knowsley Carers Centre where 72% were women and 28% men.

This could highlight

- A difference in the pattern of the caring role in Knowsley.
- Men not seeing themselves as carers.
• Not identifying male carers.
• Insufficient surveys reached male carers.
• Lack of interest in completing surveys.

Links to Other Issues

In the North West region working age carers are much less likely than healthy non-carers to be in employment or to have any formal educational qualifications. Carers are at increased risk of being unable to get or retain paid work. Tailored support is needed to enable carers with jobs to remain in employment and balance work and caring responsibilities. With the right support, those without work could move into employment, even if only part time. Lack of work can affect the physical and mental health and wellbeing of carers. It can also affect income levels.

The causes of carers' poor physical and mental ill health are identified by the A Carers Profile Report (DOH 2010) as being due to a lack of information, a lack of support (either the right kind or the right amount), worry about finances and the general stresses and strains of caring full-time with everyday life and isolation.

Increased availability of assistive technology, such as relatively simple monitoring devices, can offer carers much needed peace of mind that the person cared for is safe.

Links to Existing Strategies

A number of national and local strategies set out the kind of support that should be provided to carers. These include:

• National Strategy for Carers and Knowsley Carer Strategy
• Knowsley Dementia Strategy
• Assistive Technology Strategy
• End of Life Care Strategy

Future Implications

Between 2008 and 2030 a significant increase in the demand for personal care and support in the North West is predicted. In particular the number of people aged 85+ is set to double: The number of people with a long term illness will increase by 24%, from almost 1.5 million to over 1.8 million: More than twice as many people aged 65 or over will have dementia. This means that, in the North West, the number of carers is predicted to increase by over 96,000 or 11%. If those predictions are translated to Knowsley then there would be an additional 1900 people caring for family and/or friends by 2030.

Carers play a critical role in supporting people with long term conditions, and people who are terminally ill. Without the input of carers, the pressure on health and social care services would significantly increase.
More people will choose to spend their individual budget on alternatives to care, rather than traditional services such as home care. Providers will need to re-shape services to meet the new demands. Following a recent service review, Knowsley Council has re-focused in-house provision towards re-ablement.

The extensive statutory Place Survey carried out in 2008-09 used additional questions which identified the following confirming the estimated picture for Knowsley of 17,000 carers but provides new detail:

- 231 (17% of response) said they provided care for somebody
- 53% of the 231 said they were a main carer and 76% said they did not receive services
- If 17% of Knowsley’s adult population is a carer as identified in the survey this would equate to 19582 carers
- If 53% were the main carer this would equate to 10378 carers
- 76% of these did not receive services this would equate to 7888 potential carers without a service
- 52% of these carers providing 30+ hours of care per week could equate to 4102 carers providing high level support
- The number of carers assessed has risen by 30% since 2007/08 (an additional 393 carers) and is projected to increase by a similar rate over the next five years
- Of those assessed an additional 10% (an additional 57 people) have received social care funded services with the remainder being provided with advice or information
- Despite this rise however as indicated by the recent place survey there remains over 13000 carers in the community whose needs are not being met

Carers demand is difficult to quantify but 52% of these carers in the survey report that they provide 30+ hours of care per week equivalent to 4000 carers providing high level support. Reducing this potential unmet by 90% and applying the average yearly net cost of a critical home care package (£4500 or £85/week) produces a potential cost increase in the near future of up to £1.80m. This figure does not include the additional costs of placements in care homes that would arise if the carer was unable to provide the support required to support the person at home.

Evidence of What Works

Local councils have been allocated funding via the Carers Grant. This grant has been used to develop a range of different types of support for carers from the statutory, independent and voluntary sector. The support is based on experience of what works well for carers and includes a wide range of services. These include information, advocacy, respite care, training, stress management and day care. The type of support that is valued by carers is where they are given greater choice and flexibility. These include a voucher scheme to purchase support from a range of preferred domiciliary care
agencies and accessing a development and education fund to encourage a life outside of the caring role.

Gaps

- In August 2009 a focused questionnaire asked the question ‘What would most improve your life as a carer?’ The most popular responses were, advice and information, help in an emergency, respite breaks and someone to talk to.
- Carers need to be consulted and involved at a local level in the development and evaluation of those services, which are designed to meet their needs or the needs of those whom they care for. Particularly hidden carers and groups that traditionally are excluded from consultation.
- Any transition into adulthood can be a difficult time and this is especially true for young carers who are more likely to have missed out on learning and social opportunities due to their caring role.
- Carers services are traditionally focused more on those supporting older people and people with learning and physical disabilities. Little is known of the needs of those carers supporting people with HIV and substance misuse problems.
- The data recorded about carer activity needs improving among both third sector providers and health professionals, particularly for the provision of information and developing a system of reviews in these areas.
- Carer awareness training for local authority and PCT staff is limited to individual projects and initiatives as there is no provision with the Health and Wellbeing Workforce Development prospectus.

Recommendations for Commissioners

In response to the National Carer’s Strategy (2008) and from evidence gathered through carer consultation and engagement events six key areas have been identified as priority commissioning needs for carers and these are:

**A Life Outside of Caring:**

This includes:

- The need for personalised respite breaks away from the caring role.
- Carers should be offered the opportunity for regular breaks suited to their individual situation and the need to spend quality time for themselves.
- The need for time for carers to have the opportunities to take part in normal family life, social activities, leisure, education and to be part of their community.
- The need for support to remain in work or find employment.
- The need to have a clear plan for responding to emergencies where the carer is unable to provide support on a temporary basis.
Health and Wellbeing including:

- Carers to have access to community health services and GP Practice services that are flexible and understand and meet the needs of carers.
- Carers to be fully involved in the discharge of the person they support from hospital.

Access to information including:

- Carers being able to access and use information in the format and location that best suits their needs and situation.
- The people who work with carers to have access to appropriate information around carers and general universal services.

Carers to be consulted involved and engaged including:

- To develop meaningful ways for carers to be involved in the commissioning and monitoring process of relevant carers services.
- Strengthen and support effective consultation and engagement with carers in planning and evaluating services.

Carers to be treated as partners, being valued and respected including:

- Carers being fully involved in the assessment process and being treated as partners in the development of support plans.
- To have access to a carers’ assessment that reflects their needs and supports a life outside of caring.
- Developing a workforce with the knowledge and skills to support and understand the needs of carers.
- Ensure that carers’ needs are identified through carer’s assessments, and appropriate services or information and advice are provided at the point of first contact with all partner services.
- To develop and implement a programme of carer awareness training events for a range of staff and roles who work with and support carers.

Young Carers including:

- Supporting young carers through the transition from childhood to adulthood and the changes in formal social and health services.
- Supporting young carers to access the information and advice they need in the right format and place.

To help achieve the above and commission the services required to meet carers needs we aim to develop and implement a local Carer’s Strategy setting out how we are going to achieve the Government and local agenda to develop personalised and relevant support and services for carers. The Carers’ Strategy will be developed by the end of March 2011.
Performance Targets

- Increase the number of carers in receipt of information, advice and services to 1970 by March 2011 (42% of adults receiving a service), 2220 carers (47%) by 2012 and 2470 (52%) by 2013 ensuring geographical coverage.

3.3.4 DIABETES

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Key Needs

- Because of the increasing age of the population and the rise in levels of obesity, it is predicted that the number of people with diabetes will rise in the coming years. In 2015, 5.4% of the population are estimated to have diabetes, (8,037 people), this rises to 6.5% of the population by 2025 (9,615 people).
- In Knowsley, 23,841 people are estimated to have pre-diabetes, a major risk factor for developing diabetes.
- Of those diabetes patients who have had a HbA1c test, a blood test which indicates blood glucose control in the preceding 15 months, 71% had a reading of 7.5 or less which is higher than regionally and nationally. This indicates good levels of control in the diabetic population.
- 82% of diabetics who have their Blood Pressure recorded have a reading of 145/85 or below in 08/09. This is above both North West and National average.
- 84% of registered diabetics in Knowsley have a cholesterol reading of 5mmol/l or less. This is lower than regionally, but higher than England.
- In the final quarter of 2009/2010, 81% of eligible people with diabetes had received diabetic retinopathy screening within the previous twelve months. However, the rates of emergency admissions for poor glucose control for Knowsley residents are 9.8 per 1000 compared to 5.1 for England.
- Admissions for minor amputations are also above the England average at 1.8 per 1000 compared to 1.5 for England. However, major limb amputation rates are below the England average at 0.7 per 1000 compared to 1.0.

Description of Where / Who the Issue Affects

Diabetes is a chronic and progressive disease that impacts upon almost every aspect of life. Type 1 diabetes also known as insulin dependent diabetes
develops if the pancreas is unable to produce insulin. It usually develops before the age of 40 and about 15% of people with diabetes have Type 1 diabetes in England.

Type 2 diabetes frequently referred to as non-insulin dependent diabetes develops when the body cannot generate enough insulin or if the body cannot use the insulin generated efficiently. Type 2 diabetes is most commonly diagnosed in adults over the age of 40, although increasingly it is appearing in young people and young adults.

There were 7290 people with diabetes registered on Knowsley General Practice lists in 2008/2009. For individuals with diabetes, life expectancy can be reduced by up to 15 years. They are at an increased risk of heart disease and stroke as well as complications of the nervous system, small blood vessels, limb and digit amputations, retinopathy, which can cause sight problems and blindness and kidney disorders. The NDIS Diabetes Community Health profile for Knowsley highlights that, in general, people with Diabetes are twice as likely as people without the condition to die between the ages of 20 and 79 years. It is estimated that during 2005 in Knowsley there were 116 deaths in this age group that would have been avoided if people with diabetes had the same mortality rates as those without the condition.

Good, long term, control of blood glucose is essential in order to delay or prevent the development of the complications of diabetes. This control can be measured using the HbA1C. Of those diabetes patients who have had a HbA1c test (or equivalent), 91% had a reading of 10 or less, which shows good control. This is slightly lower than regionally and nationally. The proportion of diabetes patients who have had a HbA1c test (or equivalent) and the reading was 7.5 or less was 71%, which is higher than regionally and nationally.

Similarly the control of risk factors for cardiovascular disease is also vital. This includes blood pressure control and cholesterol measurements. Individuals with diabetes are generally well managed by GPs in Knowsley with 82% of diabetics who have their Blood Pressure recorded have a reading of 145/85 or below in 08/09. This is above both North West and National average. Of those diabetes patients who have a record of having their cholesterol measured, 84% in Knowsley have a reading of 5mmol/l or less. This is lower than regionally, but higher than England.

People with diabetes are invited for an annual assessment for diabetic retinopathy. This aims to detect the sight problems associated with diabetes early to allow for appropriate intervention. In the final quarter of 2009/2010 81% of eligible people with diabetes had received screening within the previous twelve months.

Emergency admissions may occur for a number of reasons in diabetics, including results of acute poor glucose control, either too high (ketoacidosis) or too low (hypoglycaemia or coma). In addition diabetics may be admitted
with complications of their illness e.g. amputations, myocardial infarctions, strokes and kidney failure.

The rate of emergency hospital admissions (by primary diagnosis) in Knowsley varies from 66 per 100,000 populations in South Kirkby to 196 per 100,000 in Prescot, Whiston, Cron ton & Knowsley Village. Three of the area partnerships in Knowsley have a rate that is significantly lower than the Knowsley rate of 111 per 100,000: South Kirkby (66), South Huyton (71) and Halewood (78). Prescot, Whiston, Cron ton & Knowsley Village is the only area of the Borough with a significantly higher rate than the Knowsley as a whole. The rates of emergency admissions for poor glucose control for Knowsley residents are 9.8 per 1000 07/08 and 08/09 (provisional) compared to 5.1 for England. Admissions for minor amputations are also above the England average at 1.8 per 1000 compared to 1.5 for England.

Equality and Diversity

Local data does not suggest a significant geographical pattern of diabetes diagnoses across the Borough.

However, Type 2 diabetes increases with age. The estimated prevalence of diabetes in people aged 0-29 is 0.3%, in those age 30-59 it is 3.3% and in over 60 it is 13.7%.

A report by the All Parliamentary Group for Diabetes and Diabetes UK, highlights the following issues relating to diabetes and ethnicity and culture:

- Asian and Black ethnic groups show a X6 and x5 increase in risk of developing diabetes respectively compared to white people.
- It is estimated that 20 per cent of the South Asian community and 17 per cent of the Black African and Caribbean community living in the UK have Type 2 diabetes in contrast to three per cent of the general population.
- For those with diabetes, morbidity is also much higher, especially heart disease (two to three times higher in South Asians), renal failure (four times higher in Asians) and stroke (three times higher in African-Caribbean’s).

Links to Other Issues / Topics

Diabetes is strongly linked to levels of obesity within the population and it is important that efforts continue around Healthy Weight and Physical Activity, such as the Energise Knowsley Strategy.

Prediabetes is defined by alterations in glucose metabolism that are regarded as a pre-cursor to diabetes and represent an important risk factor for developing diabetes. Work is required to provide guidance on the optimal identification and management of this group.

NHS Health Checks (cardiovascular risk assessments) were introduced in England in April 2009, as an evidence-based intervention for reducing
mortality from CVD. Community NHS Health Checks were made available to local residents in September 2008 and includes a screening test for diabetes.

**Links to Existing Strategies (incl. Policies / Services)**

The following strategies and programmes are associated with diabetes:

- Knowsley at Heart Programme
- Energise Knowsley- Healthy Weight Strategy 2009-2012
- Long term Conditions Locally Enhanced Service
- Long term Conditions Transforming Community Services Strategy

**Future Implications (Modelling / Projections)**

There are a number of risk factors for diabetes which are likely to result in an increase in the number of people who are living with diabetes within Knowsley in future.

Obesity is a major risk factor that contributes to Type 2 Diabetes in the population, statistically 58\% of type 2 diabetes can be attributed to obesity.

The 2006 Adult Health and Lifestyle Survey showed that Knowsley reflects the national trend of rising obesity levels. Over a 5 year period from 2001 - 2006 obesity has increased from 14.1\% to 20\% in the respondent adult population. This increase is reflected across all ages from 18 years to 65+ years (However, the Knowsley figure may be underestimated due to respondents’ self reporting their height and weight whereas the England figure is derived from height and weight being measured as part of the survey). In 2010, the National Obesity Observatory suggested that the prevalence of adult obesity has increased at a rate of 0.5\% per year, if this data is modelled against Knowsley statistics it would suggest that the rate of adult obesity in Knowsley is currently around 22\%.

Based on 2008/09 latest measurement data, the proportion of children in reception year who are obese is 12.1\%, which is a slight increase of 0.3\% from 2007/08.

As previously discussed prediabetes is a term used to describe changes in glucose metabolism that are linked to similar risk factors for diabetes and increase the risk of developing diabetes by up to 15 times. In Knowsley 23,841 people are estimated to have prediabetes.

Because of the increasing age of the population and the links to obesity it is predicted that the prevalence of diabetes will rise in the coming years. In 2015 5.4\% of the population are estimated to have diabetes, this is 8,037 people, this rises to 6.5\% of the population by 2025 (9,615 people).
Evidence of What Works

There are many National Guidance documents which describe the optimal management of diabetes within the NHS. A National Service Framework for Diabetes was developed in 2003 which covers aspects of diabetes management from prevention, early detection to management both within Hospital and community settings.

Because Diabetes also is a common causal factor for many other diseases of major organ system, its management of it is also an integral part of many other strategies (For example the National Service Framework for renal disease)

NICE guidance exists for aspects of diabetic care, including Type 1 diabetes, Type 2 diabetes, foot care, diabetes in pregnancy, antenatal care, chronic kidney disease, interventional procedures, patient education models and prediabetes interventions due in 2011.

Overall there is a strong evidence base for the reduction of the complications of diabetes through good glucose control, tight management of cardiovascular risk factors, such as blood pressure and cholesterol, screening and early treatment of complications such as retinopathy, renal problems and foot problems. Patient education is also vital to promote good blood glucose control and adherence to a healthy lifestyle.

There is also strong evidence for the prevention of diabetes through targeted lifestyle interventions for individuals with prediabetes.

Gaps

There is currently a lack of data on the breakdown of the local population in terms of a number of groups which would enable us to identify inequalities:

- Age and ethnicity of registered patients with Diabetes.
- The prevalence and distribution of women who develop gestational diabetes and how they are followed up long term.
- The prevalence of diabetes and management of those with special needs, including those with learning disabilities
- The prevalence and needs of the itinerant population
- Patients in residential and nursing home care
- Children

The rate of emergency admissions for ketoacidosis/ coma and minor amputation rates are high. There is a need for action to reduce these rates of complications.

There is a need for more robust outcome measures to be developed.

There is no systematic approach to the management of pre-diabetes.
Recommendations for Commissioners

- To plan high quality diabetes services responsive to expected population changes. Work closely with commissioners to ensure robust outcomes measures are specified in commissioning of new models of diabetes care.
- Promote initiatives to stem and reverse obesity locally.
- Develop a systematic approach to targeting adults with prediabetes to attend weight management support.
- Develop strategies to address the high levels of complications experienced in ketoacidosis / coma and minor amputation rates.
- Ensure appropriate education for patients on prevention of ketoacidosis, including how to manage blood glucose control during other illness episodes, and how to recognise signs and symptoms in line with NICE guidance.
- Continue to offer retinal screening to 100% of patients with diabetes and utilise the learning from recent research on improving the uptake of screening locally to inform the commissioning of retinal screening and specific campaigns.

3.3.5 DEMENTIA

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Key Needs

- In 2008, 1756 people in Knowsley experience dementia. Of this total an estimated 47%, 825, will have a mild presentation, 42%, 737 will have a moderate presentation and 11%, 193 will have a severe presentation.
- By 2010, incidence in dementia is expected to grow to 1824, of this total an estimated 47%, 847, will have a mild presentation, 42%, 776 will have a moderate presentation and 11%, 201 will have a severe presentation.
- By 2015, incidence in dementia will grow to 1958, of this total an estimated 47%, 920, will have a mild presentation, 42%, 822 will have a moderate presentation and 11%, 215 will have a severe presentation.
- Nationally, dementia currently affects over 750,000 people in the UK. Over 18,000 people with dementia are aged under 65 years, Dementia affects one person in 20 aged over 65 years and one person in five over 80 years of age.
Description of Where / Who the Issue Affects

People with dementia are amongst the most vulnerable in our society to abuse and neglect. Those without carers involved are particularly vulnerable and have, at times, been unable to express their views or have their past lifestyle and wishes taken into account in terms of decision making and advocacy.

As life expectancy for people with learning disability has increased and there is an increased risk of dementia developing in this group. Life expectancy for people with learning disability has increased and therefore there is an increased risk of dementia developing in this group. Approximately 20% of people with a learning disability have Down's syndrome and are particularly at risk of developing dementia.

Dementia is one of the main causes of disability in later life, having a major impact on capacity for independent living. The 2003 World Health Report Global Burden of Disease estimates dementia contributed to 11.2% of all years lived with a disability among people over 60 years, which was more than stroke (9.5%), muscular skeletal disorders (8.9%), cardio vascular disease (5.0%) and all forms of cancer (2.4%)

Equality and Diversity

Dementia UK in 2007 reported that nationally there are 11,392 people from Black and Minority Ethnic Groups (BME) with dementia and that 6.1% of all people with dementia among the BME groups are young onset, compared with only 2.2% for the UK population as a whole, reflecting the younger age profile of BME communities.

Links to Other Issues / Topics

Individuals with dementia are often supported by informal carers and the local authority. Supporting and living with people with dementia can put significant pressures on relationships and the health and wellbeing of informal carers. In addition, given the aging population and the likely increases in the number of individuals with dementia, significant resources will be needed from health and social care to support individuals and their families.

Individuals with dementia are more likely to experience accidents in the home and within the community and are at increased risk of falls. In addition, individuals with dementia who are admitted to an acute hospital as an emergency tend to have a greater length of stay than those without.

There is a link between dementia and alcohol misuse through the incidence of Korsakoff's Syndrome which is an alcohol related dementia. Those affected tend to be those people between the ages of 45 and 65 with a long history of alcohol abuse. Although numbers affected by Korsakoff's are small, nationally it is reported to affect 12.5% of dependent drinkers and has implications for
health and social care services as it affects a younger age group where dementia support is generally targeted at older people, this should be viewed in the context of high levels of alcohol consumption in Knowsley.

People with dementia are amongst the most vulnerable to abuse and neglect. Those without carers involved are particularly vulnerable and have, at times, been unable to express their views or have their past lifestyle and wishes taken into account in terms of decision making and advocacy.

**Links to Existing Strategies (incl. Policies / Services)**

The following strategies and policies are related to dementia:

- National Dementia Strategy
- National Carers Strategy
- End of Life
- Safeguarding

**Future Implications (Modelling / Projections)**

Data from Projecting Older People Population Information System show that there will be an increase of 28% in older people with dementia between 2008 and 2025. In terms of severity of need national research identifies that 47% with mild needs, 42% moderate need and 11% severe need.

This will put increasing pressure on resources, and the challenge will be to ensure that the resources available are used to support the maximum number of people. It is important to note that dementia appears to affect the population irrespective of social deprivation factors. However, there are some factors that may increase prevalence linked to certain long term conditions such as vascular heart disease and long term abuse of alcohol, both of which are conditions with above average prevalence in Knowsley. These significant increases need to be viewed within the context of an overall population reduction in Knowsley which means that the older age group will increase as a proportion of the total population and there will be fewer young people from which both paid and unpaid carers will be drawn.

By 2011 967 residents in Knowsley who have moderate and severe dementia needs and 422 residents who have mild dementia needs will be known to services.

**Evidence of What Works**

Early and accurate diagnosis enables older people and those caring for them to understand what is happening to them and they are more likely to access appropriate help to meet their treatment and support needs. Early interventions that are known to be cost-effective and would improve quality of life.
Gaps

- Joint Learning Disabilities and Dementia care pathway
- Awareness of dementia and services available amongst health and social care staff.

Recommendations for Commissioners

- Improve awareness and training in primary care through the use of Admiral Nurses.
- Improve awareness and training within Learning Disability services.
- Ensure early access to memory clinics
- Continue to build on initiatives to support the target for reduction of admissions for older people to residential care with dementia through intermediate care, specialist home care, and other reablement and support services
- Improve awareness, skills and capability of local acute hospital staff to provide better care for older people with dementia
- Consider the further development of the use of Telecare for people with dementia and their carers
- Design and implement a public awareness campaign locally on dementia during 2011/12.
- Develop information packs on dementia for users and carers

3.3.6 DEPRESSION AND ANXIETY

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Key Needs

While mental illness like schizophrenia and psychosis are relatively uncommon, Depression is the most common psychiatric disorder. Mild depression accounts for approximately 70 per cent of cases, moderate depression for 20 per cent and severe depression for 10 per cent

- An episode of depression serious enough to require treatment occurs in about one in four women and in one in ten men at some point in their lives. About two-thirds of adults will at some time experience depressed mood of sufficient severity to interfere with their normal activities
- Anxiety and Depression respectively account for 30% and 17% of attendances for mental health conditions at GP practices in Knowsley
- In 2004/05, 12.8 million working days were lost to depression and anxiety. About 2% of NHS expenditure goes on dealing with depression and anxiety.
Description of Where / Who the Issue Affects

In the UK, depression is thought to be responsible for 70 per cent of recorded suicides and it is estimated to cost England and Wales in the region of £8 billion annually in terms of lost productivity.

Depression is a common illness, with a prevalence of between one in ten and one in fifteen adults. It is thought at least one in six people will suffer from a depressive episode during their lifetime. Between 8% and 12% of the population experience depression in any year.

When hospitalised self harm data is presented as a ratio against a North West average of 100. The data shows that Knowsley has a significantly higher incidence of hospitalised self-harm than the North West (almost 20% higher).

Hospitalised incidence of self-harm is highest in parts of Kirkby (parts of Cherryfield, Whitefield and Northwood) and North Huyton (parts of Page Moss, Longview and Stockbridge) with ratios higher than the North West average. There are however, large parts of the Borough that have lower ratios of hospital incidence of self-harm than the North West (parts of Halewood North, Whiston South, Roby, Park, St Bartholomews and Swanside).

Equality and Diversity

Gender: most studies indicate that the incidence of depression in women is about twice that in men and in Knowsley females have higher rates of attendances at GP practices than their male counterparts.

Lack of self-esteem, not being able to be 'out' and the associated discrimination are significant factors in the mental and emotional wellbeing of the LGBT (lesbian, gay, bisexual and transgender) community.

People from BME communities can suffer inequalities in access to mental health services and in their experience of them, including language barriers, cultural barriers to assessment, lack of knowledge about statutory services and lack of access to bilingual health professionals.

The majority of people accessing GP surgeries for mental health condition were of white British origin (98%). The remaining 2% was made up of the other ethnicities. This reflects the population profile for Knowsley.

Links to Other Issues / Topics

Anxiety and depression is a major cause of impaired quality of life, reduced productivity, and increased mortality. Social difficulties are common (e.g. social stigma, loss of employment, marital break-up). Associated problems, such as anxiety symptoms and substance misuse, may cause further disability. Anxiety and Depression also linked to alcohol misuse, CVD, suicide and self-harm.
More than 70% of the prison population has two or more mental health disorders (Psychiatric Morbidity Among Prisoners in England and Wales, 1998).

**Links to Existing Strategies (incl. Policies / Services)**

The following strategies and policies are related to depression and anxiety:

- Primary Care Mental Health Strategy
- Transforming Community Services
- Forthcoming mental health strategy – which will supersede “New Horizons”
- NICE Guidance: The treatment and management of depression and anxiety

**Future Implications (Modelling / Projections)**

The economic downturn is likely to have an impact on levels of depression. Unemployed people are twice as likely to have depression as people in work.

**Evidence of What Works**

Psychological therapies based on NICE guidance can improve people’s health and well-being (including those with long-term conditions), leading to savings for the wider health economy and more cost-efficient mental health care pathways. Services/agencies working in partnership can help reduce the numbers of people on depression and anxiety related incapacity benefit.

Psychological therapies provide a significant opportunity to ‘add life to years’ by transforming the lives of people living with depression and anxiety disorders in Knowsley; and, in doing so can demonstrate a positive outcome for individuals, families, communities and the wider health economy.

- NICE Guidance Depression: The treatment and management of depression in adults.
- NICE Guidance Anxiety: The management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care.

**Gaps**

- There is a lack of Step 2 counselling in Kirkby
- No dedicated services for returning combat veterans
- Data intelligence and analysis including predictive modelling relating to anxiety and depression needs to be refined.
Recommendations for Commissioners

- Continue to invest in services for common mental health problems including social marketing and communication initiatives
- Develop messages to raise awareness of self harm in the Borough.
- Identify data / intelligence Requirements (to include improvements to data quality, needs assessments/ equity audits / insight etc.)
3.3.7 RESPIRATORY DISEASE

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<td>Chronic respiratory diseases are long-lasting diseases of the airways and other structures of the lung. Some of the most common are asthma, chronic obstructive pulmonary disease (COPD), respiratory allergies and occupational lung diseases.</td>
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<td>Since 1995 - 97 the trend for respiratory mortality in Knowsley rose to a peak of 57.6 deaths per 100,000 population in 1998 – 2000. Thereafter it fell to 45.5 deaths per 100,000 population before rising again. The rate has fallen in each of the last two periods and is now 45.8 deaths per 100,000. Although variable rates, the rate has fallen overall by 15% since 1995 – 97 it remains significantly higher than the North West and England.</td>
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<td>Although there are no areas of the Borough with significantly higher levels of mortality than Knowsley as a whole, there are some areas such as Kirkby, Huyton, Prescot, Swanside and Halewood with relatively high levels. Swanside and Halewood West electoral wards have significantly lower levels of respiratory disease mortality than Knowsley as a whole.</td>
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<td>Respiratory disease mortality has fallen by 12.8% between 2001 – 03 and 2006 - 08 in the most deprived areas of Knowsley. This has been a faster rate of reduction than the Borough as a whole and as a result in the gap between these areas and Knowsley has also decreased in absolute and relative terms.</td>
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<td>Significantly high levels of emergency hospital admissions for respiratory disease can be found in North Huyton and around Kirkby Town Centre. There are areas of Knowsley that have significantly lower levels of hospital admissions when compared to the Borough as a whole: Shevington, Prescot, Whiston, South Huyton and parts of Halewood.</td>
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<td>Between 1997 and 2008 the rate of emergency hospital admissions for respiratory disease increased by 65% in Knowsley which is significantly higher than the North West and England. However this rate has reduced in 2008 probably as a result of the commencement of the Knowsley Community COPD Service.</td>
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<td>Childhood hospital admissions from asthma have increased in Knowsley since 2003-05. The rates of hospital admissions were highest in South Huyton and South Kirkby in 2006-08. Highest rate of hospital admissions for asthma were in children aged 0-4.</td>
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Description of Where / Who the Issue Affects

COPD (Chronic Obstructive Pulmonary Disease)

Several electoral wards in Knowsley have a significantly high level of emergency hospital admissions for COPD compared to the Borough as a whole: Northwood, Park, Cherryfield (all in Kirkby), Stockbridge, Longview and Page Moss (all in Huyton).

Between 1997 – 99 and 2006 – 08 emergency hospital admissions for COPD increased by 5.5% in Knowsley. However over the last two time periods the rate has fallen and is now at 405.8 admissions per 100,000 population. Despite the improvement the Knowsley rate is approximately twice as high as the North West and England.

Pneumonia

Between 2006 and 2008 Stockbridge, Longview and Halewood West had a significantly higher level of admissions than Knowsley as a whole. Emergency hospital admissions have increased by 70% in Knowsley between 1997 - 99 and 2006 - 08. Knowsley has significantly higher rate of admissions than England and the North West the gap over this period has widened between Knowsley and its comparators.

Asthma

The rate of emergency hospital admissions for asthma in Knowsley has increased in all but one year between 1997 – 99 and 2006 – 08. As a result the rate has increased by 38% in nine years; the gap has widened between the Borough and regional and national comparators even though the North West has seen an increase over the same period. Childhood hospital admissions from asthma have increased in Knowsley since 2003-05. The rate of emergency hospital admissions for asthma was 5.24 per 1000 in 2006-08. The rates of hospital admissions were highest in South Huyton and South Kirkby in 2006-08. The highest rate of hospital admissions for asthma were in children aged 0-4 followed by the 5-9 age bracket.

Equality and Diversity

Respiratory disease mortality for males in the most deprived areas of Knowsley has fallen by 26.7% between 2001-03 and 2006-08 and as a result the gap between the area and Knowsley has narrowed. However, female mortality has increased over the same period in the most deprived areas and the gap has widened.

As the major cause of respiratory disease is smoking, its effect on particular vulnerable groups mirrors those groups with high smoking prevalence, such as manual workers, those economically inactive, individuals with mental health conditions and those living in the more deprived areas of the borough.
Links to Other Issues / Topics

Respiratory disease is influenced by occupation, pollution, allergens and lifestyles. The main preventable cause of respiratory disease is smoking. Smoking in the home was a particular issue raised at the stakeholder events. There are high levels of respiratory disease among those who are economically inactive, who are also more likely to smoke. High rates of respiratory disease in areas of the borough and in particular groups mirror those with higher smoking prevalence such as in North Huyton and Kirkby.

The history of parts of Knowsley may have an impact on respiratory disease due to periods of unsuitable housing and economic conditions. A combination of poor living conditions, exposure to hazards at work and unemployment will have contributed to unhealthy lifestyles. Other concerns expressed at stakeholder events were the links between increasing road usage and the pollution it causes, housing conditions of older people (heating and maintenance) and the perceived increasing use of cannabis.

Links to Existing Strategies (incl. Policies / Services)

Respiratory disease links into the following local strategies and reports:

- Tobacco Control Strategy
- Cardiovascular Disease Strategy
- Cancer Prevention Strategy
- Health Advisory Group Report on Respiratory Disease
- Consultation on a Strategy for Services for Chronic Pulmonary Disease in England
- Knowsley Community COPD Service
- Fag Ends
- Paediatric asthma Knowsley selected focus for DH-led Long Term Conditions QIPP ignition phase programme

Future Implications (Modelling / Projections)

Respiratory disease in Knowsley is significantly above that seen nationally. Although deaths from the disease have been decreasing, it is still a concern that hospital admissions are on the increase in some areas. Levels of smoking are still much higher than the national average - particularly in women - which may affect future levels of respiratory disease in the Borough. If the current smoking quit rates continue, this could result in lower hospital admissions, deaths and inequalities due to respiratory disease in the worst affected areas. Tackling smoking prevalence will continue to be a priority to help address respiratory disease.

Of particular concern is the need to identify COPD at an early stage. It is believed that at least half of all people with COPD have not been diagnosed. Early diagnosis will increase the recorded levels of the disease and use of treatment resources, but should also reduce disability and early death.
A respiratory disease group has been formed, involving GPs and nurses from across the Borough. This group will design a local enhanced service to provide incentives for earlier diagnosis and improved management of COPD by practices. It will also need to develop a programme to support practices to improve the management of asthma.

In addition, a community based service has been commissioned to provide diagnosis, treatment and rehabilitation services for people with COPD. There is also a new intermediate care service for people with COPD, which will help them to be better managed from within their own homes, and should help to reduce hospital admission rates.

For childhood asthma, insight with parents and stakeholders have identified the need for parent/carer and child education to increase the understanding of the condition and enable a self-management approach. Furthermore, frontline staff training and education was recognised as crucial to enable appropriate management and rapid recognition of exacerbations. This should be delivered to various services that children come into contact with.

In addition, in the long term, an in-depth approach using social marketing techniques was identified as being required to understand the behaviours and cultures and, in return, market and inform people with the right messages and in a timely manner about asthma.

**Evidence of What Works**

National evidence emphasises that the most effective strategy to reduce respiratory disease prevalence is to encourage and support people to quit smoking. For individuals with asthma, there are recognised treatment pathways and care plans in place and asthma guidance has been produced locally. Clear care planning, involving the child and parents can prevent hospital admissions.

There is NICE Public Health programme guidance on smoking cessation services and intervention guidance on smoking cessation and workplace smoking. There is also NICE Public Health programme guidance on behaviour change.

**Gaps**

- More work needs to be done to understand the increase in hospital admissions for childhood asthma from some parts of the Borough.
- Detailed air quality measures are monitored in Kirkby but not in the rest of the Borough. There may be a need to undertake similar monitoring in Prescot, Whiston, Cronton and Knowsley Village.
- More targeted interventions need to be developed to reduce smoking cessation relapse rates, which is still relatively high.
Recommendations for Commissioners

- Continue to work with Primary Care and patients to ensure that all patients with COPD are offered referral to the Community COPD Service.
- Re-specification of the Community COPD Service as contract ending in 2012 and Knowsley going out to procurement.
- To improve the early management of asthma in children work should be undertaken by providers of care, patients and families to optimally manage asthma and recognise and treat the early signs of exacerbation.
- Consider conducting environmental monitoring in areas with high respiratory disease admissions.
- Work with schools to raise awareness of paediatric asthma and develop policies.
- Develop model of care for Paediatric asthma
- Conduct a health needs assessment on childhood asthma to establish reasons for the increasing hospital admissions in certain areas of the Borough. Ensure that any recommendations produced are acted upon.
- Continue to invest in smoking cessation services as a high priority across Knowsley and in particular in areas of high smoking prevalence.
3.3.8 VULNERABLE ADULTS

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<th>Reader Information</th>
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<tr>
<td>Need Identified: Vulnerable Adults</td>
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<tr>
<td>Lead Author: Patricia Cammell</td>
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<tr>
<td>Approved by: Tony Foy</td>
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<td>Date completed: 16/12/10</td>
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**Key Needs**

The Audit Commission consider that the effect of ageing will be significant on public spending stating - the biggest single financial impact will be on social care spending estimating a 3-4% growth per annum if services continue to be delivered in the same way.

The impact in Knowsley is likely to be greater as areas with previously poor health and relatively young populations when ageing are characterised by an effect described as ‘adding years to life but not life to years’ resulting in poor outcomes and high care costs.

**By 2015** the total adult population in Knowsley will have increased by 1300, an increase of 1.1% from 2010 to 2015 in the total adult population, however breaking this down by adults and older people, there will be a 0.3% decrease in the adult population (18-64) and a 7% increase in the older people’s population (65+).

A total of 5494 adults were in receipt of services during 2009-10, 4579 were in receipt of community based services and the remaining 1217 were in receipt of residential or nursing care. A small number of clients have been in receipt of both a community based and residential service in the year.

The forecast increase in the adult population, particularly for older people will have a significant financial impact on adult social care. **Cost implications**

Between 2010 to 2015 (based on POPPI/PANSI and SWIFT projections)

- **Homecare** 101 people more will receive care - £0.603m (126 people - £0.759m SWIFT projections)
- **Supported accommodation** 1 person more will receive care - £0.033m (14 people - £0.520m SWIFT predictions).
- **Residential/Nursing expenditure** – 214 more people will receive care - £5.3m (99 people - £2.6m SWIFT projections)
- **Day Care** 27 people more will receive care – £0.058m (41 fewer people - £0.045m SWIFT projection)
- **Direct Payments** - 609 people more will receive care - £5.1m (SWIFT projection)
- **Carers demand** - reducing the potential unmet demand by 90% and applying the average yearly net cost of a critical home care package (£4500 or £85/week) still produces a potential cost increase in the near future of up to £1.80m
Description of Where / Who the Issue Affects

Within Knowsley of the 5494 adults who received services commissioned by adult social care, 31% were adults aged 18-64 and 69% were adults aged 65. For those adults of working age the service user split was 35.2% of people with a learning disability, 18.1% of people with mental health issues, 43.3% of people with a physical disability and 3.4% of people categorised under substance misuse.

Homecare - A total of 1417 people are currently in receipt of homecare (excluding supported accommodation, April 2010). The majority of home care support is provided to individuals over the age of 65. Indeed, an analysis of current Knowsley residential and nursing care demand shows that 1 in 55 people aged 65 – 74; 1 in 18 people aged 75 – 84 and 1 in 7 people aged 85 + require some form of home care. In comparison, 1 in 261 people aged 18 – 64 – require home care.

Homecare demand should be distributed by age and health deprivation and to a degree analysis by ward shows this, for example, Shevington has the lowest usage as expected with a younger, more affluent population. The effect of age distribution shows in the high numbers (107) in Prescot West, with Page Moss (85) showing a possible connection with health inequalities. It is reasonable to expect that ill-health especially the prevalence of long-term limiting conditions such as CVD and COPD will have an impact on homecare demand. There may be significant unmet need indicated by unexpectedly lower usage in some areas of higher health deprivation. Continued monitoring will determine whether an increase over time of demand, driven by aspirations and expectations for a better quality of life is concentrated in areas of higher deprivation.

The high number of people receiving less than 10 hours per week is an indication of the relatively low level of support provided to older people, which will increase in the current service model as the age profile increases. The trend will be for higher cost packages along with higher numbers as the demand will be concentrated in the older age groups.

Supported Accommodation - (people supported in own tenancies or small group homes) - This model is predominantly used for people with a learning disability. An analysis of current Knowsley supported accommodation demand shows that people aged 18 -64 are more likely to require supported accommodation. Indeed, 1 in 561 people aged 18 – 64 are likely to require supported accommodation. In contrast, 1 in 1236 people aged 65 – 74 and 1 in 2819 people aged 75 – 84 require supported accommodation. Supported Accommodation packages tend to be high cost LD 18-64, projected growth in the LD population is expected to be very small.

Residential and Nursing analysis - An analysis of current Knowsley age-related residential and nursing care demand shows that 1 in 326 people aged 18 – 64 are likely to require some form of residential care and not surprisingly the older people become the more likely they are to need residential care.
Indeed, 1 in 67 people aged 65 – 74; 1 in 16 people aged 75 – 84 and 1 in 4 people aged 85 + require residential care of some form.

What this tells us is that those people in the 18-64 and 65-74 age groups are more likely to receive home care/supported living than residential care (1 in 261 and 1 in 55 as reported above), a positive outcome in supporting people independently. Those people however who are over 75 are more likely to require or at least, receive residential care as opposed to home care meaning potentially we are not supporting better outcomes for this group.

Equality and Diversity

A full needs assessment is carried out prior to any adult being provided with a service. The Single Assessment Process assessment takes full account of individual holistic needs and ensures services are matched to individual needs; 98.8% of those people in receipt of services during 2009-10 were White British and the remaining 1.2% were categorised as other BME groups which is low, however aligns with the low levels overall within the borough.

In terms of service provision for service user group Knowsley currently provides the highest per 10000 rate for Learning Disability services (1/15) in the North West, the fourth highest Physical Disability rate of service (4/15) provision and the 5th lowest Mental Health service provision rate (10/15). Source RAP P1 all services report.

Links to Other Issues / Topics

For working-age disabled adults, including people with learning difficulties, the Spending Review could result in increased, not reduced, demand for social care as a result of cuts and changes to welfare benefits (time-limiting Employment Support Allowance and changes to Disability Living Allowance). Whilst continuing the Disabled Facilities Grant and ‘Supporting People’ is very welcome, this is partially offset by real anxieties about changes to social housing and the lack of funding for new, affordable and adaptable homes.

Links to Existing Strategies (incl. Policies / Services)

- Transforming Health and Wellbeing Strategy (Transforming Community Services and Transforming Adult Social Care)
- Personalisation
- A Positive Age - Older People’s Strategy
- Fair Access to Care Services: Knowsley’s eligibility criteria for adults of working age and older people
- Vulnerable Adults Strategy – ‘meeting needs and changing behaviour’
- QIPP – quality, innovation, productivity and prevention.
- Carer’s Strategy
- Sustainable Communities Strategy
Future implications (Modelling / Projections)

It is predicted that by 2015, there will be a 7% increase, equating to an additional 1600 people. The impact of an aging population in Knowsley will have a significant impact on health and wellbeing services and in particular on Social care provision. The effect will be compounded because the largest increases are in the numbers of people aged over 80 years old, with a 29% predicted rise in 85+ age band (an additional 700 people) and 6% in 80-84 age band (an additional 200 people). This will have a significant impact upon adult social care as more people will require support to live independently. For example an analysis of current Knowsley homecare demand shows that 1 in 18 people aged 75 - 84 and 1 in 6 people Aged 85 + are likely to require home care. Or put another way people over 85 are 37 times more likely to need services than people aged 18-64.

At the same time, there is projected to be an overall decrease in the adults of working age population by 2015, meaning potentially there will be less people to provide unpaid or paid care to support older people within the Borough.

Planning for and responding to the aging population is a key challenge for Health and social care. Indeed it is the biggest single financial impact for Councils will be on social care spending and estimating a 3-4% growth per annum if services continue to be delivered in the same way. Concern about the way councils were failing to plan for the impact of demographic change was expressed nationally in the report Audit Commission and Care Quality Commission report “Under Pressure – Tackling the financial challenges of an ageing population”.

The impact of an aging population is likely to be greater in Knowsley as areas with previously poor health are characterised by an effect described as ‘adding years to life but not life to years’, pointing out the effect of people growing old with the impact of long-term limiting conditions. Life is prolonged but without health improvement with an associated demand for all health and social care services. Significantly high rates of respiratory disease, cardiovascular disease linked to a high prevalence of smoking underpin demand for services.

Knowsley’s population also exhibits a marked trend to use crisis and emergency services as seen in the high rate of admissions to hospital in emergency with relatively low uptake until recently of preventative/screening services. The impact of ill health on carers is well evidenced but not apparent in Knowsley with relatively low numbers of carers asking for help although we outperform all of our statistical neighbours.

The service demand for both health and social care in places such as Knowsley is likely to become a greater financial issue if services continue, at least in the short term, to provide the same options and the population behaves in the same way. Failing to change service responses and demand through behaviour change and modernisation of services will produce an unsustainable financial position by 2015.
Knowsley’s spend on Adult Social Care as a proportion of overall LA spend appears to be one of the lowest in the NW at 29.5% (an increase on previous year which was 24.8%). Set against levels of deprivation we are an outlier significantly below expected spend. This is probably due to low unit costs (the effect of external procurement) and pooled funds, but moreover the effect of integration efficiencies and effective joint commissioning. The impact of unit costs can be seen in a comparative chart at the end of this section which shows, other than the weekly unit costs for home care (indicative of higher levels of support per person) and Residential and Nursing care for adults with a learning disability, there are no other significant comparative variances from this low cost/low investment model.

Residential care for older people represents the highest percentage spend of the older people social care budget. John Bolton’s report “Use of Resources in Adult Social Care” identifies that no more than 50% of social care budgets should be spent on residential care for older people. The Knowsley figure is 52.8%, significantly better than many of our comparators and a decrease on the previous year at 55.7%. Admission rates for older people typically at around 200 per year, much less than 10% of the relevant population which, together with few admissions directly from hospital to residential, are features of well-balanced services and positive outcomes with low costs.

Services although of lower cost and delivering positive outcomes may be spread too thinly and that as other demographic features especially ageing and ill health increase in their impact, without the options of increased efficiency and lowering unit costs expenditure will rise quickly with a likelihood of worsening outcomes e.g. increased residential admissions.

Residential and Nursing analysis - The projected increase in demand in people 75 and over could be split evenly between residential and community options, however the high usage of residential care for people 75 and over is significant and represents 75% of the entire growth in residential care, an unsatisfactory result in terms of outcomes as well as cost if the trend continues.

Based on projections from POPPI/PANSI the projected increase in expenditure by 2015 will be £5.3m, this figure is based on the following increase in demand: 18-64 – 1 person = £28,000, 65-74 – 7 people = £156,000, 75-84 – 21 people = £561,000, and 85+ - 186 people = £4,581,000. Based on the trend from SWIFT data the forecast increase is £2.6m this figure is based on the following: 18-64 - 10 = £326,00, 65-74 – 13 = £317,000, 75-84 – 37 = £994,000 and 85+ - 39 = £957,000

Importantly the calculation does not take account of the increased lengths of stay. The current average costs for residential and nursing care are outlined as: 18-64 - £625.00, 65-74 - £457.00, 75-84 - £510.00 and 85+ £473.00 N.B. all financial figures are gross. The total spend of around £40.00m is reduced by approximately £10.50m to account for PCT and service user contributions
The challenge of ill-health and dementia or depression in this latter group will present a significant challenge to demand and outcomes with a significant cost pressure developing quickly if there is an overuse of the residential option.

**Homecare** - Between 2010 and 2015 POPPI and PANSI predict 101 people more will receive homecare if trends continue and need and services do not change, predictions based on SWIFT activity would be 126. The impact this will have on costs would be £602,000 based on DH projections and £759,000 based on SWIFT projections, with the same cautionary note that the effect of unmet need from dementia and ill-health deprivation is excluded and similarly that the low levels of service delivery for older people continue.

Average growth projections from 2010 to 2015, based on historical information from Swift since 2006 indicates the main increase will be in the 85+ age band (24% increase). There is little difference in what is being predicted in the three other age bands (18-64 – 1.5% increase, 65-74 – 4.7% increase, 75-84 – 4.8% increase). The overall growth is predicted at 8.9%. The 7.1% growth predicted by POPPI is slightly lower than that the SWIFT activity prediction of 8.9%.

Based on average costs the increase in population suggests the main financial burden will be apparent in the 85+ age group, equating to an increase in costs from 2010 to 2015 of £513,926. Smaller increases can be seen in the other age bands (18-64 - £41,742, 65-74 - £70,165, 75-84 - £133,464).

There appears to be a degree of under-delivery of care against expected need/age trend, a possible result of low expectations and/or carer support masking real need. The percentage of people within the weekly bands show the effective use of low level packages particularly in older people and are:

- £0-£100 = 58%, £101-£200 = 28.0%, £201-£500 = 13.0%, £501-£1000 = 1.0%, £1000+ = 0.4%

**Supported Accommodation** (people supported in own tenancies or small group homes) - It has been predicted that there will be an increase of between 0.6% (an additional person) and 7.9% (an additional 14 people) dependent upon the model used (PANSI and SWIFT respectively). This would equate to an increase of between £33,000 to £520,000 in the period 2010 to 2015.

Effect on costs is relatively high given the small number of people due to 93% of current service users being in the 18-64 age group with an average weekly unit cost of around £745 per week. The average weekly unit cost for 65-74 is £628, and for people aged 75-84 years old it is £173 with an overall average unit cost of £570 for all ages. The projections are based on the average costs outlined, there are currently no service users aged 85+:

Although average cost for the 18-64 age group is £745, there is a significant number of people (currently 51 or 29% of all packages) whose service costs
over £1000 per week, the most expensive being £3900 per week. Whilst this is a small service user group any increase could have a significant affect due to high cost in care. Therefore given the variation in projections, caution should be exercised with this forecast as any unexpected rise, however small would have a significant affect.

**Day Care analysis** - There is a low level of use of day-care as an option for older people and a much higher rate for younger adults particularly people with a learning disability. This may be down to the model of day-care that has developed. For older people the use of a break from caring/ social contact tended to produce patterns of 1 day per week for a small number of older people, usually in the middle of the age range; the frailty of people over 80 tending to preclude usage partly because of the travel element. For people with a learning disability, a model historically meeting the needs of working-age carers and the perceived need for ‘meaningful activity’ in a non-inclusive model. Modernising of day services is progressing but alternatives such as employment models for people with a learning or physical disability and increased use of day-care for older people as an intermediate care option to support recovery and hospital discharge need exploration as a means to deliver better outcomes and control long-term costs.

POPPI and PANSI are predicting increases in all age groups; however a disproportionate increase can be seen within the 85+ age group where there is predicted to be a 30.47% growth. However, in contrast based on SWIFT data there is only a predicted increase in the 18-64 age group, with decreases in all other age groups.

Dependent upon the projection source this would mean an increased cost of £58,000 by 2015 or a decrease in expenditure in the region of £45,000.

**Direct payments and Personal budgets** - The aim of a personal budget/direct payment is to improve personal outcomes and give more flexibility in how services are provided. By giving individuals money in lieu of social care services, people have greater choice and control over their lives, and are able to make their own decisions about how their care is delivered. The law has been changed so that it is a duty to make direct payments. This means that councils must make a direct payment to eligible individuals who are able to provide consent. Personal budgets including direct payments should be discussed as a first option at each assessment and each review as the principal means to improving choice and control, and independence.

Personal budgets are clearly a better way to meet people’s needs and as direct payment rates are set lower than block homecare rates there is a potential efficiency. This however has not resulted presumably from the nature of the assessment process – to get the service user or carer to look to better outcomes, raising expectations and thus demand. The average costs of direct payments are referenced above. To date none of the personal budgets implemented have made a reduction in cost of care delivered.
Significant improvements have been made in implementing direct payments. Since 2006 Knowsley have provided an additional 119 people aged 18 – 64 with a direct payment which equates to a 98% increase. The largest increase however can be seen in older people where an additional 176 people have been provided with a direct payment. The growth has been based on the % change between 2008/09 and 2009-10 to account for the disproportionate growth in the early phase. The trend is likely to increase with the success of the model and the demand from DH to accelerate choice and control in the wider personalisation agenda which remains a high priority for this government.

Projections from 2010 to 2015 show the following increases based on previous trends from swift; 18-64 – 298 people = £2.7m, 65-74 – 96 people = £654,000, 75-84 – 192 people = £1.6m, 85+ - 23 people = £133,000, a total – 609 people = £5.1m. The average overall weekly cost of a direct payment is £156.69 (actual package cost).

Following the implementation of the outcome focussed review process personal budgets only began in Knowsley during January 2010. Given the lack of historical information it makes it difficult to project activity however Knowsley have committed to 1500 people either having a personal budget or Direct Payment by April 2011.

Evidence of What Works – Innovation & Prevention

Depression in older people can be treated by a combination of well-being approaches, medication and psychological therapies which avoid dependency-making services and hospital or permanent residential admissions. There is strong evidence that psychological therapies are effective with older people and their carers in the management of a wide range of mental and physical conditions. The Knowsley Primary Care Mental Health Service which delivers psychological services is available to older adults within Knowsley.

POPPs example – Mental Health and Older People
Bradford and Leeds POPPs projects also targeted older people’s mental health needs for preventative approaches – in both these cases the prevention was aimed to avoid excessive use of hospital admissions and general demand for services.

IKAN the Knowsley POPPS project overall proved that preventative services can improve wellbeing.

- The evaluation found that of the 20 wellbeing items assessed, 12 demonstrated a significant improvement following the IKAN intervention.
- The PSS Adult Placement Service has demonstrated significant improvements on two wellbeing items in service users and carers.
- The evaluation identified a reduction in costs of £476,193 associated with selected HRGs which the preventative approach used by the IKAN team could be expected to impact upon. This demonstrates the ability of
preventative projects to generate savings which can then be moved upstream to prevent acute service use.

- The IKAN team was found to be very effective at accessing the hard-to-reach older people.

The Knowsley Partnership for Older People Project developed the innovative IKAN multi-disciplinary community assessment service and piloted alternatives to residential respite for older people with mental health needs. Over 800 assessments a year have successfully put older people in touch with universal and preventative services including support from Age Concern, home improvement agencies and the Fire Service. Feedback is exceptionally good with high levels of improved wellbeing and personal safety among the reported improvements.

**Assistive Technology** - Assistive Technology - telecare and telehealth use relatively simple technology to monitor the health and wellbeing of vulnerable people in their own home and community. This assistive technology is often provided at moderate cost while reducing the need for more intensive and costly services. Assistive Technology supports vulnerable people to remain independent, living in their own homes in their local community for longer, often at moderate cost and perhaps preventing or delaying unnecessary admissions to hospital and residential care. Assistive technology can also provide carer reassurance and an extra risk management option for assessors when care planning. It can reduce the need for home care and other specialist health care services and so bring cost savings in that element of needs where risk rather than direct personal care is present – almost all packages contain some element of risk management including simple prompting for medication or general wellbeing checking. It can contribute to preventative self-care and independence at moderate cost. It is strongly recommended by the Alzheimer’s Society to support people with dementia and their carers. The model is as follows:-

**Devices to oversee daily activity** - It is possible to install sensors to monitor a person's activity in their own home over a period of time. This can sometimes help relatives or community services get a better idea of a person's activity during the day and night. A system such as this can allay fears that the person with dementia is not managing well, and may help those around them to step back and not take over unless it is absolutely necessary.

**Re-ablement** - Re-ablement covers a range of short-term interventions which help people recover their skills and confidence after an episode of poor health, admission to hospital, or bereavement. Re-ablement can help people to continue to live independently in their own homes without the need for an on-going social care package. The Government is supporting an expansion of re-ablement across the NHS and social care, with £70m in new resources in 2010/11 and up to £300m a year earmarked for re-ablement in the next Spending Review period.

Social care and health services will always need to make best use of limited resources. Demographic projections also show an increasing demand on all
modes of care. The approach needs to ensure that the lowest appropriate level of intervention is provided set within an active and ongoing assessment process to balance risk against ‘quality of life’ for adults who need care. Other initiatives such as telecare services will also play a significant part in supporting people in their ‘home’, whether it be an individual residence, sheltered or extra care housing.

Gaps

In the current financial climate where budgets are under increasing pressure, hard decisions need to be made about spending. Currently the information and intelligence that is harnessed to drive spending decisions tends to focus on the delivery of services typically measuring activity and volume, driven largely by the requirements of regulators and government departments.

There is a need to develop better information on outcomes. Without information on the outcomes of activity, it is impossible to assess value for money accurately. Information from people receiving support on the outcomes achieved is therefore urgently needed to understand the real returns on investment and to support better financial decision-making. The business case for self-directed support is that people can have better lives with costs being the same or less than for under previous arrangements. This makes it essential to check that good outcomes are actually being achieved. As well as making sound financial sense, an understanding of the impact of personal budgets on people’s quality of life enables councils to be more accountable to their local populations

Recommendations for Commissioners

**General conclusions** - The analysis shows significant costs pressures driven by demographic change and ill-health but also the presence of historic patterns of service, some indicating under-delivery, some the reverse against forecast levels. The effect of long-term limiting conditions and mental ill-health/dementia will add complexity to care if not increasing numbers receiving social care. Cost implications without effective change services to meet needs and demand are shown.

**There is a significant age and ill-health related demand** - an increase within the 85+ age band which is predicted to rise by 29% (an additional 700 people) and 6% in 80-84 age band (an additional 200 people) by 2015. The impact if services remain as currently configured is that an estimated 139 (swift projection) more people over 85 will receive care by 2015 and that around 39 will need residential or nursing care, around 60 more people 75-84 will also need services split by 37 requiring residential or nursing care and 23 requiring care at home. **Ill health impact** - of these groups (around 6,400 by 2013), a significant but not quantified number will have needs related to dementia, depressions or long-term limiting conditions including a combination of these making future care highly complex. To tackle this impact we will continue to rely heavily on our **integration with NHS Knowsley**, maintaining a preventative focus increasing the amount of self-care and lower
cost community treatment. Increased use of pooled funds based on long-term conditions is an option to explore.

**Knowsley's current spend on Adult Social Care** as a proportion of overall LA spend appears to be one of the lowest in the NW at 29.5% (an increase on previous year which was 24.8%). Set against levels of deprivation we are an outlier, significantly below expected spend. This efficiency is likely to be down to effective procurement, joint commissioning and the benefits of integration and pooled funds. However, it may mask some unmet need seen from carers and the effect of up-to-now, low expectations for good health and wellbeing, a trend which is likely to alter. The increases in the traditional service measure of ‘intensive social care’ both in numbers and unit costs indicate that demand is already high, complex and rising.

The current fairly positive picture of **residential care** being close to 50% of the social care budget and rates of admissions will worsen given the forecast increase in ill-health including dementia and long-term-limiting conditions, and in a limited market may be subject to increased prices.

Much smaller population effects are seen in people 18-64 but **demand for learning disability services** already higher than might be expected, unit costs are relatively low but an estimated excess of 68, rising to 100 people with a learning disability receive services. The approach here is to capitalise on increased expectations and targets for employment, as an alternative to conventional sessional services.

**Assistive technology** can reduce demand for homecare and produce improved outcomes, being very cost effective if the scenarios can be delivered, a revised strategy will be needed to move to a more enhanced model of telecare that meets the needs for people with dementia and or long-term conditions. A significant initial loss in year one is rapidly offset by care package/personal budget reductions which in the least cost reduction scenario could produce **savings of around £0.73m**

The expected positive effect on outcomes and cost control expected of the **Reablement** service has yet to be delivered, leaving an unclear position. Further work will be undertaken to determine the barriers to delivering improvements and revise savings estimates.

**Good partnership working** between health and social care is vital for helping people with long term conditions manage their condition and live independently. The long-term conditions chronic care model within the Department of Health’s Quality, Innovation, Productivity and Prevention (QIPP) programme is exploring how different services can work together to promote self-care, preventative care and early intervention, minimizing the need for hospital and residential care.
3.3.9 END OF LIFE

READER INFORMATION

<table>
<thead>
<tr>
<th>Need Identified</th>
<th>End of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Author</td>
<td>Kelly Jones</td>
</tr>
<tr>
<td>Approved by</td>
<td>Michelle Creed</td>
</tr>
<tr>
<td>Date completed</td>
<td>02/12/10</td>
</tr>
</tbody>
</table>

Key Needs

- Approximately 1% of the population die each year; this is approximately 1500 people per year in Knowsley.
- National research suggests that nearly 90% of people would prefer to die in a community setting (home, hospice or care home), however in Knowsley in 2009, provisional data shows that only 44.7% of people died in a community setting. Therefore the support available for those who wish to die in the community needs to be expanded and improved.
- More people die from long term conditions in Knowsley than do of cancer, therefore there is a need to provide an increased emphasis on support at the end of life for those with non-cancer diagnoses.

Description of Where / Who the Issue Affects

End of life care will at some time touch the lives of everyone in the borough whether this is through needing care themselves or through having a relative or friend die. National evidence studies\(^\text{25}\) suggest that around 56% of people asked would prefer to die at home, whilst 11% suggested that their preference would be to die in hospital and 24% in a hospice; 9% of people would prefer to die in a care home or elsewhere. This means that over 90% of people would prefer to die in community settings.

In Knowsley in the year 2009, provisional data suggests that 55.3% of people died in hospital, 23.4% died at home, 13.1% died in residential (Inc. nursing) care, 5.2% died in a hospice and 2.9% died elsewhere. Although the proportion of deaths in hospitals has decreased from 60.6% in 2007, the wishes of people are still not being met.

Knowsley has a higher level of mortality for all causes than the national averages. Increases in specific disease groups, particularly dementia is likely to increase the need for improved choice and quality of services at the end of life.

At the centre of improving care for the dying is the ability to effectively plan services to meet their needs. These needs vary significantly, particularly for those with non-cancer diagnoses. One of the biggest problems if we try to improve advance care planning, particularly when considering non cancer diagnoses is the unpredictable nature of some illnesses e.g. the trajectory for cancer is often characterised by a period of high function with a rapid decline into low function and then to death whereas organ failure and chronic obstructive pulmonary disease is characterised by a gradual decline in function with periods of low function and then some improvement and then death. This makes it more difficult for practitioners to prognosticate for non-cancer diagnoses and therefore this group of patients often do not have the opportunity to discuss advance care plan. Data collated by the End of Life Care Intelligence Network for the years 2005 to 2007 show that Knowsley has significantly higher than the national average deaths from cardiovascular disease and respiratory disease in hospitals and significantly higher than the national average of deaths in residential care homes.

Equality and Diversity

There are no equality and diversity issues identified in relation to race (including BME, faith, religion or belief groups), disability (including physical and mental impairments), gender (women, men and trans-gender), LGBT, age (plus life stages)

The key equality issue in end of life care relates to the difference in the quality of end of life care and achievement of preferred priorities for care for those with long term conditions compared to those with malignancies.

Links to Other Issues / Topics

End of life care is inherently linked to the incidence of diseases and the ageing population.

Currently 90% of practices nationally claim the Quality and Outcomes Framework (QOF) palliative care points in the GP Contract (equates to 90% adoption of GSF Level 1). Two other independent surveys indicate that over 60% of practices in the UK are using GSF more fully, and 10-15% have fully embedded it.

In 2009 the RCGP approved the College End of life Care Strategy, supporting further progress with GSF. In June 2009, the fully refreshed and revised GSF Primary care Next Stage Programme ‘Going for Gold’ was launched with new training programme, support and resources to support practice teams to move on to the next stage with use of GSF in their teams.

In 2004 GSF was adapted and piloted for use in care homes, and a new GSF in Care Homes Training Programme was developed, with a more structured curriculum, training programme and formalised accreditation process. A national phased programme with up to 10 project bases a year has now involved almost 1000 care homes (nursing and residential homes) in the UK,
with about 3-400 a year currently in training and 100 a year being accredited. Evaluations have shown improved quality of care provided, improved staff confidence, improved processes/documentation, plus a significant decrease in crisis hospital admissions (about a third) and decrease in hospital deaths (almost half).

The principles of GSF have been adapted for various settings but retain common features, to ease cross-boundary communication, as patients move from one setting to another. Since 2006 there have been adaptations for children, new programmes in Acute Hospitals, with further programmes for Prisons, Community Hospitals and other areas in development.

The ‘toolkit’ of resources and tools has also developed to, plan ahead, audit provision etc. There are now specific training programmes include means to better identify patients nearing the end of life, assess their needs for GSF Care Homes and GSF Primary Care, with GSF in Acute Hospitals and Prisons in development.

**Links to Existing Strategies (incl. Policies / Services)**

End of life care is a priority area of development for Knowsley Health and Wellbeing and was identified and supported through the Commissioning Strategic Plan 2008. End of Life care is also a key feature in strategies for long term conditions.

- The Department of Health End of Life Care Strategy (2009)
- The Department of Health End of Life Care Quality Markers (July 09)
- The NHS End of Life Care Programme (2005)
- The Royal College of General Practitioners (2007)
- The White Paper 'Our Health our Care Our Say' (2007)
- NICE Guidance for Supportive and Palliative Care (2004)
- The House of Commons Health Select Committee Report (2004)
- Macmillan Cancer Support (2002-4)
- The National Council for Palliative Care (2003)
- Mentioned in many National Service Frameworks – e.g. for CHD, Renal and Neurology.

**Future Implications (Modelling / Projections)**

Knowsley has set a target to reduce the proportion of deaths in hospitals from 60.6% in 2007 to 50.6% by the end of 2012 by improving and increasing the care available in community settings. This equates reducing the number of hospital deaths each year from 909 to 759, based on average deaths of 1500 per year. These patients will still die but will die in community settings. As a result of this the workforce in community settings will need to change and possibly expand.
Evidence of What Works

Since the launch of our various initiatives, provisional data for 2009 indicates that we have reduced the proportion of deaths in hospital to 55.3%. This indicates that the work that has been undertaken in working with nursing homes to get them ‘Gold Standards Framework’ accredited, education of clinicians, advance care planning and access to specialist advice and support is working.

The Five Key Goals of the Gold Standards Framework are to provide for patients with any final illness:

1. Consistent high quality care
2. Alignment with patients’ preferences
3. Pre-planning and anticipation of needs
4. Improved staff confidence and teamwork
5. More home based, less hospital based care

Gaps

In order to continue this pace of improvement it is necessary to continue the established initiatives.

Key gaps are workforce knowledge, skills and competencies which are currently being explored through a competency based workforce pilot project and community capacity.

Recommendations for Commissioners

Continue with the initiatives already commenced. These support:-

Data/Intelligence requirements:

- Improving planning and co-ordination of care for end of life patients

Service Provision issues:

- Developing capacity in community settings for end of life patients.
- Supporting patients, families and carers and end of life
- Developing quality at end of life in community and acute settings.
- Supporting the development of local hospice provision.
3.3.10 NEUROLOGICAL CONDITIONS (REHABILITATION)

<table>
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<tr>
<th>NEED IDENTIFIED</th>
<th>Neurological Conditions (rehabilitation) – Physical Disabilities</th>
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<tbody>
<tr>
<td>LEAD AUTHOR</td>
<td>Michelle Creed</td>
</tr>
<tr>
<td>APPROVED BY</td>
<td>Michelle Creed</td>
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<td>DATE COMPLETED</td>
<td>02/12/10</td>
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**Key Needs**

- There is no comprehensive care pathway for a patient with a specific condition once they had been diagnosed.
- Single pathways exist for individual services such as physiotherapy but there are no links to other services on discharge.
- Services are poorly co-ordinated.
- There is poor communication between different professionals, organisations and agencies.
- Patients have to navigate a complex health and social care system if they needed help.
- There is a lack of knowledge about the role of different professionals and agencies amongst the staff themselves resulting in delayed discharge to community services, gaps in service provision and poor co-ordination.
- People with long-term neurological conditions living in the community need to have ongoing access to a comprehensive range of rehabilitation, advice and support to increase their independence and autonomy and help them to live as they wish.

**Description of Where / Who the Issue Affects**

A ‘long term neurological condition’ results from disease of, injury or damage to the body’s nervous system (i.e. the brain, spinal cord and/or their peripheral nerve connections) which will affect the individual and their family in one way or another for the rest of their life.

This may affect the individual and their family/carer in one way or another for the rest of their life. There are a wide variety of long term neurological conditions and people have very different experiences. Conditions may be present at birth or be acquired later in life. Some, such as cerebral palsy and hydrocephalus may be associated with varying degrees of learning disability. Some conditions appear in childhood, for example Muscular Dystrophy, or develop during adult life, such as Parkinson’s disease. Long term neurological conditions can be broadly categorised as follows:

- **Sudden onset conditions**, for example acquired brain injury or spinal cord injury, followed by a partial recovery. (Note: stroke for all ages is covered within Cardiovascular Disease pathways)
• **Intermittent and unpredictable conditions**, for example epilepsy, certain types of headache or early multiple sclerosis, where relapses and remissions lead to marked variation in the care needed

• **Progressive conditions**, for example motor neurone disease, Parkinson’s disease or later stages of multiple sclerosis, where progressive deterioration in neurological function leads to increasing dependence on help and care from others. For some conditions (e.g. motor neurone disease) deterioration can be rapid. (Note: dementia for all ages is covered in the Mental Health pathway)

• **Stable neurological conditions, but with changing needs due to development or ageing**, for example post-polio syndrome or cerebral palsy in adults.

The time course of conditions also varies widely. The average time between diagnosis and death for someone with motor neurone disease is 14 months, while someone with multiple sclerosis may live with the condition for decades. Even within specific conditions, the needs of individuals, for example for social care support, vary widely. A key feature of the National Service Framework, is supporting people with long term neurological conditions to live independently, often for many years. Long term neurological conditions can cause a range of different problems for the individual, including:

• Physical or motor
• Sensory
• Cognitive or behavioural
• Communication
• Psychosocial and emotional

A brief description of the incidence and prevalence of neurological conditions and their impact in the UK has been described in the document Neuro Numbers\(^2\). Using the rates described in this document and other sources\(^3\), estimates have been calculated of the incidence and/or prevalence of LTNCs for the borough of Knowsley. Furthermore, the Cheshire and Merseyside Neurosciences Network recognised that the range of long term neurological conditions is vast (around 130 conditions). It was therefore decided that it would, in the first instance, focus on a range of the most common conditions which are identified in Table 1. The conditions selected embrace different condition pathways, particularly those that require significant adjustments to changes in lifestyle, across adulthood.

It is not an exhaustive list, but it includes the most common LTNCs and/or those with greatest impact on the individual and health and social care for which estimates of incidence and/or prevalence exist. These estimates need to be treated with caution as the sources of some of these estimates are published studies which may not be applicable. However due to the absence of nationally recognised data sources such data is all that is available until the Better Metrics Project delivers its findings in 2011 (Care Quality Commission).
Table 1. Estimates of incidence and prevalence of long term neurological conditions per 100,000 population.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Incidence (100k pop’n)</th>
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<th>Approx NW Incidence</th>
<th>Approx NW Prevalence</th>
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<tbody>
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<td>175</td>
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<td>11,900</td>
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<td>186</td>
<td>n/k</td>
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<td>40</td>
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<td>430-1,000</td>
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<td>29,000-68000</td>
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<td>n/k</td>
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<td>Motor Neurone Disease</td>
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<td>Multiple sclerosis</td>
<td>3-7</td>
<td>100-166</td>
<td>200-475</td>
<td>6,800 - 11,333</td>
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<td>Muscular dystrophy</td>
<td>n/k</td>
<td>50</td>
<td>n/k</td>
<td>3,400</td>
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<td>Parkinson’s disease</td>
<td>17</td>
<td>200</td>
<td>1,156</td>
<td>13,600</td>
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<td>Post-polio syndrome</td>
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<td>n/k</td>
<td>n/k</td>
<td>12,000</td>
</tr>
<tr>
<td>Spina bifida and congenital hydrocephalus</td>
<td>n/k</td>
<td>24</td>
<td>n/k</td>
<td>1,632</td>
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</table>

Half of neurology outpatient referrals originate in GP practices, but an estimated 30-50% of these referrals is inappropriate for specialised care or contains insufficient clinical information to triage patients. Neurology referrals from District General Hospitals, either to tertiary centre outreach clinics or directly to the neuroscience centre account for the remaining 50% of initial outpatient attendances. An estimated 50% of all referrals are requests for advice on patient management only.

Referrals to neurosurgery outpatient clinics have increased by over 50% in the period 2006-07 to 2008-09; this may be due to GP direct access schemes, changes in clinical responsibility for spinal surgery services from local hospital orthopaedic directorates to specialised neurosurgery services and to improved triage systems such as Neurological Integrate Clinical Assessment and Treatment centres.

Neurological conditions affect all ages and people may experience the onset of a neurological condition at any time in their lives. There is increased prevalence of neurological conditions in older people as some conditions particularly affect older people and others are lifelong conditions. People with neurological conditions can experience difficulties ranging from living with a condition which may weaken or disable them for periods of time through to needing help for most everyday tasks.

- Approximately 10 million people across the UK have a neurological condition. These account for 20% of acute hospital admissions and are the third most common reason for seeing a GP.
- Approximately 350,000 people (0.6% of the UK population) require help for most of their daily activities.
Over one million people (2% of the UK population) are disabled by their neurological condition
Over eight million people are affected by a neurological condition, but are able to manage their lives on a day-to-day basis

Neurological conditions are the most common cause of serious disability and have a major, but often unrecognised, impact on health and social services

Each year 600,000 people (1% of the UK population) are newly diagnosed with a neurological condition
10% of visits to Accident and Emergency Departments are for a neurological problem
17% of GP consultations are for neurological symptoms
19% of hospital admissions are for a neurological problem requiring treatment from a neurologist or neurosurgeon
About one quarter of people aged between 16 and 64 with chronic disability have a neurological condition
Approximately one third of disabled people living in residential care have a neurological condition
850,000 people care for someone with a neurological condition.

The diagnosis or onset of a long term neurological condition generally marks the beginning of profound changes in the life of the person and the lives of their carer, family and friends. It may affect relationships, career prospects, income and expectations for the future.

People with neurological conditions may have complex needs that affect their ability to function not only physically but also emotionally and mentally. The condition may impact on different aspects of their lives including family and carers, education, housing, finance and employment. A person centred service therefore requires that all aspects of an individual’s life are taken into account when assessing needs, often involving a number of different professionals and agencies across health and social care.

An effective person centred service needs:

- good co-ordination
- services planned and delivered in an integrated way around the needs of the patient
- an understanding of the skills of different professionals and the role of different agencies
- an integrated assessment of health and social care needs
- up to date information given at the appropriate time along the patient pathway
- involvement of the patient and carers in the decision making process
- access to general and specialist advice as necessary
- support to help patients manage their condition themselves
- encouragement to the patient to join any of the support groups relating to their condition
In other words, seeing the right person at the right time in the right setting with the right information to help make informed decisions.

Supporting people with long term neurological conditions to apply for Direct Payments; assessments for social care services in line with guidance on Fair Access to Care Services and prompt and fair assessment of eligibility for fully funded NHS continuing care could help meet this need. Steps to ensure equity and consistency of criteria and assessment processes, which include taking account of the needs of people with long-term neurological conditions, will be part of ongoing work to improve the provision of NHS continuing care.

**Equality and Diversity**

A number of local demand management and good practice initiatives have been developed in recent years, but there has been no independent or consistent evaluation of these schemes to provide comparative data, or to disseminate findings across the North West. Individual initiatives may disadvantage other service users, leading to inequity of access, duplication of services and lengthening of patient pathways; collaborative working on a zonal or regional basis would lead to more equitable service provision.

Good practice is embedded in a number of historic documents, such as 10 High Impact Changes, Action on Neurology and the National Service Framework for Long Term Conditions, but has not been applied systematically and evaluated.

Knowsley’s ‘Physical Disability or Sensory Impairment Audit’ (February 2008) highlighted a range of experiences from service users and carers, areas where agencies need to improve and a desire from a significant number to be involved in service development. The key areas were around difficulties securing the right care and support; difficulties accessing services and transport; gaps in communication and information; employment issues and social exclusion issues. The results were used to start the development of a Business Plan for the development of services for people with a physical disability or sensory impairment within Knowsley.

Carers often have to sacrifice their own work or leisure time. For example, family caregivers provide on average between five and 12 hours of care per day to people with moderate and severe MS. Partners caring for someone with Parkinson’s disease are 40% less likely to get out of the house at least once a week or to take a holiday than their peers. Carers’ health is often compromised – about half suffer physical injuries such as a strained back and half experience stress-related illness. Carers may be all ages. Whilst many carers are elderly, a significant number of children and young people are carers of people with neurological conditions.
Links to Other Issues / Topics

The North West Primary Care Trusts (PCTs) have noted that referrals to neuroscience services have increased significantly over the last five years; this is confirmed by national perceptions of service demand. Some of this increase could be explained by changes in social trends including behavioural patterns such as increased alcohol intake, or as a result of national demographic changes. Other contributing factors are medical sub-specialisation, changes in systems of clinical management, improved clinical coding and government policy initiatives on patient choice, waiting times, Payment by Results, independent sector provision and expansion of elective capacity.

In June 2009 the North West Specialised Commissioning Group, comprising representatives from all 24 PCTs, requested that a comprehensive review of service demand was undertaken as a high-priority project in the 2009-10 work programme with an initial report to the December 2009 meeting.

This Review is set in context of a challenging economic climate with an expectation that the NHS will need to save between £15 and £20 billion over the next three years.

A Cheshire and Merseyside Neurological Network is currently working on an action plan for tertiary services with PCT representation.

Links to Existing Strategies (incl. Policies / Services)

The following strategies and policies are related to neurological conditions;

- NHS Improvement Plan: Putting People at the Heart of Public Services (2004)
- Supporting People with Long Term Conditions – An NHS and Social Care Model (2005)
- Independence Wellbeing and Choice (2005)
- Action on Neurology (2005)
- 10 High Impact Changes (2004)
- Transforming Community Services: Ambition, Action, Achievement Transforming Rehabilitation Services (2009)

Future Implications (Modelling / Projections)

The numbers of people with neurological conditions will grow sharply in the next two decades due to improved survival rates, improved general health
care and infection control, increased longevity and improved diagnostic
techniques.

It is estimated that over £1.5 million p.a. could be saved for every 10% reduction in referrals to specialist services. This can be achieved through increased usage of referrals guidance such as Map of Medicine, the use of referrals criteria and pro forma referral letters, and continuing professional education for GPs and secondary care general physicians.

There is still a significant amount of neuroscience activity at District General Hospitals commissioned locally and these hospitals are also charging a variety of tariffs and have differing cost bases. The cost bases (reflected in reference costs) for neurosurgery and neurology outpatients varies widely between the NW tertiary providers and the national average for these services. Local tariffs charged by NW tertiary centres vary widely.

“Commissioning in a Cold Climate” (King’s Fund, June 2009) projects an increase in the population of the United Kingdom from 60.6 million (2009) to 71.1 million (2031), the equivalent of an average annual growth rate of 0.69%, or 17.3% over the 25-year period, with a corresponding increase in life expectancy. This will impact on the level of future demand for neuroscience services.

These known national factors, together with revised commissioning arrangements proposed in the National Definitions Set for Specialised Neuroscience Services (3rd edition, 2009), contribute to the conclusion that uncontrolled access to tertiary services is unaffordable. Therefore all sectors of the health economy need to take responsibility and consider what solutions can be proposed and implemented to manage patients in an appropriate setting.

Evidence of What Works

Although this National Service Framework focuses on the needs of people living with neurological conditions, it will make an important contribution to delivering the government’s overall strategy to improve NHS and social care support for all people living with long term conditions.

The document sets out eleven quality requirements which are derived from research and expert evidence specific to neurological conditions, but many elements of them are relevant to people with other long term conditions, for example:

- prompt diagnosis;
- providing information and support;
- person centred care and choice;
- providing information and support for the safe and effective use of medicines;
- care planning and integrated service provision involving different agencies, including closer working between health and social services;
• planning and liaison when people make transitions between services;
• supporting self-care and considering health promotion needs;
• prompt access to treatment which complies with National Institute for Clinical Excellence (NICE) guidelines and timely referral for appropriate specialist intervention;
• rehabilitation and support in the community and vocational rehabilitation;
• providing equipment and adapted accommodation;
• equitable assessment for fully funded NHS continuing care and adult social care under Fair Access to Care Services;
• providing palliative care to people who have conditions other than cancer;
• supporting carers;
• managing long term conditions effectively when in hospital (or other settings) for other problems.

Gaps

• Many clinicians would rate their understanding of the brain and nervous system as less good than other organ systems.
• There are very few population based registers for neurological Health and Wellbeing needs of people with neurological conditions are not known in sufficient detail to plan for service provision.
• There are disparities in the number of neuroscience consultants and specialist nurses across the three zones within the North West.
• There is a lack of robust care pathways in place.
• Little data is available on the degree of disability.

Recommendations for Commissioners

Data / Intelligence Requirements

• A Health Needs Assessment should be undertaken for people with Neurological conditions in Knowsley.
• An agreed definition of which conditions should be considered as LTNCs should be developed.
• There is a need to have improved and unified systems across the Cheshire and Merseyside Neurosciences Network for routine collection of data on incidence and prevalence of long term neurological conditions.
• There is a need for activity data related to the management of LTNCs in the community including social services and in palliative care to complement the HES data which exists for secondary and tertiary services.

Service Provision Issues:

• There is a need to map current provision and data relating the access and uptake of rehabilitation services.
• Alternative ways should be explored of evaluating access to, and the appropriateness of social care provision for those with LTNCs and their families and carers.
References
1. Neuro numbers; a brief review of the numbers of people in the UK with a neurological condition. Neurological Alliance in conjunction with the Association of British Neurologists (ABN), Society of British Neurological Surgeons and the Royal College of Nursing (RCN), 2003.
2. Long-term neurological conditions: a good practice guide to the development of the multidisciplinary team and the value of the specialist nurse, National Workforce Projects, Manchester, 2008.

3.3.11 LEARNING DISABILITIES AND AUTISTIC SPECTRUM DISORDER

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<tr>
<td>Approved by</td>
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<td>Date completed</td>
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Key Needs
- People with learning disabilities are 2.5 times more likely to have health problems than other people (Disability Rights Commission 2006).
- Adults in Knowsley have higher rates of epilepsy, Asthma, and hypothyroidism than the rest of Knowsley population.
- Four high priority groups of people often excluded from community services:
  - people with complex needs
  - people from black and minority ethnic groups and newly arrived communities
  - people without a learning disability who are on the autistic spectrum
  - offenders in custody and the community

Description of Where / Who the Issue Affects

Adults with a Learning Disability

Adults with a learning disability experience a range of health inequalities; Equal Treatment: Closing the Gap, Disability Rights Commission (2006) highlighted failings in access to health care and appropriate treatment for people with learning disabilities. While Death by Indifference, Mencap (2007) described the circumstance surrounding the inappropriate deaths of six people with learning disabilities while they were in the care of the NHS. Finally, Healthcare for all (2008) concluded that people with learning disabilities have higher levels of unmet need and receive less effective treatment.
### Adults with a learning disability registered with Knowsley GP practices 31 Dec 2008

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<tr>
<td>Kinloch</td>
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Adults with Learning Disability in Knowsley are:

- On the average, younger than the rest of Knowsley population. This is consistent with the national picture.
- Have higher rates of epilepsy, Asthma, and hypothyroidism than the rest of Knowsley population. It has similar levels of circulatory diseases as the rest of the population. The prevalence of type 2 diabetes is slightly higher in adults with learning disabilities; this may be due to the higher levels of Obesity in this group.
- One in ten adults with learning disability use tobacco. This is less than the Knowsley average of one in four adults and is consistent with other research findings.
• More likely to be underweight (BMI<20) than the rest of Knowsley population (8.7% compared to 2%). They are also more likely to be obese (BMI>30) than the rest of Knowsley population (40.5% compared to 20%).
• More likely not to have breast and cervical screening. (33% compared to70.6%; 74%)
• Have visual and hearing impairments missed.
• Have higher rates of difficulty in swallowing than the rest of the population.
• Have complex medical needs requiring higher use of acute trust resources

Valuing People Now: a new three year strategy for people with learning disabilities (2009) identifies four groups of adults with learning disabilities who are often excluded from community services:

• people with complex needs
• people from black and minority ethnic groups and newly arrived communities
• people on the autistic spectrum; and
• offenders in custody and the community.

Getting community services right’ for these groups will ensure that all adults with learning disabilities can access person centred services at a time, in a place, and in a way chosen by them.

Community Learning Disability services should be founded on the principles enshrined in Valuing People and re-affirmed in Valuing People Now that embraces ‘Rights, Independent Living, Control and Inclusion’, with services delivered in a person-centred way with access to mainstream services, including mainstream health services, wherever possible. Services should also subscribe to the key objectives of Putting People First26 and High Quality Care for All27 which include choice and control, personalisation, health and well-being, prevention, early intervention, enablement, and delivering services as locally as possible. There is a significant focus on meeting the needs of people with challenging behaviour and this has taken its direction from the “Mansell report”28

**Adults with an Autistic Spectrum Condition**

The indication from recent studies is that the figures for adults with autism in the United Kingdom cannot be precisely fixed, but it appears that a prevalence rate of around 1 in 100 is a best estimate of the prevalence in children. No prevalence studies have ever been carried out on adults.

Estimates of the proportion of people with autism spectrum disorders (ASD) who have a learning disability, (IQ less than 70) vary considerably, and it is not possible to give an accurate figure. It is likely that over 50% of those with

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26 Putting People First – DH Dec 2007
27 High Quality Care for all – DH 2008
ASD have an IQ in the average to high range, and a proportion of these will be very able intellectually. Some very able people with ASD may never come to the attention of services as having special needs, because they have learned strategies to overcome any difficulties with communication and social interaction.\textsuperscript{29}

**Knowsley Picture**

Currently in Knowsley from the numbers of adults (aged over 18) with a learning disability known to health and wellbeing services; 228 people have been identified as having an Autism Spectrum Disorder (ASD) and 119 people have both Autism Spectrum Disorder and ‘Challenging Behaviour’.

The National Audit Office study highlighted the uncertainty about the prevalence of autism. The National Autism Society have indicated that our local desktop assessment of adults with learning disabilities indicating a prevalence of 34% of adults with learning disabilities is broadly representative. The local study did not identify people with high functioning autism which would not be identified through learning disability services.\textsuperscript{30}

**Adults with an Autistic Spectrum Condition**

The above profile was secured via a first phase desk top exercise which included adults diagnosed with autism as well adults defined as displaying autistic traits. It is envisaged that during a second phase of profiling these figures may change as individuals and their families will have the opportunity to ‘self define’ whether a clinical diagnosis was actually secured, or judgements were made by other professionals/workers. The establishment of the Autism Service Development Group (ASDG) and representation from carers and people with Autism will assist in this goal and in delivering the Autism Strategy locally through our Knowsley Delivery plan.

The adult services ASDG is working to link closely and learn from the work in children’s services where a multi-disciplinary approach to diagnosis has been adopted. The increase in diagnosis of Autism via the children’s pathway should also in future lead to a more informed picture as young people with a clear diagnosis become adults.

**Equality and Diversity**

Recent reports have highlighted evidence that people with learning disabilities have higher levels of unmet need and receive less effective treatment, despite legislation that explicitly sets out a legal framework for the delivery of equal treatment (Disability Rights Commission 2006 and 2007, Mencap 2007, Michael 2008)

\textsuperscript{29} National Autistic Society, Statistics - How many people have autistic spectrum disorders (May 2007)

\textsuperscript{30} Supporting People with Autism through Adulthood, National Audit Office 2009
There is an increase in the number of people with a learning disability that may be explained by\textsuperscript{31}:

- increased life expectancy, especially among people with Down’s syndrome
- growing numbers of children and young people with complex and multiple disabilities who now survive into adulthood
- a sharp rise in the reported numbers of school age children with autistic spectrum disorders, some of whom will have learning disabilities
- greater prevalence among some minority ethnic populations of South Asian origin

**Adults with Complex Needs**

The label `challenging behaviour' is used to describe a range of behaviours that an individual may display. Further information is still required in relation to the cause of `challenging behaviour' which can often be as a result of environmental factors as well as a diagnosed condition. It is anticipated that detailed self-directed support and health action planning will assist to evidence the cause of `challenging behaviour' and inform future interventions and commissioning arrangements in Knowsley for groups including:

- adults with complex health needs, e.g. requiring assistive technology and or specialist health interventions
- adults who display complex behaviours
- adults with a sensory impairment
- adults with a mental health issue
- adults who are at risk of or have offended

**Offenders in Custody and the Community**

There is limited information available in relation to how many offenders with a learning disability are currently in custody or live in Knowsley. Anecdotally, the specialist community core team work with individuals who are already known to services, are referred from youth offending services, and or diversionary panels. Understanding the size and specific needs of this group is a key area for development for Knowsley.

**People from Black and Minority Ethnic Groups and Newly Arrived Communities**

Currently there are only 4 adults with a learning disability who are defined as ‘from black and minority ethnic groups and newly arrived communities’ known to services. This figure is reflective of the non-learning disabled population accessing services across Knowsley. It is envisaged that embedding a more person centred approach within services will encourage greater take up of services from black and minority ethnic groups and newly arrived communities.

\textsuperscript{31} Valuing People DH 2001
Links to Other Issues / Topics

Housing

Valuing People Now and our local TCS pathway build on existing programmes including Supporting People to increase the housing options available to people with learning disabilities. Many people with learning disabilities do not choose where they live or with whom. More than half live with their families, and most of the remainder live in residential care. Nationally and locally work needs to be undertaken to ensure that mainstream housing policies are inclusive of people with learning disabilities.

Work, Education and Getting a Life

People with learning disabilities want to lead ordinary lives and do the things that most people take for granted. They want to study at college, get a job, have relationships and friendships and enjoy leisure and social activities. Using the measurement criteria for PSA 16, currently in Knowsley less than 2% of people with learning disabilities are in employment.

Work needs to continue locally to improve transition arrangements across children’s health and social care, including consolidating person centred approaches for people with learning disabilities and embedding transition reviews for people with learning disabilities in both special education and mainstream schools.

Relationships and having a Family

The Valuing People Now Strategy and Knowsley’s TCS pathway emphasises the importance of enabling people with learning disabilities to meet new people, form all kinds of relationships, and to lead a fulfilling life with access to a diverse range of social and leisure activities. It also emphasises their right to become parents and the need for adequate support to sustain the family unit. There is evidence that people with learning disabilities have limited opportunities to build and maintain social networks and friendships.

Links to Existing Strategies (incl. Policies / Services)

The following strategies and policies are concerned with addressing the needs of people with learning disabilities:

- Bradley Report - The report, written by the Rt Hon Lord Bradley, makes recommendations to Government to improve the treatment of people with mental health problems and learning disabilities who are involved in the criminal justice system.
- Valuing Employment Now – radical increase in the number of people with moderate and severe learning disabilities getting employment
- Valuing People Now & PSA 16 Housing Delivery Plan (2010-11) - The delivery plan is supported by the Socially Excluded Adults Public Service Agreement target (PSA 16 target) that aims to increase the proportion of
adults with moderate to severe learning difficulties in settled accommodation

- Inclusion Health – Cabinet Office 2010
- Improving the life chances of Disable People – DH 2005
- Our Health, Our Care, Our Say – DH 2006
- Health and Social Care Act – 2008
- Disability Discrimination Act - 2005
- Human rights Act - 1998
- Valuing People Now
- CQC strategic plan 2010-2015 – position statement and action plan for learning disability
- National Framework for NHS Continuing Healthcare
- Mental Capacity Act 2005
- Mental Health Act 2009
- Autism Act 2009
- Autism Strategy – Fulfilling and Rewarding Lives
- Aiming High for Disabled Children
- Transforming Community Services
- Transforming Social Care
- Transforming Community Equipment

Future Implications (Modelling / Projections)

In 2004, a research paper from the Institute for Health Research at Lancaster university estimated that there were 985,000 people with learning disabilities, including 190,000 aged under 20, 127,000 aged 65 or over, and 795,000 adults (defined as over 20 and under 65) of these, 224,000 were people in England known to social services. The remaining 761,000 people had mild to moderate learning disabilities, may not be known to services, and may not need very much additional support beyond their own families, friends and social networks. However, without information about and access to a range of mainstream services, and help at points of crisis, their needs may escalate to the point where their support networks break down. Emerson and Hatton also estimated that the total number of adults with a learning disability (aged 20 or over) will increase by 8% to 868,000 in 2011 and by 14% to 908,000 by 2021. Significantly all the growth projection shows much higher increases in the number of adults aged over 60.

In 2009, a project was undertaken to estimate change in the future numbers of adults with profound multiple learning disabilities (PMLD) in England over the period 2009 to 2026. The data and assumptions suggested sustained and accelerating growth in the numbers of adults with PMLD in England over the time period 2009-2026 (and hence the need and demand for health and social care services for adults with PMLD), with an average annual

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33 Estimating Future Numbers of Adults with Profound Multiple Learning Disabilities in England (DH 2009)
percentage increase of 1.8%. The rate of increase grows markedly toward the latter end of the forecast period due to increases in birth rates in the general population.

The good practice guidance ‘Commissioning specialist adult learning disability health services’ identified significantly increased numbers of people with learning disabilities, partly caused by people living substantially longer as a result of medical and technological advances – and thus people needing additional support around illnesses linked to old age, in particular dementia and people with Downs Syndrome.

Significant changes in the demographic profile with increased numbers of people with complex needs requiring input from specialist health professionals. This particularly applies to young people with multiple disabilities and, together with the above point, will require commissioners to consider levels of investment in both mainstream and specialist health services.

In 2009 – 2010 the overall budget for services for adults with learning disabilities across health and social care was £22,640,782.00. With reduced resource available over the next 5 to 15 years then commissioning strategies and priorities must reflect the need to develop targeted approaches to early intervention models and personalised support that has less focus on residential accommodation and crisis intervention.

Evidence of What Works

The Learning Disability Local Enhanced Service (LES) promotes partnership working between specialist learning disability nurses, primary care clinicians and health and social care providers by developing the skills and competencies of primary care and other key staff to work with people with learning disabilities to ensure equal access to services and to improve their health outcomes. A Directed Enhanced Service (DES) has been operational from April 2009.

- In December 2007 the DOH guidance: ‘Good practice in learning disability nursing’ cited the learning disability (LES) in Knowsley as a good practice example.
- In February 2008 the Chief Nursing Officer for the NHS further commended this work in the DOH CNO Bulletin.

A recent National Audit Office report ‘Supporting people with Autism through Adulthood’ found:

- Existing services for people with ASC could be improved by better strategy and planning, based on good information and raising levels of knowledge

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34 Commissioning specialist adult learning disability health services - Good practice guidance (DH 2007)
35 Supporting People with Autism through Adulthood, National Audit Office 2009
and awareness of the nature of Autism and the potential needs of autistic people.

- There is scope for better targeted support for people with high functioning autism/Asperger’s Syndrome.

Gaps

- A lack of comprehensive community services for people with complex needs
  - No clear pathway to diagnosis for people with ASD
- A lack of involvement of people with learning disabilities and family carers.
- Very few people got annual health checks from their doctor.
- People and their family carers had bad experiences of services while they were in general hospital.\(^{36}\)
- Data on ethnicity, severity of learning disability and clinical diagnoses uniformly is incomplete, and is not uniformly captured. Only 1 in 5 (20.8%) had a record of the severity of their learning disability specified during the last assessment
- Difficulties in getting a diagnosis for people with higher functioning ASC when were in childhood or more latterly in adulthood
- Poor understanding of the needs of adults with ASC in hospitals
- No point of contact to navigate through services
- Insufficient choice of services with capacity to respond to the needs of people with ASC
- Insufficient employment services with ability to respond to the needs if people with ASC

Knowsley has a range of service providers delivering support to adults with learning disabilities with additional complex needs including autistic spectrum conditions. However, Knowsley has no local specialist ASC services.

Recommendations for Commissioners

Service Issues

Commissioning of services for adults with LD and ASC will be based on:

- Person centred commissioning
- Personal control of individual budgets
- Advance planning of the service to ensure structure and predictability is inherent in the service environment where the person will live and work
- Access to settled accommodation
- Access to employment
- Comprehensive support from community services
- Well trained and competent workforce
- Access to advocacy
- Communication Standards

\(^{36}\) Care Quality Commission – Strategic plan 2010-2015 for learning disability 2009
Comprehensive community based services will be developed in partnership with children and young people’s services that enable people with more complex needs to be effectively supported in the community. Reduction of inpatient services should be begun by 2012

- Reduction of out of borough placements by 10% by 2013

Information, awareness raising and training needed on ASC for families, service providers, health and social care workforce. Training should involve people with ASC and their families

- A workforce development plan to be agreed by 2011

The Autism Development Group will develop a local delivery plan for communicating and engaging with the local population of people with ASC and agree local priorities for service improvement by December 2010

The Autism development Group will undertake a baseline assessment by 2011 to determine whether there is a need to further develop mainstream services to meet the needs of this population group or the develop specialised ASC service in Knowsley.

The key priorities of the TSC pathway for Learning Disabilities and Autism will be implemented and monitored by the Strategy Implementation Group

**Data / Intelligence Requirements**

Work is needed with Public Health to develop a more robust approach to collating the population and health needs of adults with autism spectrum conditions

GP practices are now expected to record the severity of learning disabilities as part of their Directly Enhanced Service requirements. It would of great advantage if information gathered across primary care services could be used to aid with demographic information

Recording of clinical diagnosis is incomplete in many cases. This reflects the difficulty that may arise in finding the appropriate medical diagnosis in these groups of patients. Correctly identifying the diagnosis is very useful in planning for services for PWLD and if possible this should be made available.
3.4 WIDER DETERMINANTS OF HEALTH

3.4.1 CHILD AND FAMILY POVERTY

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**Key Needs**

- In Knowsley, 58% of children and young people live in poverty, the second highest of the Merseyside boroughs (with Liverpool at 60%) and greater than the averages for the North West (46%) and England (40%).
- Children in disadvantaged families are three times as likely to suffer mental health disorders.
- Lack of money and access to a car (only 56% of households in the most disadvantaged areas of Knowsley) means that parents are shopping for less healthy food options in certain shops.
- By age 3, being in poverty makes a difference equivalent to nine months development in school readiness.
- Just under 13% of working age people claim Incapacity Benefits/Employment support Allowance (12,470 people) compared with 6.7% nationally; with over 80% of all Incapacity Benefits claimants claiming for 2 years or more.

**Description of Where / Who the Issue Affects**

Children in households receiving less than 60% of median income are defined as living in poverty. The previous Government was committed to halving the level of child poverty by 2010 and eradicating it by 2020. The Child Poverty Act received Royal Assent on the 25 March 2010.

The Conservative – Liberal Democrat Coalition has pledged to maintain the goal to end child poverty by 2020 and retain the Part 2 duties for local authorities. However the Coalition Government will not issue formal statutory guidance on Part 2 of the Act or lay regulations for local child poverty needs assessments, this means local areas have more flexibility to decide how best to respond to the Child Poverty Act based on local strengths and priorities. The Coalition Government’s approach to tackling child and family poverty is still emerging, however the view of senior politicians remains that for many work is the best route out of poverty.
Locally, The Knowsley Partnership has committed to reducing child poverty in the Borough. Recognising that poverty is about more than income, the local approach will also seek to address the poorer outcomes, which characterise the lives of children living in poverty. These include health inequalities and lower school attainment.

Children in workless lone parent families have a 56% risk of poverty. Knowsley has twice the national average of lone parents (4.5% compared with 2.2%), concentrated mainly in North Huyton (7.4%) and North and South Kirkby (5.7% and 5.9% respectively). Children in families where there is one or more disabled adult are also more at risk of poverty.

Low pay is another major cause of poverty. It is thought that about half of children defined as living in poverty are in households where at least one person works, although this may not be full time.

Equality and Diversity

The recent review on Health Inequalities ‘A Fair Society and Healthy Lives’ also known as the ‘Marmot Review (2010)’ confirms that although there have been substantial improvements in life expectancy and infant mortality across all socio-economic groups, the gap remains between the poorest and richest children and families. The report suggests that much of the work around health inequalities has focused too narrowly on addressing inequalities in mortality and that greater resources should be redirected to upstream interventions that would prevent the onset of medical problems. The review calls for increased investment in early years and co-orientated action across all the social determinants of health including education and skills, housing and employment.

In Knowsley, where a small proportion of the population are in BME groups (around 2.5%), there is no evidence that they are more likely to experience low or poverty-level incomes or higher levels of worklessness than any other group. Anecdotal evidence suggests the contrary – many in the local Asian community are known to be employed in the medical professions, for example. Even in thriving BME families, cultural factors – diet, for example - may still have an impact on general child wellbeing. These issues require greater study before inclusion in the assessment.

Links to Other Issues / Topics

Children who grow up in poverty are more likely to lack the skills and qualifications they need to access higher paid jobs; increasing the risk their own children will also live in poverty. Knowsley Local Strategic Partnership has identified the importance of improving life chances if the cycle is to be broken.

Most children in poverty experience it as a persistent condition. Nationally, more than two-thirds of those below the threshold have been in poverty for at
least three out of four years. Locally, 70.6% of workless households with children have claimed the benefits for over 3 years.

National analysis shows that 50% of children living in poverty are in families where at least one person is working. This suggests a need for improved adult skills and continued training of employees to allow progression to better paid work.

There is a direct correlation between areas of the borough with high rates of children living in poverty and poor health outcomes for children such as low breastfeeding rates and low immunisation uptake.

**Links to Existing Strategies (incl. Policies / Services)**

The requirement for Local Authorities to produce a child poverty needs assessment was introduced by the Child Poverty Act (2010). KMBC and LCR partners took the decision to broaden the assessment to cover ‘child and family’ poverty in acknowledgment that poverty impacts on entire families.

The Child Poverty Act received Royal Assent on the 25 March 2010. This was a landmark occasion for the child poverty agenda as it enshrined in law the Government’s commitment to eradicating child poverty by 2020. The Act also has important implications for the way in which local authorities are required to address child poverty.

**Main requirements of the Act for Local Authorities**

Part 2 of the Act places a number of duties on local authorities and other local delivery partners to work together to tackle child poverty, specific duties include:

**Local Child Poverty Needs Assessment** - Local Authorities must make arrangements to prepare, publish and keep under review a local child poverty needs assessment.

**Joint Child Poverty Strategy** - Local joint child poverty strategies must be developed to set out the measures partners propose to take for the purpose of reducing and mitigating the effects of child poverty.

**Co-operation to reduce Child Poverty** - Promotes cooperation between local partners with a view to mitigating the effects of child poverty. Local Authorities can provide staff, goods, services, accommodation or other resources, or the creation of a pooled fund amongst partners, to ensure the requirements of the act are met.

**Sustainable Community Strategy** – The Act also requires responsible local authorities to take their responsibilities to tackle child poverty into account when preparing or revising their Sustainable Community Strategy.
To respond to the Child Poverty Act based on local strengths and priorities the following strategies are in place:

- Knowsley sustainable Communities Strategy 2008-2023
- Children and Young People’s plan 2008 – 2011

**Future Implications (Modelling / Projections)**

Continued high levels of child poverty have implications for future health and wellbeing. Babies born into poverty are more likely to be premature, have a low birth weight or die in the first year of their life. Other health outcomes include links to obesity, child tooth decay and reduced resistance to respiratory infection. Joseph Rowntree Foundation estimates that nationally, 1,400 children’s lives could be saved annually if child poverty was eradicated.

Over 1 in 5 children from families where the parents have never worked are likely to develop a mental health disorder, compared to 1 in 20 children from a professional background. Children in poverty are also more likely to be victims of crime.

The average weekly wage for Knowsley residents is £362. This is below the rest of Merseyside, the North West and England. Yet Knowsley workplace earnings average £426, the highest compared to all other Merseyside boroughs and the North West average. Analysis shows that Knowsley imports more workers into higher paid and senior positions than residents occupy outside the borough.

While Knowsley has significantly closed the gap between itself, and the North West and England averages for 5 GCSE grades A*-C, attainment remains lower. Tackling child poverty through access to well-paid work will require continued improvement in the number achieving good qualifications at 16.

**Evidence of What Works**

**National**

The Coalition Government is keen to encourage families with children below the poverty line to enter and sustain employment because worklessness and low pay are the biggest causes of poverty. A child in a family where no-one works has a 58% chance of living in poverty – this is reduced to 14% when one or both parents work.

**Local**

A number of positive trends demonstrate that some of the key local issues which contribute to keeping Knowsley’s children in poverty are being tackled. Since 1999/2000 there has been an increase of 14,200 in the number of working age residents who work. Knowsley’s employment rate has also risen and is closing the gap on the national rate. Figures suggest more Knowsley
residents are actively seeking work, with a 17.85 decrease in those described as economically inactive since 1999/2000. The number of residents with no qualifications has reduced by 7.3% in the same period.

A number of key and recurrent themes are merging; many of them reinforce the view that the causes and consequences of child poverty are broader than household income. They are frequently complex, interrelated and have a major impact on a parent’s ability to enter the labour market. They also have an impact on children’s experience of parenting, and can comprise development.

**Gaps**

While information is available from the various Government statistical sites, this has tended to suffer from time delays and pose comparison difficulties as the information is rarely ‘like for like’. Knowsley was involved in national work to develop a child poverty toolkit to address this. The toolkit collates all relevant documentation on one website and provides up to date material as soon as it is published. This enables Knowsley to track the local trends in child poverty.

Knowsley MBC has embraced the challenge to eradicate Child Poverty by developing a Child Poverty Programme approach. In 2009 Knowsley MBC and partners decided to take an innovative approach to the issue of tackling Child Poverty and secured funding for a variety of two year projects which will work at reducing Child Poverty. These projects sit within the Child Poverty Programme which drives forward the strategic direction of the Child Poverty Programme Board.

In this economic climate it is essential that efforts are maintained to limit the inter-generational impact of poverty. While the Local Authority may place an immediate focus on meeting the economic needs of families, efforts through the child poverty programme will ensure that there is an integrated approach which also addresses the broader determinants of family life that supports children’s healthy development and their ability to realise their full potential.

**Recommendations for Commissioners**

- Ensure that progress against the child poverty target is measured locally and that those who are most at risk are supported appropriately.
- Ensure that all local partners and stakeholders understand and become committed to tackling child poverty in Knowsley.
- Continue and build on Knowsley’s early intervention/prevention approach based on supporting families.
3.4.2 CRIME

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Key Needs

The 6 following key needs summarise some of the key issues when looking at the wider determinants of health from the perspective of crime & disorder through the Safer Knowsley Partnership (SKP). The list is to compliment the range of products already provided to the JSNA team covering a range of themes.

The 6 key needs are (in no particular order):

- **Perceptions of crime & disorder in Knowsley** – what are the perceptions of crime in Knowsley relating to satisfaction and feelings of safety and is there any variation between different communities?
- **The distribution of crime & disorder in Knowsley** – which are the key locations for all crime or specific types of crime in Knowsley and has this pattern changed over recent years as recorded crime falls?
- **Becoming a victim of crime and in particular specific types of crime (offences and repeat victimisation)** – crimes such as violent crime (domestic abuse, hate crime and personal violence) and personal theft crime such as burglary can influence health & wellbeing
- **Anti-Social Behaviour in Knowsley** – levels of repeat victimisation in our communities against some of the most vulnerable potentially. Is there geography to long-term ASB in Knowsley?
- **The impact of substance misuse in Knowsley** – covered mainly in the substance misuse needs assessment which is a specific section in the JSNA
- **The impact on individual health if ‘you’ are an offender** – looking at the issue from a different perspective and the impact of offender health on that specific cohort.

Description of Where / Who the Issue Affects

The Safer Knowsley Partnership (SKP) has a remit to reduce the impact of crime and disorder in the borough. This task has two specific elements though – reducing the levels of crime but also the perceptions of crime. The current political landscape may also see a shift away from the formal performance landscape of National Indicators (NIs) to addressing locally determined priorities and issues and the perceptions of our communities. This is
especially important in areas such as Knowsley which have experienced in recent years significant reductions in recorded crime levels yet like other research shows (such as the annual British Crime Survey) the perceptions of crime have not fallen at the same rate.

In Knowsley we have developed a ‘Safe, Clean, Green’ (SCG) ‘Tracker Perception Survey’ which is undertaken on a quarterly basis across each of the 6 Area Partnership Boards (APBs). The survey looks at a range of key issues, including perceptions of Anti-Social Behaviour (ASB), specific crime types such as burglary and vehicle crime, satisfaction with the cleanliness of our parks, streets and shopping centres, satisfaction with council and partner services and whether or not the Partnership itself is communicating with residents to tackle their fears and perceptions.

The survey has now run for just over a year with some interesting results. At a borough level it shows key perception priorities, such as tackling ‘youth disorder’, ensuring parents take responsibility for their children actions, tackling fears around drug misuse and ensuring the Partnership continues to communicate effectively with residents. It has though highlighted some real positives as well especially over people’s satisfaction with the area and services they receive and in some cases has shown that our own perception of what is important to residents may not be always accurate. There is though a geographic pattern to this and we are using newly developed ‘Problem Solving Groups’ (PSGs) to tackle these perceptions at an APB level so the perception priorities in North Huyton are different to those in Halewood and we have a forum now for tackling those at a real localised level.

Recorded crime is falling in Knowsley. Over the last full financial year recorded crime fell in Knowsley by 10%. The reductions over a longer period of time are more significant (over 20%) and a similar reduction has also been achieved for ASB and certain types of specific crimes.

Yet the distribution of this crime, at a Partnership board level, has not changed or altered significantly over this period. Places such as North Huyton, despite them at a local level experiencing reductions in crime, still account for around 25% of all crime and Police recorded ASB incidents. Areas such as South Kirkby and PWCKV then usually follow in terms of percentage cut and again this pattern has remained consistent followed by South Huyton, North Kirkby and Halewood. The key strategic locations remain the same for Knowsley and the long-term impact of crime on these communities & residents will naturally include a health aspect. Again the PSGs are now tasked with tackling these long-term issues and threats.

The distribution of crime is not an even one – certain communities experience a higher level of crimes than others as the information above has shown. Yet within our communities there are certain victims who are more vulnerable than others. National research has shown that repeat victimisation levels for certain types of crime, such as Domestic Abuse, Hate Crime, Bogus or Distraction burglary and Criminal Damage are higher than other offences and we have in
Knowsley schemes such as the Domestic Abuse and Hate MARAC (Multi Agency Risk Assessment Conference)

The impact of Anti-Social Behaviour (ASB) can be significant, both on the communities who suffer it (for example recorded ASB through the Police has fallen by over 30% in recent years yet areas such as Page Moss in North Huyton, Westvale in South Kirkby and Northwood in North Kirkby still account for a higher proportion than other communities) but also on vulnerable victims and adults (as highlighted by some research at a national level by NACRO that highlighted the increase level of risk and victimisation). Recent high profile cases of vulnerable victims have shown the importance of highlighting vulnerable victims but from a range of agencies perspective.

The previous sections have highlighted some of the clear links between crime and health in particular becoming a victim of crime through direct involvement such as being a victim of a violent offence, suffering a bogus burglary, becoming a victim of domestic abuse or by having increased fear and stress due to victimisation or having a fear of becoming a victim of crime.

There is also the direct impact of substance misuse which is focused more on the offender aspect of crime & disorder (though it can’t be forgotten that there are potential victims of crime through individuals having addictions to drugs and alcohol). One of the main impacts on the wider health perspective in Knowsley is the problem of Substance Misuse. Substance misuse clients are supported across the borough but the majority of “Drug Misusing Offenders” are clients of the Knowsley Drug Intervention Programme (DIP).

Analysis of this particular cohort shows that the majority of the clients come from the North Huyton area, with the main problematic class A drug in the borough being Cocaine. (Cannabis is by far the most prevalent drug in the borough). More targeted substance misuse data will become available in 2010 to enable us to look in more detail at the cohort in Knowsley. This should also be coupled with the work around alcohol misuse particularly by the ASK (Alcohol Services Knowsley) Team.

Equality & Diversity

Crime can target and focus on some of the more vulnerable groups/communities and as the previous section has shown there are some key groups that are a priority for the Safer Knowsley Partnership and they should also be the focus when looking at the health of the borough as well.

Repeat victimisation around domestic abuse, hate crime, ASB and criminal damage are areas that can have a major impact on the personal safety and health of individuals. Research for Domestic Abuse has shown nationally one in four women and one in six men suffer some form of domestic abuse (which can be violent, emotional or financial abuse) and the levels of reporting are known to be historically low as often for each incident there can be 35 other incidents that go unreported. Offences such as bogus burglary, which are low
in Knowsley but have a significant impact, often target elderly and vulnerable victims in our communities.

Repeat victimisation though can also have an impact on the wider community. Research has shown that a number of factors influence satisfaction with people’s local area and crime & disorder can link to this. Crime is reducing in Knowsley yet certain patterns as highlighted in the previous section remain – what is the long term impact on health, of both individuals and communities, of living in such communities?

Tackling the perceptions of crime is a priority and there is a clear impact to the health agenda in terms of people’s fears and experiences that can have a direct impact on the individual. Our tracker survey has highlighted that perceptions vary across the borough and national data, such as the ACORN community profiling system, has shown that those in more deprived communities (classified by ACORN as ‘Hard Pressed’) experience a higher fear and perception of crime as well higher levels of reported crime. ACORN though is a community profiling tool and these ‘hard pressed’ communities are often also those with poorer health levels. Within Knowsley the spread of these ‘Hard pressed’ communities is like the distribution of crime – uneven with areas such as North Huyton and Kirkby having higher levels than Halewood and Prescot (though pockets of these communities do appear across the borough).

A key challenge in some areas of crime & disorder is tackling underreporting. This is especially true for offences such as Domestic Abuse and Hate crime which are underreported and also have a direct link into the health of the individual given the severity and repeat victimisation levels of this offence.

**Links to Other Issues / Topics**

Evidence has shown that the key localities for thematic partnerships are the same. For example work such as the Stockbridge Village project showed this location was a key area for serious crime and offenders but that location was a key location for educational attainment, poorer health levels and increased deprivation. Other analysis such as the Index of Multiple Deprivation (IMD) or the Vulnerable Localities Index (VLI) which uses a range of datasets often point to the similar locations as ‘stand-alone’ analysis on a crime issue.

So addressing the issues is often best done from a range of perspectives and the below summaries some of the key issues and projects.

Community Cohesion is a priority issue for the authority and has links in to every strategic partnership. The link between Community Cohesion (CC) and the SKP is a clear and obvious one – the issues of hate crime have a clear link to the issues of cohesion but tackling the varying perceptions of crime & disorder, tackling ASB and also the poor perceptions of young people (intergenerational work) and the uneven distribution of crime are also key aims for this work from a crime & disorder perspective.
Links to Existing Strategies (incl. Policies / Services)

- Links to the development of a reducing re-offending strategy which will be produced over the next few months which will look to bring together the range of strategies around reducing re-offending. One particular aspect will be around ‘pathways’ including accommodation, health and substance misuse for offenders.
- Development of a ‘recovery based model’ within the drug treatment service
- Links to wider corporate ‘behavioural change’ strategy to tackle issues around ASB for example
- The above will have strong links to the Community Cohesion work to look at how groups behave within communities to lessen the impact of crime & disorder

Future Implications (Modelling / Projections)

The impact of shifting trends and patterns can have a major impact on service planning and service delivery.

Over the last few years the Safer Knowsley Partnership (SKP) has achieved some significant reductions in recorded crime yet can this reduction be sustained over the longer term? The latest projection data from iQuanta shows that all crime is projected to continue to decrease over the short & medium term yet over the longer term can the reductions achieved (for some crime offences reductions of 30% over the last 3 years have occurred).

There are a large number of influences that can have an impact on crime levels both at a national and local level. The population projections for UK and Knowsley may this influence crime patterns in the future (e.g. vulnerable people) and this information from the Corporate centre will influence these discussions.

One of the major discussion points around the impact of the recession is the potential effect on crime levels with many observers making the simple link between poorer economic times and increased crime levels. Currently in Knowsley the true impact of the recession is not fully known. The impact in terms of some headline crime & disorder figures has not yet been seen in Knowsley (see recent reductions in crimes such as burglary or vehicle crime) and there is varying evidence to show the impact on crime anyway. Could the impact of the recession in communities such as Knowsley (deprived communities – from the recent IMD Knowsley is ranked the 5th most deprived borough nationally) be a longer-term one which could have a broad range of impacts in terms of crime.

April 2010 saw a general election in the UK and the new coalition government are now beginning to review the landscape around the public sector and in the light of the financial deficit the impact of budget cuts on key services must be factored into future service delivery and planning. There are also signs of new policy shifts and directions, such as the ‘Big Society’ but also a range of other
discussions, especially around the welfare state, that may have an impact in future years. Some of the other policy implications are in the following areas:

- Review of licensing legislation and potential impact of schemes such as minimum pricing for alcohol
- Ensuring hospitals share data over the impact of alcohol admissions
- Review of ASB legislation and powers
- Review of Home Office and the relationship between central and local government

The further spending review, due in October 2010, will provide further guidance into the specific areas of budget cuts and review.

**Evidence of What Works**

Tackling our priorities and key issues over the next few years (given the potential for budget cuts) may become harder and harder. Understanding what works is therefore crucial so the resources available are targeted in the right areas in the right way and that we are able to identify our key priorities from a whole range of issues.

Within a crime & disorder landscape there has over the last few years been a number of guidance documents issued centrally to assist Community Safety Partnerships (CSPs). In Knowsley we have always worked to these and in fact beyond these which has been recognised in a number of key projects.

A previous section highlighted how certain crime types and certain communities experience patterns that are strategic and historic. Adopting a relentless approach in terms of tackling crime & disorder throughout the communities of Knowsley is a key principle of the SKP – recorded crime has reduced in Knowsley over the last few years significantly and the Safer Knowsley Partnership has achieved some significant reductions in terms of reducing violent crime, domestic burglary, vehicle crime and criminal damage. Identifying key locations and maintaining them as key locations is a significant factor in this.

The Hallmarks of Partnership working have helped us in this task. Having a range of in-depth analytical products supported by a multi-agency business approach to Partnership working has helped develop new and innovative projects and methods of looking at problems. Examples of this include the Multi Agency Approach to problem solving for the issues of Hate Crime, Domestic Abuse and Gun Crime which have had good success in recent years as information is shared effectively and the solution goes beyond ‘simple enforcement’. The Anti-Social Behaviour Unit (ASBU) is another good example of this with the team co-located with colleagues from the Police, Offender Management team, probation and Fire Service in one office.

A new development for the SKP is the development of localised Problem Solving Groups (PSGs). Their remit is to tackle the ‘safe, clean and green’ agenda in each of the areas of Knowsley and address the medium to long
term strategic problems from a multi-agency perspective. There will be some links to the health agenda – for example if an area is addressing violent crime there is a natural link to the alcohol agenda and behavioural change.

Gaps

Although great links have been formed enabling us to gain better access to data around the main different aspects of health in Knowsley, there are still some areas that would benefit from greater data analysis including;

- **Identifying Locations of Substance Misuse Clients** – Although data has been accessed at a very basic postcode level, more identifiable data around the client group, enabling us not just to help the clients themselves but also to look at the wider implications on each community and support those communities.
- **Whiston Hospital Data** – Detailed A&E data around assaults should be available by late 2010 which will in turn allow for greater planning by the Partnership to target repeat problematic locations such as licensed premises which have a high rate of assaults.
- **Working with Service Providers** – As the Service Provider for Knowsley changed in 2009, links should be formed again with the intelligence team at Addaction to ensure that data is available to the SKP to ensure that more detailed analysis can be undertaken to help the most vulnerable.
- **Identification of Vulnerable groups** – Anti Social Behaviour can be analysed through the main source of information which is recorded Police data. There is though a push towards identifying “vulnerable victims” which can be done through this method yet are we able to map out those who are vulnerable in communities. These may be groups or people not calling the Police to report ASB so there is a need to identify groups such as the elderly, those with mental health problems and others deemed vulnerable by other partner agencies.

Recommendations for Commissioners

The majority of recommendations will come from the identified gaps as shown on the previous page, including;

- **Greater Access to Identifiable Data around Alcohol and Drug Misusing Clients** – Enabling the SKP to help not only offenders but also the communities in which they live.
- **A&E Data** – Showing the areas in which Alcohol can blight communities and identifying licensed premises and areas that could benefit from greater awareness of the health/C&D impacts of Substance Misuse. The TIIG group’s work with Whiston Hospital to improve this data should be a key aim for 2010/2011.
- **Impacts of the Coalition Government** – To ensure that that, whatever changes are made either politically or financially, that the needs of the clients in Knowsley are met.
3.4.3 EDUCATIONAL ATTENDANCE & ATTAINMENT

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Key Needs

- Attainment levels have risen sharply over the last three years with headline rates of achievement at Foundation Stage and Key Stage 2 now matching or exceeding national figures and those for comparator boroughs. Results at Key Stage 4 have also risen and all secondary schools now exceed the 30% threshold for achievement of 5 good GCSEs including English and mathematics. However rising expectations present further challenges such as the English Baccalaureate.
- Attendance issues have also improved significantly with a specific focus on rates of persistent absence and permanent exclusion.
- Attendance and attainment continue to be major priorities for The Knowsley Partnership’s programme to implement the Sustainable Community Strategy.

Description of Where / Who the Issue Affects

National research demonstrates strong links between attendance and attainment and a wide range of mental and physical health issues including resilience, obesity, teenage pregnancy and misuse of tobacco, alcohol and other substances.

The local evidence does not wholly match this picture, showing low levels of bullying and relatively good emotional health. However underachievement is a major contributing factor in the depth and concentration of deprivation, poverty, reduced aspirations and low levels of economic activity seen across the Borough. These factors are exacerbated by the tendency for higher achievers in primary schools to move to secondary schools outside the borough.

The impact is therefore inter-generational and nearly universal although there are pockets of relative affluence and these match areas with high levels of attainment.
Equality and Diversity

Again the national position can be contrasted with that locally. National figures show that boys do worse than girls, children eligible for free school meals, those with disabilities (Inc. special educational needs), having English as an additional language, having caring responsibilities or being (or having been) in the care of the local authority generally fare worse than their peers.

Evidence specific to Knowsley shows that the gaps in attainment associated with eligibility for free school meals are low compared to those found elsewhere – possibly because children eligible for free school meals are spread widely across the borough rather than being concentrated in small areas as is often the case in more affluent boroughs. Also the attainment gap between pupils with SEN and those without SEN is smaller in Knowsley than the national average at KS2 and KS4. Knowsley has relatively few BME pupils and small numbers of children looked after so that figures for these groups are not statistically significant.

Links to Other Issues / Topics

Educational achievement can be a determining factor on a number of key quality of life and wellbeing issues in adult life. Low educational attainment and attendance can have a negative impact on economic wellbeing, parenting, health, housing, levels of resilience and whether the child is currently leading a ‘good’ or ‘content’ childhood as well as risk taking behaviour and subsequent lifestyle choices. It will also affect the number of young people defined as NEET (Not in education, Employment or Training) and increase the risk of youth offending.

Links to Existing Strategies (incl. Policies / Services)

Due to the inter-related links between the JSNA and the Children and Young People’s Needs Assessment, the education and attainment information contained in this document provides only an overview of the attainment and attendance situation in Knowsley. For more specific information please see the Knowsley Children and Young People’s Needs Assessment.

Educational attainment and attendance also links to the following strategies:

- The Sustainable Community Strategy
- Children & Families Board policy framework
- Corporate Parenting Strategy
- Children Looked After Strategy
- Strategy for Inclusion

Future Implications (Modelling / Projections)

Trend rates of improvement in Key Stage 4 attainment are rising but are not yet closing the gap. However recent Key Stage 2 results are in line with those
achieved nationally providing a much better platform for further improvement at Key Stage 4.

Evidence of What Works

The improvements highlighted above are the result of a very high level of commitment on behalf of all partners supported by major national and local programmes. Recent changes in Government policy have resulted in a change of emphasis so that improvement funding now sits with schools who are developing an area-based model for in-sector improvement support.

Gaps

All schools have comprehensive pupil monitoring and performance management systems. Optional tests and assessments are undertaken by all schools in selected age groups. A more comprehensive approach is being developed in response to emerging Government policy but it is too early to assess the effectiveness of this or to identify any gaps.

Recommendations for Commissioners

All parties are recommended to coordinate activity through the policy framework being developed by the Children & Families Board which is now replacing the Children & Young People’s Partnership and Plan. This includes an Excellence & Equity thematic which will focus on attendance and attainment and the following cross-cutting priorities:

- To reduce child poverty
- Improve the outcomes for vulnerable groups/groups with additional needs, targeting children with disabilities and children at risk.
- Young people have the skills and opportunities to achieve in learning, life and work.
3.4.4 ECONOMY

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| Economic inactivity | The employment rate is currently 67.6% (October 2008-September 2009). North West (NW) and Great Britain (GB) employment rate are 70.3% and 72.9%.
| Worklessness rate \(^1\) for Knowsley is 24% (February 08 to November 2009). NW and GB Worklessness rate is 16.3% and 13.3%.
| Knowsley's Working age people on Out of work benefits (JSA, Incapacity benefits/Employment support allowance, Lone parent and Income support) is 24% (Quarter 3 of 2009). The NW and GB 16.2% and 12.7%.
| An enterprise gap | Business density for Knowsley is 369.41 per 10,000 population (2010). The NW and United Kingdom (UK) business density is 646.23 and 677.66.
| Self employment rates | Knowsley self-employed percentage is 7.2. NW and GB is 7.9% and 9.1%.
| Lower than average incomes | The average residents' weekly wage is £413.30. NW and GB average weekly wage is £460.20 and £491.00 (2009).
| High levels of deprivation | Knowsley is the 5th most deprived in the Country
| Knowsley ranks 2\(^{nd}\) on the IMD 2007 for local concentration, a ranking which is based on the number of localised hot spots of deprivation
| Knowsley has a dependence on the public sector | Public sector employment accounted for 32% of total employment in Knowsley in 2007\(^{1}\)  

Description of Where / Who the Issue Affects

Economic Inactivity

Knowsley's employment rate\(^{37}\) is currently 67.6% (October 2008-September 2009), which is the 2\(^{nd}\) lowest in the Liverpool City Region (LCR)\(^{38}\). However

\(^{37}\) Employment rate cannot be calculated below a Borough level.
Knowsley has seen a steady increase in its employment rate from January 2008. Knowsley’s employment rate is lower than the NW 70.3% and GB 72.9%. The gap between Knowsley and NW and GB is beginning to close because of Knowsley’s employment increasing and the NW and GB rate decreasing. In October 06 to September 07 the gap between the NW and GB was 6.4% and 8.7%, whereas now (October 08 to September 09) it is only 2.7% and 5.3%.

People who lack but want paid work divide into two broad groups, those who are

- Unemployed\(^\text{39}\) or
- Economically inactive\(^\text{40}\) but nevertheless want paid work

Knowsley has 6,400 unemployed (October 2008 to September 2009) which equates to an unemployment rate of 9.1% (of aged 16 and over), which is higher than the NW (8.3%) and GB (7.4%).

Knowsley has 24,400 (October 2008 to September 2009) economically inactive residents, which equates to 26.3% of Knowsley’s working age population. This is higher than the NW and GB percentage of 23.2% and 21.1%. Of Knowsley’s 24,400, 6,400 want paid work, whilst the remaining 18,000 do not or they are not available for work. The main reasons why people are not generally seeking work or are not available are long term sick or disabled, looking after family/home, students or retired.

Knowsley’s economical inactivity rate (26.3%) is higher than the NW and GB figure of 6.0% and 5.6%. There is a higher percentage of economically inactive (working age) females (28.8% October 2008 to September 2009) compared to economically inactive (working age) males (23.7%).

Knowsley’s Worklessness rate (working age people claiming out of work benefits divided by the resident working age population) 23.9% (February 09 to November 09), is the 2\(^{nd}\) highest in the LCR and is higher than the NW (16.4%. November 2009) and the GB (13.40%. November 2009). Knowsley has seen an increase in its Worklessness rate of 1.43% when you compare February 08/November 08 rate to the February 09/November 09 rate. However the NW and GB has seen a similar increase over the same period (NW +1.63% and GB +1.55%).

Northwood, Stockbridge, Kirkby Central, Page Moss and Longview are the top 5 wards in Knowsley who have the highest Worklessness count in February 2009 to November 2009.

\(^{38}\) Liverpool, St. Helens, Wirral, Sefton, Halton and Knowsley

\(^{39}\) The unemployment rate comprises all those with no paid work who were available to start work in the next fortnight and who either looked for work in the last month or were waiting to start a job already obtained.

\(^{40}\) Differs from unemployment because they are not able to start work immediately or because they are not actively seeking work. For example, Lone parents, sick or disabled, looking after a home or retired
“Employment is one of the most strongly evidenced determinants of health. People’s employment status and the nature of their work have a direct bearing on their physical and mental health and even their life expectancy. This is related to income, a sense of making a valuable contribution and increased social networks gained through work.”

High levels of absenteeism and low productivity because of poor health of employees restricts Economic growth and business sustainability.

**An Enterprise Gap**

The Liverpool City Region, NW and GB saw an overall increasing trend of **Business Density** from 2001 to 2009, but in 2010, the majority of geographies are saw a decrease.

In 2010 Knowsley is identified as having a business density rate of 0.67. The North West and Great Britain business density are 0.76 and 0.79.

The Jobs Density figures refer to the number of jobs per resident of working age (16-59/64). The figure gives a measure of the mismatch between the supply and demand for labour in an area. For example, a job density of 1.0 would mean that there is one job for every resident of working age.

Knowsley saw an increase in **business births** in 2009. (2008-360 births, 2009-385 births) and it also saw a decrease of **businesses deaths** (2008-265, 2009-250). Kirkby Central, Prescot West, Prescot East, St Bartholomews and St Gabriels saw the highest amount of business births across Knowsley (during 2009-2010).

Knowsley has seen an improvement in its **Self-employment rate**. During April 2007 to March 2008 Knowsley had a self-employment rate of 5.7%, which was the lowest of the LCR. Its rate for the period October 08 to September 09 is 7.2% which is the 2nd highest in the LCR. The NW and GB rate has stayed fairly static so the gap between Knowsley and the NW (7.9% October 08 to September 09) and GB (9.1% October 08 to September 09) has closed.

The Knowsley self-employment rate gender split (Male 11.1% and Female 3.4%) mirrors the NW (NW = Male 11.6% Female 3.9%) and GB (Male 12.7% Female 5.2%) gender split.

A low Business Density provides a higher supply compared to labour demand. This would restrict employment opportunities (Employment is one of the most strongly evidenced determinants of health)

Enterprise development has a key role to play in poverty reduction. Enterprise development can promote responsible business and sustainable

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41 London Health Commission “Sustainable Local Economies for Health Project” 2006
livelihoods for low income and vulnerable households, ensuring that benefits of economic growth are more equitably distributed.

**Lower than Average Incomes**

The average Knowsley residents’ weekly wage is £413.30 which is £46.90 less than the NW\textsuperscript{42} and £77.70 less than the GB\textsuperscript{43}. It should be noted that the average weekly wage for people who work in Knowsley is £464.90 which is £51.60 higher than the average residents weekly wage.

Longview, Stockbridge, Page Moss, Northwood and Kirkby Central are the top 5 most income deprived in Knowsley\textsuperscript{44}

Males (in full time work) in 2002 were paid £101.40 more than females, the gap has narrowed and the gap now only stands at £67.30.

Poor health is one of the major problems associated with low income. However poor health can lead to low income as well. Income and employment impact on living standards, social role and behaviour, which affects health. Parent’s income impacts on the children’s development of the child’s health capital (limiting illness) and income potential (education)

**High Levels of Deprivation**

Knowsley is one of the most deprived local authority areas in the country. Overall the index of Multiple Deprivation (IMD) 2007 ranks Knowsley as the fifth most deprived in the Country – an improvement since the IMD 2004 where Knowsley was the third most deprived. Knowsley ranks second on the IMD 2007 for local concentration, a ranking which is based on the number of localised hot spots of deprivation

**Equality and Diversity\textsuperscript{45}**

People from ethnic minorities, children and lone parent families are more likely to live in a low income household.

**Age**

In the UK the proportion of children living in low-income households fell from 34% of all children in 1996/97 to 31% by 2007/08. Nevertheless, children are still much more likely to live in low-income households than adults: 31% compared to 19%. The proportion of UK pensioners living in low-income households fell from 29% of all pensioners in 1996/97 to 18% in 2007/08. Pensioners are now less likely to be living in low-income households than non-pensioners - their rate being a bit lower than that for working-age adults

\textsuperscript{42} NW average income is £460.20

\textsuperscript{43} GB average income is £491.00

\textsuperscript{44} Based on IMD Income Domain Score 2007

\textsuperscript{45} Source: www.poverty.org.uk
(with dependent children 26% and without dependent children 18%) and much lower than that for children (31%).

**Family Type**46

50% (2005/06 to 2007/08) of UK lone parent families are in low income. This is more than twice the rate for couples with children. It is, however, an improvement from 1995/96 to 1997/98 figures of 62%. The rates of low income for the other family types (working-age couples without dependent children 12%, working-age singles without dependent children 25%, and in working-age couples with dependent children 22%) have saw no significant change.

**Ethnicity**

39% of UK people from ethnic minorities live in low-income households, twice the rate for White people, 21% (2007/08). This as improved from 1997/98 figures of 47% for ethnic minorities living in low income households. The rate for white people has remained almost the same at 23%.

**Gender**

The proportion of all adult UK Women living in low income households is 19% (2007/08), all UK men is only slightly more with a proportion of 21%.

However the gap between single men and single women is reversed, with 29% of single women living in low income households, whereas the proportion of single men is lower at 24%. One reason for the gender gap is that single female pensioners and female lone parents are both more likely to be in low-income households than their male equivalents. A second reason for the gender gap is that most lone parents – (a group at high risk of being in low income), are women. Nonetheless the gender gap between single men and single women facing low income has decreased from a gap of 12% (1997/98) to 5% (2007/08). This is likely to increase in the future given the Governments proposed cuts.

**Income Inequalities**

Comparing 1997/98 UK incomes to 2007/08 UK incomes, the bottom 10% poorest incomes did not see a rise in their average incomes, however all other groups did, with the top 10% richest incomes saw the biggest incomes of 39%. In fact the income of the richest 10% is more than the income of all those on below-average incomes (i.e. the bottom five tenths) combined.

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46 All the statistics in this indicator relate to numbers of individuals rather than numbers of families or numbers of households.
Low Pay by Industry

In the UK the highest risk of low pay are hotels & restaurants and retail & wholesale with 67% of employees earning less than £7 per hour. 49% of employees in the retail & wholesale sector also earn less than £7 per hour. The lowest risk of low pay is the public sector: admin with only 7% earning less than £7 per hour.

Access to Training

In 2009 only 9% of UK people who had no qualifications received job-related training whereas 28% of people with qualifications. Also the lower a person's level of educational qualifications, the less likely they are to receive job-related training.

The best access to training is in the public sector (42% accessing job related training) whereas Manufacturing, Construction, Retail and wholesale and Hotels and restaurants are all below 20%.

The above three points will impact on living standards, social role and behaviour, children’s development of the child’s health capital (limiting illness) and income potential (education). All of these affect health.

Links to Other Issues / Topics

Economy and Housing

Housing can enhance economic performance and competitiveness but it can also lead to segregation and spatial concentrations of poverty. In turn Economic development has impact on affordability, mortgage interest rates, labour demand and migration of residents. Neither Housing nor Economic development on its own will achieve sustainable development.

Economy and Employment

Economy growth attracts investment and employers to the area. This increases employment opportunities for its residents.

Knowsley works with its employers in the borough to provide customised recruitment and training packages to ensure people have the right skills for the job.

Also Knowsley needs a skilled healthy workforce to attract employers and investment.

Economy and Transport

Transport infrastructure is crucial for businesses. Transport networks need to reflect the business needs, in order for them to deliver sustainable growth and
employment. If the transport infrastructure does not meet the needs of employers, this impacts on businesses productivity and the ability for Knowsley to attract investment.

Access, affordability, reliability and punctuality is essential for residents to access work.

**Economy and the Environment**

The low carbon economy offers a growth market for the economy. However businesses are being put under pressure to reduce their carbon, which requires investment and skills.

The image and security of industrial estates can attract inward investment and retain jobs.

**Economy and Education**

Education attendance and attainment is essential to create a high skilled workforce. Also staff development by improving training and skills so they can progress and make their employment less susceptible to the economic downturn.

**Links to Existing Strategies (incl. Policies / Services)**

- Knowsley Economic Regeneration strategy
- Knowsley Employment and skills strategy
- Knowsley Interim Housing Strategy (Will be replaced by the Knowsley Housing Strategy 2011-2014 Currently in draft form)
- Local Transport Plan 2. (Will be replaced by Local Transport Plan 3, due to be adopted in April 2011)
- Unitary Development Plan (Will be replaced by the Local Development Plan in 2012)
- Knowsley Child Poverty Needs Assessment
- Knowsley Sustainable Communities Strategy
- Knowsley Climate Change Strategy
- Knowsley External Funding Strategy
- Knowsley’s Children and Young People’s Strategic Plan
- Liverpool City Region Strategies

**Future Implications (Modelling / Projections)**

Knowsley has a dependence on the public sector. The Public sector employment accounted for 32% of total employment in Knowsley in 2007. With prediction of major cuts within the sector, job losses can be predicted. This will increase unemployment and the competition for jobs, but also will impact of the public sector workers (stress of job losses and potential lower incomes will impact health)
Unfortunately the forecast work of Cambridge Econometrics is now mostly out of date due to recent Government budget cuts and policy changes. However we can predict that manufacturing and the public sector, will face significant employment decline. As stated previously Knowsley current employment 32% of public sector and 19.8% of manufacturing.

If Knowsley and the Liverpool City Region do not experience Economic growth in the next 5-10 years the divide between the Liverpool City Region and the rest of the UK will widen. This will increase inequality.

At present the most deprived areas in Knowsley are experiencing health inequalities. These health inequalities will hinder the attraction of economic development in the areas of most need.

Implementation of targeted initiatives which address clear need will close the gap between deprived and affluent areas.

**Evidence of What Works**

The Knowsley Apprentice is an innovative and pioneering programme securing employment and training opportunities for young people in Knowsley. It provides local businesses with the opportunity to employ some of the brightest and best talent in the borough in a structured and supportive apprentice programme. This assists Knowsley in creating a more dynamic, well qualified workforce for the future. The council alone has recruited 211 apprenticeships since 2009.

The School gate employment support project aims to improve non-working partners awareness and take up of employment or self-employment opportunities.

The main link to health would be to increase income levels for Knowsley residents. For example key services would be:

- Working with employers to encourage and provide training
- Programmes of action to assist residents to work, training and education
- Business start-up support, including self-employment
- Attracting investment and businesses to the area (Increase business density and job density)
- Linking areas of deprivation to affluent areas

Knowsley has several hard to reach groups and a lack of enterprise culture. These are the core issues that we are trying to address using the above services. This will include targeted support to deprived areas, to narrow the gap between deprived areas and more affluent areas

**Gaps**

- Local Economic Assessments are currently being developed to identify and address any data/intelligence gaps in provision
3.4.5 ENVIRONMENT / CLIMATE CHANGE

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Key Needs

- Address the health impacts of climate change including increased risk of heat related illness and death, skin cancer, vector borne diseases and health risks in relation to flooding.
- Plans to address potential disruption of services to vulnerable residents in extreme weather.

Description of Where / Who the Issue Affects

As a result of climate change, Knowsley is predicted to experience hotter/drier summers, warmer/wetter winters and more extreme weather events such as heat waves and flooding. This has the potential to affect Knowsley residents in the following ways:

- Increase risk of heat-related deaths, particularly affecting the very old and young, chronically ill and poor.
- Increased risk of death and hospital admissions for people with respiratory difficulties due to an increase concentration of ozone.
- Increased risk of drinking water contamination, water-borne infections, injuries, deaths, stress and mental health problems for people affected by flooding.
- Increased risk of skin cancer and cataracts for outdoor workers and residents due to increased exposure to ultra-violet light.
- Increased risk of food poisoning due to warmer summers leading to an increase in food-borne disease.
- Increased risk of vector-borne diseases such as malaria arriving in the UK.
- Disruption of services to vulnerable residents in extreme weather.

Equality and Diversity

It is likely that climate change will adversely affect the following groups:

Disability – there is an increased risk of heat related illnesses to people with disabilities and potential disruption to support services in extreme weather

Age (older people and young) – there is an increased risk of heat related illnesses to the young and older people, and potential disruption to support services in extreme weather
Poverty/low income – people on lower incomes are less likely to have insurance in the event of flooding, possibly leading to stress and mental health problems.

Links to Other Issues / Topics

Taking action to reduce carbon emissions (and lessen the impact of climate change) links closely to other health agendas. For example, encouraging walking and cycling will reduce carbon emissions, improve physical health and reduce obesity. This also links to providing high quality green spaces which can encourage the take up of these activities. Improvements in air quality will lead to reduced respiratory illness. Action to tackle obesity will result in lower food consumption, reducing the carbon emissions associated with food production.

Links to Existing Strategies (incl. Policies / Services)

The Knowsley Partnership is developing a Climate Change Strategy for the Borough. This strategy will seek support from partner organisations to reduce carbon emissions in the borough. This links to the Good Corporate Citizenship Strategy for the NHS. As part of the LSP Climate Change Strategy, Knowsley Council is leading on the development of a risk based action plan to address adapting to climate change in accordance with the methodology outlined for National Indicator 188. There are also links to the Council’s Green Space Strategy which includes working in partnership to utilise and develop green infrastructure, especially green corridors to provide walking and cycling routes, and also addresses the role of green spaces in adapting to future climate change.

A Heat wave plan is in place for Knowsley.

Future Implications (Modelling / Projections)

The future implications of climate change are difficult to accurately predict. In 2008, the Health Protection Agency/Department of Health produced a lengthy report ‘Health Effects of Climate Change in the UK 2008’. The headline findings of this report are outlined above. Since the report was produced, updated data on future climate change scenarios have been published by the UK Climate Impacts Programme.

Further work needs to be undertaken to fully assess the health risks in Knowsley associated with future climate change, and the service response required to address the issues. Detailed assessment of the current data and information will be required to fully assess the future implications.

Evidence of What Works

Guidance and best practice in this area is still evolving. Further research and analysis needs to be undertaken on the information available. For example,
Hertfordshire Council and NHS have published a specific assessment of climate change impacts on Health and Adult Care Services which should be reviewed for relevance to Knowsley.

Gaps

As outlined above, action on addressing the impacts of climate change is still evolving. Further research needs to be undertaken to assess the current climate change predictions, identify vulnerabilities and opportunities and develop a risk based action plan.

Examples of actions that may be required include construction/refurbishment of buildings to improve cooling and reduce the impacts of heat waves, provision of shade in public areas, guidance to the public on the increased risk of skin cancer, heat stress etc., adaptation of emergency plans and addressing inequalities. It should be noted the role that our green spaces can play in climate change adaptation, for example providing shaded areas in heat waves and sustainable urban drainage systems for flood relief.

Recommendations for Commissioners

- Undertake a comprehensive risk based assessment of the health impacts of climate change in Knowsley, in line with the approach outlined for National Indicator 188 by 31\textsuperscript{st} March 2011
- Develop a comprehensive action plan to address the health impacts of climate change in Knowsley by March 2012 as part of Knowsley’s overall plan to adapt to climate change

3.4.6 EMPLOYMENT AND UNEMPLOYMENT

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**Key Needs**

- How to increase employment at a time of reducing support services and potential job losses, particularly (but not solely) in the Public Sector;
- Reducing benefits claims;
- Increasing work skills and educational attainment.

**Description of Where / Who the Issue Affects**

In general, working is better for health and wellbeing than not working. Those who are not in employment are more likely to suffer poor physical and /
or mental health. While health problems may have led to unemployment, an individual’s wellbeing may be worsened by not working. This is particularly true in relation to mental health. For example, someone may lose (or fail to gain) work due to a physical health problem. A period without work can lead to depression.

In October 2010, a total of 5,572 Knowsley residents were receiving Jobseekers Allowance, representing 5.8% of the working age population (96,100). Of these, 1,695 were aged 18-24.

A further 12,710 residents were on Incapacity Benefit or its successor Employment Support Allowance in May 2010 (13% of the working age population). During the same period there were 3,260 lone parents on Income Support (3.4% of working age population).

In all, 21,542 residents of working age were not in employment: – more than one in five. In the 12 months to October 2010, there was an average of 812 vacancies notified to Jobcentre Plus for the Borough. The low number of local vacancies reinforces the importance of transport access to employment sites (see below).

There are also geographic concentrations of benefit recipients. Four wards have been identified as most vulnerable in this respect as part of the development of the proposed Total Place initiative. The wards are Northwood, Whitefield, Kirkby Central and Longview.

**Equality and Diversity**

Lack or loss of employment can have a differential effect across age groups. As shown above, the largest cohort of claimants of Jobseekers Allowance is 25 – 49 year olds.
The plans for welfare benefit changes are also expected to affect those currently receiving Incapacity Benefit and Employment and Support Allowance, with 40% of those going through the current Work Capability Assessment being deemed fit for work. The reductions of £18bn over the Parliament in welfare payments announced in the Budget 2010 and Comprehensive Spending Review 2011-15 will also have a significant but as yet undefined impact.

Links to Other Issues / Topics

The ability to enter or stay in employment can be affected by a number of other factors which themselves have an impact on health and wellbeing.

Education: Those with low or no skills are less likely to gain or retain employment or progress beyond low paid work.

Child and Family Poverty: there is a negative impact on child development and wellbeing if their parents are out of work. The recently published review into life chances conducted by Frank Field identified the need to focus on early intervention in the early years. The levels of in work poverty are also increasing, which means that work is still required to encourage individuals to develop higher levels of skills for higher paid jobs.

Transport: Low car ownership and inadequate public transport links to main employment sites can limit work opportunities.

Financial inclusion: People on benefits or in low paid jobs can have problems opening even a basic bank account. This can adversely affect their ability to manage their budget and access affordable credit.

Links to Existing Strategies (incl. Policies / Services)

City Region Employment and Skills Strategy: Led by Knowsley Council, the Strategy takes a City Region-wide approach to creating employment opportunities and supporting people into work.

SCS: The Partnership strategy for establishing sustainable communities

Local Development Framework: the Borough’s spatial planning strategy that is key to determining issues such as land availability for employment and housing, among other things.

Community Cohesion Strategy: from the perspective of localisation and greater emphasis on community sector involvement, role of community enterprises, for example.

Knowsley Financial Inclusion Strategy: The strategy brings together a wide network of stakeholder organisations to provide advice and support to people on workless benefits or who are moving from benefits into employment. For
example, there is targeted advice for people receiving Housing and / or Council Tax benefit on how to manage the change in circumstances.

Child Poverty Strategy: About half of households identified as suffering child poverty are on workless benefits. The remainder have at least one person in work, although this is most likely to be poorly paid and / or part time.

Merseyside Local Transport Plan: A new Local Transport Plan is in development for implementation from April 2011. As with LTP2, there is a focus on accessibility. One of the goals in the preferred options for the new Plan is to ensure the transport system supports equality of travel opportunity by enabling people to connect easily with employment, services and social activities.

Future Implications (Modelling / Projections)

It is anticipated that there will be an increase in the number of jobs lost in the Public sector as a result of both the reduction in funding for local authorities and the re-organisation of the NHS. The exact numbers and profile of these reductions cannot be predicted but it is expected there will be a loss of at least 1,200 public sector jobs by Knowsley residents.

At the same time, major welfare reform is under way. In particular, current claimants of Incapacity Benefit and Employment and Support Allowance will all be reviewed by 2014. Changes to a range of welfare benefits (including housing benefits) are expected to reduce payments to recipients. Linked to this, the increase in VAT from January 2011 is expected to have a regressive impact on families in levels of deprivation.

In addition, changes to Income Support criteria for lone parents will result in a higher number of residents, mostly women, being directed towards work. The criteria will change in stages until the benefit stops when the youngest child becomes seven years old. This is likely to increase demand for part time work, which in turn tends to be low skill and low pay.

Service Utilisation

Services need to be accessible, flexible and adaptable to individual need. There are many real and perceived barriers to employment. Individuals are likely to face a number of barriers to differing degrees, making a personalised service more appropriate than a standardised process.

Not all services are available to people needing support to enter employment. For example, the Condition Management Programme (see below) is available only to claimants of Incapacity Benefit. Evidence suggests that physical and mental health can deteriorate from the point of becoming unemployed. Early support in managing pre-existing health conditions could minimise this decline and increase the potential for an early return to working.
Evidence of What Works

NICE guidance on sickness absence and incapacity for work include a recommendation to take a multi-disciplinary / multi-agency approach. This approach has been shown to work locally with a number of schemes.

For those for whom health is barrier to employment, local activity includes the Condition Management Programme, which takes referrals from Jobcentre Plus, and Retain Regain, which takes self-referrals as well from employers.

Other effective local programmes include the former Working Neighbourhoods Pilot, which operated in Tower Hill and Northwood, and the current School Gates Pilot, which forms part of local action to reduce Child Poverty.

Gaps

Although a wide range of support is available, the level of need is such that there is often unmet demand. There is a need for more effective co-ordination of support in order to maximise the use and impact of resources.

Intervention earlier in the journey from unemployment to work is also needed. At present, for example, new claimants of Jobseekers Allowance receive minimal support as it is assumed they will find work quickly. This situation has improved during the recession with group support offered from the outset, but it is not clear if this will continue.

Recommendations for Commissioners

- Work locally and sub-regionally to develop a robust process for replacing the Condition Management Programme, which is due to end in March 2011. This will be particularly important during the gap between the end of the initiative and the start of the new national Work Programme, due to start in Summer 2011.
- Develop and implement the Total Place initiative, targeting resources at the four most vulnerable wards in the Borough. Preparatory work to be completed by March 2011. The focus will be on actions with greatest impact.
- Develop and implement actions to increase employment and reduce benefit claims across the Borough, linking to the City Region Employment Strategy. The Knowsley Employment and Skills Group was re-formed in September 2010 to take this forward.
- Continue to monitor the impact of welfare reform
3.4.7 HOUSING NEEDS

Key Needs

- Fuel Poverty in Knowsley has reduced from 37% to 19.8% over the last six years. Continually rising fuel bills will however mean that more households will be tipped back into Fuel Poverty.
- Knowsley has lower levels of owner occupation and higher than average social housing stock as a proportion of the total stock (31.5%), compared to the Merseyside average of 24.0%, the North West average of 20.1 and the national average of 19.3%.
- Good-quality, affordable, safe housing is essential to our wellbeing. Non-decency in Private sector, is at 27.4% (12,550) which is lower than the national average of 35.8% for equivalent tenures.
- Overcrowding and under-occupancy is a major issue in the borough. Achieving the most efficient use of the current housing stock and addressing the needs of existing and new forming families in this sector is essential.
- There are issues regarding the ability of local people to afford housing within the borough which are based on the their level of income and their ability to access housing finance.
- There is predicted to be a significant increase in the population aged 65+. This increase in older householders will have implications for health and support services, extra care housing, and the long term suitability of accommodation, equity release schemes, adaptations, and other age-related care requirements.

Description of Where / Who the Issue Affects

The links between housing and health are well reported, with more recent studies reporting the significant financial costs generated by poor housing (Good Housing Leads to Good Health, CIEH, 2008). Evidence suggests that poor housing condition can be linked to increases in home accidents and falls. Damp and cold properties can cause increased prevalence of illnesses such as asthma, bronchitis and arthritis, resulting in excess winter deaths. Overcrowding may lead to low educational attainment within children and a number of mental health problems including increased stress, anxiety and depression.

Levels of health can also be affected by types of housing tenure. Housing conditions in homes that are owned tend to be better than in homes that are
rented, both privately and socially (Scottish Government, Communities Analytical Services, September 2010,). However, it is recognised that this is not always the case, for example where homeowners are elderly and have to survive on particularly low incomes.

**Housing in Knowsley**

According to 2010 Strategic Housing Market Assess (SHMA) there are 64,629 households in Knowsley. Knowsley has lower levels of owner occupation and higher than average social housing stock as a proportion of the total stock (31.5%), compared to the Merseyside average of 24.0%, the North West average of 20.1 and the national average of 19.3%.

People in social housing have either qualified by being homeless and in ‘priority need’ or have been on the housing register and been in sufficient ‘housing need’. Households in social housing include higher numbers of lone parents, more female-“headed” households, more people from vulnerable groups, more under 16s and over 64s, and more retired people overall than all of the total households in Knowsley.

The 2001 Census found significantly higher levels of unemployment and long-term sickness or disability among social housing tenants than among owner occupiers and those renting privately. Many of the most deprived areas of Knowsley, as measured by the Index of Multiple Deprivation 2007, are those areas where social housing is concentrated.

**Decent Homes**

Good-quality, affordable, safe housing is essential to our wellbeing. Poor housing or homelessness can contribute to mental ill health or can make an episode of mental distress more difficult to manage. This may also be compounded by the fact that poor housing and homelessness are often linked to other forms of social exclusion, such as poverty.

Decent homes are important for the health and wellbeing of those living in them. In order to meet central government’s Decent Homes Standard, a home must:

- Be free from any of the hazards categorised as most serious under the Housing Health and Safety Rating System.
- Be in a reasonable state of repair
- Have reasonable modern facilities and services
- Provide a reasonable degree of thermal comfort
If a dwelling fails any one of these criteria it is considered to be “non decent”. The following characteristics were identified in relation to non decency in Knowsley:

- Non decency in Private sector, at 27.4% (12,550), was lower than the national average of 35.8% for equivalent tenures. Failure rate was largely driven by Category 1 hazards, disrepair and energy efficiency standards.
- Non decency will have increased since April 2006 with the introduction of the Housing Health and Safety Rating System.
- By sub-area, the highest rate was recorded in Prescot and Whiston at 30.4%, above the authority rate. It also had the highest proportion of vulnerable households living in non decent homes (34.8%).
- The 50 to 59 age group had the highest proportionate rate of non decency (32.5%), just under 5,000 households.

**Fuel Poverty**

Fuel Poverty is the cause of and contributes to a range of health problems including bronchitis, heart attacks and accidents. Treatment of respiratory illness such as asthma and bronchitis imposes an enormous burden on health service resources every winter. Temperatures lower than 12o C (54o F) cause blood pressure to rise in the elderly, increasing the risk of heart attack. A drop in body temperature causes the blood to thicken making circulation more difficult and contributing to heart disease and strokes. It also greatly increases the likelihood of falls and accidents. Temperatures below 16o C (61o F) can lower the body’s resistance to respiratory infections.

- Fuel Poverty in England has increased from 1.2 million households in 2004 to 2.9 million households in 2007. Excess Winter deaths contribute to 1 in 20 of all deaths per year. There were estimated to be 36,700 excess winter deaths in England and Wales in 2008/09.

During the 2008-09 winter period there were 108 extra deaths in Knowsley when compared to the rest of the year.

- There has been an increase in recent years in the number of extra winter deaths in Knowsley.
- The number of deaths during the winter period has remained roughly stable since 2001-02, with the fall in average non-winter deaths being the principle cause for the recent rise in excess winter mortality.
- Excess winter mortality is dependant on a variety of factors ranging from temperature to levels of disease within the population e.g. influenza.
- Mortality trends for both cardiovascular disease and respiratory disease show large seasonal variations, with the two diseases accounting for the majority of extra deaths during the winter period.
- The majority of extra winter deaths occur among those aged 65 and over.
Households from particular ethnic groups can differ in terms of their housing or accommodation requirements, particularly in relation to property size. Knowsley has a BME population of 4.6% (2,844 implied households).

Gypsy and Traveller Households

Knowsley Council, in partnership with other local authorities were part of the Merseyside Gypsy and Traveller Accommodation Needs Assessment.

The Assessment indicated there was no current provision of pitches in Knowsley; however it was recommended that a minimum of five pitches be provided by 2016.

In the North West Plan Partial Review (July 2009) in states that provision will be made for at least 825 net additional residential pitches across the North West for Gypsy and Travellers over the period 2007 to 2016.

In Knowsley there is a planned provision for an additional 10 permanent residential pitches and an additional 5 transit pitches between 2007 and 2016.

For Travelling Show people provision will be made for at least 285 net additional plots across the North West region over the period 2007 to 2016. However, there are no proposed plots required over this period for the whole of the Liverpool City Region sub region, including Knowsley.

Housing with Support Needs

- Housing may need to be purpose built or adapted for households with specific support needs including Older People with support needs and people with physical, mental and learning disabilities. Information about the characteristics of these households can inform the Council’s Supported living Strategies. The number of households in Knowsley containing a household member with a disability or limiting long term illness is 36.2%, around 65% of those households also said that they had a care / support need.
- Similar to the needs of households who have support needs, housing may need to be purpose built or adapted for households with older residents. There is likely to be a deal of crossover between the need to elderly people and those requiring supported housing due to a disability, for example, in older people requiring assistance due to mobility difficulties. The increase in older householder will have implications for support services, extra care housing, and the long term suitability of accommodation, equity release schemes, adaptations, and other age related care requirements. Some of the future requirement will be addressed by flow of the existing sheltered stock, but acceptability of existing stock to meet today’s standards will need to be assessed in calculating the scale of new delivery. There is no direct correlation between population growth in the older population and the need for specialist accommodation. The policy change to keep people in their own homes and the issues relating to the acceptability of current sheltered
stock affect all Councils nationally and require a detailed strategic review of the future requirements of this sector.

- The need of BME elders for independent accommodation should be further examined. In the context of an ageing population, the needs of BME elders should be considered alongside the needs of all older people in the Borough.

**Links to Other Issues / Topics**

The recession has affected several of Knowsley Council’s priorities. Fewer affordable homes have been built as the construction industry has slowed. There has been an increase in the number of 16 -18 year olds not in employment, education or training and unemployment levels across the borough have increased, all factors have a negative impact on the health of those who suffer from unemployment and overcrowded conditions.

- Specific areas of needs within the borough which have links to housing are identified as follows;
- Low educational attainment and attendance caused by overcrowding of properties can have a negative impact on quality of life and wellbeing issues in adult life, including in relation housing.
- Prevalence of cardiovascular disease is influenced by a variety of factors linked to people’s lifestyles and wider influences such as housing conditions.
- Respiratory disease including asthma is influenced by factors such as housing condition, particularly that of older people in the heating and maintenance of properties.
- Worklessness - Being on benefit or having a low income can affect the ability of Knowsley residents to buy and/or maintain their own home. The transition from benefits to employment may involve starting to pay rent, changing demands on the household budget. There is also increased risk of becoming homeless if arrears build up.
- Safeguarding Children and Child Protection - There will be an increased need for safeguarding if families are living in areas poor housing.
- Mental Health problems can be the result of a broad range of issues, including poor housing conditions.
- People living independently at home - The JSNA recommends that partnerships with providers of social housing and other third sector agencies promote development of a range of suitable housing options.
- Long term care in residential settings - The JSNA recommends that the range and choice of options to remain at home or move to extra care continues to develop for all age groups and health conditions.
- Excessive alcohol consumption leads to a wide range of public health problems and can be linked to housing tenure.
- Substance Misuse - The JSNA recommends that housing and employment representation is built into the newly constituted substance misuse thematic group to ensure that they form part of the strategic and local response.
Links to Existing Strategies

The following strategies are associated with housing needs:

- Knowsley Strategic Housing Market Assessment 2010
- Knowsley Housing Market Assessment 2009
- Knowsley Housing Needs Survey 2007
- Knowsley Interim Housing Strategy 2010
- Knowsley Private Stock Condition Survey July 2010

Future Implications

Single Person Households

Projections made by the SHMA indicates that the increasing trend in single person households will continue, so that single person households will account for a higher percentage of households by 2016. They anticipate that the proportion of lone parent households will also increase, though by much less, while a corresponding decrease occurs among couple households, some of whom have children, and other multi-person households.

Older People

There is an overall predicated increase in the population aged 65+ of 10,800 people between 2006 and 2031 an increase of 47.0% over the forecast period. In the 85+ age group there is a rise of 2,700 people (135.0%). The increase in older householders will have implications for health and support services, extra care housing, and the long term suitability of accommodation, equity release schemes, adaptations, and other age-related care requirements.

Overcrowding and under-occupancy is a major issue in the borough. As indicated by the 2010 SHMA, the overall over occupation level in the Borough is 5.6%, or 3,479 implied households, higher than the average UK level indicated by the Survey of English Housing Preliminary Report 2007 / 08 of 2.7%. It is particularly high in the social rented sector at 8.7%.

There is no comparable data against which to measure the overall under occupation figure of 35.1% but it is close to, albeit slightly lower than the average figures found in other recent housing surveys (around 40%). Under occupation in the social rented stock was 23.0%, equating to 4,220 households. This is an issue for Housing Strategy to consider, both to make best use of the housing stock and address the needs of existing and new forming families in this sector.

The future needs of older people were addressed in the Knowsley Housing Needs Study. Existing households were asked whether they had older relatives (over 60) who may need to move to the area in the future. Only 1% of existing households said that they had an elderly relative who may need to move to the Borough within the next three years.
The study also showed that expected demand for accommodation from existing older residents was mainly focused on living with respondent with the need for an extension / adaptation (30.3%) or the possibility of moving into sheltered accommodation (26.3%). The main tenure of housing preferred by those requiring supported housing is Housing Association Sheltered Housing at 55.4% followed by Independent Accommodation with external support at 32.7%.

Although a high proportion of older people may have their own resources to meet their accommodation (and care needs and provision should not be exclusively in the social rented housing sector), others will need financial support to enable them to access housing support services.

Some of the requirement will be addressed by flow of the existing sheltered stock, but acceptability of existing stock to meet today's standards will need to be assessed in calculating the scale of new delivery. Additionally, the aforementioned population projections regarding older people suggest that there will be a significant shortfall in sheltered accommodation stock in the Borough in the medium-term, as demand for Extra Care accommodation increases.

More detailed analysis is required of this sector in view of the acceptability of some of the existing stock and the changing requirements of current and future older people. This analysis is more complex than simple quantitative stock supply and demand and it is recommended to be undertaken, assessed and monitored as part of the on-going Older Persons Strategy.

Evidence of What Works

Overcrowding and Under Occupation

Following the further funding for the overcrowding pathfinder programme 10/11 we are developing a future strategy to tackle overcrowding and under occupation in Knowsley.

Communities and Local Government have set the following outcomes from the overcrowding grant funding 2010/2011.

- A robust strategy to tackle overcrowding in all tenures
- Housing options visits and services which give practical, realistic advice to overcrowded households
- Using the private sector as an option to assist overcrowded social tenants
- An allocation framework that gives appropriate priority to overcrowded households and increases transfers to make best use of stock
- An allocation framework that gives priority to under occupiers
- Local targets for 2010/11 being set that aim to reduce overcrowding in the social stock, with a particular focus on those households that are severely overcrowded
• Continuation of existing schemes that accord with good practice and support under occupiers who are looking to downsize. A local target which increases the number of moves in 10/11
• Action plans complete with outcomes for partnership working with Registered Social Landlords to support overcrowded households across all social stock. Action plans completed by 30 June 2010
• Ongoing participation in the CLG’s data collection, including Registered Social Landlords data.

Fuel Poverty

The Knowsley Warm Streets Scheme is a thermal insulation scheme offering loft, cavity wall insulation and hot water tank jackets to Knowsley owner occupiers and privately renting residents. This scheme is part funded through CERT and Knowsley Capital funding. The scheme was launched in 2003. To the end of March 2010 has:

• Installed 19,195 measures
• Into 14,591 homes
• This breaks down into
  • 10,629 cavity wall insulated
  • 7,920 lofts insulated
  • 646 hot water tank jackets fitted
• Reduced impact on climate change through an average saving of one tonne of CO2 per property per year
• Annual average decrease of fuel costs of £185 per property

The Knowsley Warm Front Excess Scheme; It is the house that receives the grant, triggered by the eligibility of the householder. Sometimes the householder will apply for a Warm Front grant and find that because either they themselves or a previous occupant has had measures under the Warm front scheme for that property the amount left of the £3,500 Warm Front grant for the property will not cover the cost of the measures they are now requesting under the scheme – this shortfall is known as a warm front excess.

This scheme enables residents to have Warm Front measures installed into their properties because their excess is paid through this scheme. This has enabled residents who might have had to refuse a grant due to being unable to pay the excess, being able to go ahead and have a warmer comfortable home.

• To date 417 residents have benefited from the scheme
• Average excess contribution is £650 per measure
• Each Warm Front Grant is up to £3,500 (max) This would not be invested in the borough if the resident could not find the excess payment.
• Knowsley has invested £271k into this scheme, bringing in up to £1.4m Warm Front funding into the borough.
Increasing the thermal efficiency of a property and ensuring a working programmable heating system is in place has an impact in that it brings properties up to Decent Homes Standard. Both the Knowsley Warm streets scheme and the Knowsley Warm Front Excess schemes have helped bring properties up to decent homes standard.

Design and Accessibility Schemes

The Code for Sustainable Homes

The Code for Sustainable Homes has been developed to enable a step change in sustainable building practice for new homes. It has been prepared by the Government in close working consultation with the Building Research Establishment (BRE) and Construction Industry Research and Information Association (CIRIA), and through consultation with a Senior Steering Group consisting of Government, industry and NGO representatives.

The Code is intended as a single national standard to guide industry in the design and construction of sustainable homes. It is a means of driving continuous improvement, greater innovation and exemplary achievement in sustainable home building. Amongst other outcomes, the code will;

- **Lower running costs**: Homes built to Code standard will have lower running costs through greater energy and water efficiency than homes not built to the Code standard, so helping to reduce fuel poverty and reducing the wider determinants of health.
- **Raise sustainability credentials**: The Code will enable social housing providers to demonstrate their sustainability credentials to the public, tenants and funding bodies.

Lifetimes Homes Standard

The Lifetime Homes concept was developed in 1991 and encompasses 16 design features that ensure a new house or flat will meet the needs of most households. This does not mean that every family is surrounded by things that they do not need. The emphasis is on accessibility and design features that make the home flexible enough to meet whatever comes along in life. The overall aim of The Lifetime Homes Standard is to make homes suitable for people at all stages of their lives.

A Lifetime Home can offer particular benefits to older people and people with physical impairments, whether they actually live in the property or want to visit relatives and friends without difficulty. Bringing Lifetime Homes design into the general housing stock should, over time, allow older people to stay in their own homes for longer, reduce the need for home adaptations and give greater choice to disabled adults and young people who cannot achieve independent living due to lack of suitable housing.
Recommendations for Commissioners

Data and Intelligence Requirements

Continue to develop an Older Persons Housing Strategy to address the current and future growth in older people and frail older households across all tenures, and their related care and support needs to:

- Assess and prioritise the need for support services and adaptation required to keep people in their own home;
- Re-assess existing sheltered stock in meeting today’s housing standards and preferences;
- Assess the need for ‘extra care’ accommodation for the growing frail elderly population.
- BME Housing Needs Assessment to help engage, profile and map housing demand for vulnerable BME groups.

Service Issues

Explore the possibility of including Lifetime Homes and the code for sustainable homes in all future developments through a proposed supplementary planning document.

In view of the 85+ population increase, the housing and support needs of older households must be considered at a strategic level.

- The Older Persons Housing Strategy should involve a detailed assessment of the support required to help the majority of people to remain in their own home and audit the existing sheltered stock in meeting today’s housing standards and preferences. Although a high proportion of older people may have their own resources to meet their accommodation and care needs and provision should not be exclusively in the social rented housing sector, others will need financial support to enable them to access housing support services.
- The demand for Extra Care accommodation is likely to increase due to the growth in the older population over the next 10 year period and should be assessed and monitored as part of the on-going Older Persons Strategy.
- Develop an Affordable Housing Policy to deliver affordable housing options, reducing the overcrowding and under-occupation burden on the social and private rented sector.
- Little is known about the relationship between overcrowding, children’s mental health, educational attainment and childhood growth and development. A CLG review identified that there was some research on mental health and childhood development and two studies on childhood development and education. However, none of these covered all three elements and their interconnecting relationships.
3.4.8 LEISURE AND CULTURE

**Key Needs**

In accordance with the Sustainable Communities Strategy, the key needs in relation to leisure and culture within Knowsley are as follows:

- Increased levels of physical activity within Knowsley residents, particularly young people, to improve health in general and reduce health inequalities.
- Increased opportunities that bring people together and help people to support themselves and develop stronger citizenship; creating safer more cohesive communities and preventing poor health and wellbeing.
- Improved skills levels within the community, voluntary and faith sector to support quality and sustainability of opportunities.
- Improved pathways into education, training and employment for local people by building confidence, attainment and connections.
- Increased levels of children and young people engaged in positive activities.
- Increased leisure and cultural offer that supports Knowsley’s regeneration.
- Improved quality of place to help to make Knowsley the ‘Borough of Choice’ and attract inward investment, thereby enhancing the potential for thriving sustainable communities.

**Description of Where / Who the Issue Affects**

The following evidence has been collated to demonstrate the above-mentioned key needs within the borough.

- Knowsley’s adult participation rate in physical activity is at 19.3%; lower than the national average of 21.8% and North West average at 21.7%. Research shows a drop off in engagement in physical activity for reception and year 6, age 15/16 (girls aged 14/15), single mums, males 30-40 and those with specific long term medical conditions or at risk (Active People Survey 2009).
- It is recognised that the creation of leisure and cultural activities has a strong role to play in bringing together different generations, which it reported is an important element in reducing the fear of crime (IDeA). A particular priority for Knowsley is vulnerable adults, including isolated
people; where there is a need to increase social interaction in order to reduce poor health and wellbeing for this target group.

- Volunteering levels in sports in Knowsley at 3.3%, whilst the national average is 4.7% (Active People Survey 2009). The development of local clubs and groups, and in particular volunteers’ skills and knowledge can lead to increased capacity and participation in other community and employment opportunities. Given that Knowsley has high employment targets, there is a need to maximise the impact of training and jobs through culture and leisure, to address this priority.

- Evidence suggests that young people’s participation in organised sport improves their numeracy scores, on average, by 8% above that of non-participants. Up to 20% of young people within Knowsley are thought not to be in education, employment or training. Research shows that young people who are NEET and at risk of becoming NEET are generally visual and practical learners and engage well through creative arts programmes and sporting vocational training.

- Nationally, there is a 21.1% drop-off in engagement in the arts between adults aged 45-64 years and those aged 75+. Nearly 25% of adults nationally volunteered their time in 2008-9 although only 2% volunteered time specifically related to the arts.

- In consultation for Knowsley’s Cultural Plan 80.9% felt that art in public spaces was relevant to making Knowsley a better place to live, work and play.

- The Knowsley Young People’s Commission found that young people in Knowsley are positive and aspirations but for a variety of reasons it appears that this potential is difficult to unlock. Unlocking this potential will support positive lifestyles.

Equality and Diversity

The following evidence suggests that within Knowsley there are population groups which are less likely to participate within leisure and culture activities and therefore should be targeted by future interventions, particularly in a way that improves access for these people to mainstream opportunities.

- The Taking Part survey shows that 61% of adults who describe themselves as ‘white’ engage in the arts 3 times annually compared with 49% of adults who describe themselves as black and minority ethnic.

- The Active People survey shows that;
  - 79.5% of people with a limiting disability do not participate in any physical activity compared to a national average of 73.6%.
  - Female participation in physical activity (3x30 mins) within Knowsley is 15.4%, compared to NW figures of 18.2% and nationally figure of 18.9%.
  - That 12.7% of adults over the age of 45 participate in physical activity (3x30 mins) compared to 14.99% regionally, and 15.93% nationally.

- Only 59% of adult males engaged in the arts 3 times annually compared with 63% of female.
• For those with a specific medical condition, there is an approximately 30% risk reduction of all cause mortality across all studies, when comparing the most active with the least active.
• There is a 20% to 35% lower risk of CVD, CHD and stroke for those who participate in physical activity.
• Aiming High has identified that disabled children and young people are less likely to access ‘mainstream’ activities and opportunities.
• The Transforming Social Care ‘Citizenship and Prevention’ strand has identified that vulnerable adults and older people are less likely to access mainstream leisure and cultural activities apart from those based within leisure centres.

Service Utilisation

Key services which should be in place to tackle the issues identified include;

• **Physical activity resources:** access to high quality and accessible facilities and resources, GP exercise referral scheme, healthy workforce programme, pathways from bespoke to mainstream opportunities, family opportunities in leisure centres.
• **Arts & Heritage Development:** Creative solutions and neighbourhood visioning, arts development with individuals and groups, volunteering, pathways for progression (including events), opportunities to showcase success and grow participation, increased skills, improved citizenship through arts and heritage, arts and heritage on prescription, cultural events and festivals.
• **Sports Development:** Sports development with individuals and groups, volunteering, coach and club development, pathways for progression (including events), opportunities to showcase success and grow participation, increased skills, improved citizenship through sports, sports events.
• **Culture and Regeneration:** public art programmes that engage with communities, exhibitions and showcase opportunities, tourism and visitor attraction developments that support the Borough of Choice and raise aspirations.

It should be noted that many of these services overlap in supporting more than one of the key needs identified. The above should be both universal and targeted as appropriate, with specific interventions undertaken to support programmes for the target groups mentioned in the above sections. In particular, the new Leisure Facilities Strategy prioritises access for disabled people.

Links to Other Issues / Topics

Other issues linked to the provision of leisure and cultural opportunities within Knowsley include; the development of the community, voluntary and faith sector, entitlement to cultural activity with pathways for progression and lifelong engagement, coordinated strategy for lifelong learning, integrated approach to use of facilities and open spaces, strategic approach to design in
the public realm, children and young people (families); adults; older people, healthy lifestyles, the economy and job creation, maximising the potential of tourism and heritage assets and the power of culture to drive regeneration. The Knowsley Culture Plan, based on the Borough’s Sustainable Communities Strategy, connects the need and opportunities together and is a reference point for commissioners.

**Links to Existing Strategies**

Continuing from the section above, links to existing strategies and programmes include;

- Sustainable Communities Strategy
- Health and Wellbeing Plan
- Culture Plan for Knowsley
- Public Arts Strategy
- Shakespeare North Development
- 2012 and Proud and Spirited Programme
- Children and Young People’s Plan
- Knowsley Young People’s Commission
- Transforming Community Services (including Prevention/Citizenship)
- Behavioural Change Policy Framework
- Child Poverty Strategy
- Mental Health Promotion Strategy
- Leisure Facilities Strategy
- CVD Strategy
- Total Place
- Putting People back into participation (DCMS)
- Cultural Capital – Investing in Culture will build Britain’s Social and Economic Recovery
- Aim higher scheme

**Future Implications**

Within the population of Knowsley, the age groups that are increasing in numbers are the most vulnerable. This includes the youngest (0-14) and oldest members of the community, particularly those over 80. Support for this latter group will become a major challenge in the next few years, demand increases for adult social care and cost pressures for current service configurations across the Council. Consequently leisure and culture services that increase activity and engagement at these pivotal ages, which support skills, confidence, independence, mental health and wellbeing and physical health will in turn support older people to live healthier, happier and more independent lives and will support young people to make positive life choices.

**Evidence of What Works**

There are many models of good practice to tackle some of the issues raised within this section. The following are some of the most relevant;
• When commissioning targeted provision programmes, consider what is in place to ensure a ‘pathway’ to the universal offer thereby reducing the gap in access to mainstream provision.

• When commissioning a community or young persons programme consider the most appropriate ‘process and approach’ needed to ensure the best outcome in terms of capacity building, skills, empowerment, sustainability and citizenship.

• Consider what works well, such as Activity for Life, which is successful because of the whole system approach considering social elements, behavioural change and interventions to reduce the gap between targeted provision and the universal offer. Also Neighbourhood Visioning projects that bring creative solutions to neighbourhood issues and which empower communities (process not just project).

• Consider market segmentation intelligence and also data on participation levels (active people survey and 5 hour offer survey) to ensure of the biggest impact on outcomes and effectively measure effectiveness.

• Consider what motivates people to stay engaged in physical activity and cost benefit analysis of ensuring people stay engaged as opposed to attempting to reengage them once they have ceased physical activity.

• When commissioning projects which promote access to local leisure facilities consider the following: price, information, quality facilities / equipment, better transport & better childcare.

• When considering more medical treatments, consider whether the outcomes for health and wellbeing can be more successfully and sustainable achieved through other leisure and culture interventions and opportunities.

Knowsley approach to leisure and culture is ‘preventative intervention’ whereby programmes are developed to combat future more costly issues arising i.e. managing the health and wellbeing consequences of inactivity and social isolation. For example, Activity for Life works alongside or in place of medical intervention, reducing clinical costs. This programme has shown an 81% increase activity levels at 12 weeks and 72% improvement in mental health and wellbeing at 52 weeks. This programme has also led to participants establishing their own social and physical activity programmes which supports sustainability and empowerment.

Other examples of what is effective on a local level include:

• Supporting the five-hour sporting and cultural offer develops active young people, reduces obesity levels and supports overall wellbeing.

• Knowsley’s Young People’s Commission challenges the predominant focus on academic achievement as the only measure of success for children and young people. Participation in leisure and cultural opportunities provides new ways to engage young people in positive activities, offers informal accreditation and nurtures aspirations outside of formal education.

• Targeted training for staff, practitioners and volunteers has led to increasing numbers of disabled children accessing universal cultural
opportunities. There is a need for more training to support this integration and equality of access.

- Safeguarding Policy requires secure pathways for participation. 44 (37%) sports clubs, out of an estimated 118 constituted clubs in Knowsley, have been accredited (quality and safe)
- The coach education programme has resulted in higher demand from coaches, which resulted in 389 coaches becoming qualified. There is a need to continue to develop skills within Knowsley residents.
- Creative mentoring, in Knowsley, has been able to reach some young people, who are NEET, in a way that other interventions haven’t. There is a need to continue to use innovative approaches to getting people back into education, employment and training.

Gaps

Access to leisure and cultural opportunities and facilities in Knowsley needs to attract the target groups mentioned above in order to reduce health inequalities, as well as the general population of Knowsley as a whole. Current gaps in service provision include;

- The need for informal personalised community sport and physical activities for those deemed inactive or unengaged, which can lead to regular participation, volunteering and an uptake in a healthy lifestyle.
- Increased use of leisure and cultural opportunities to support behavioural change in individuals.
- Increased use of leisure and cultural opportunities to build confidence, knowledge and experience, which will empower local communities.
- More leisure and cultural opportunities are needed for children and young people, who have disabilities, to engage and participate. The Aiming High scheme highlighted the need for targeted and integrated opportunities for children and young people with impairments and conditions.

Recommendations for Commissioners

It is recommended that commissioners seek to involve colleagues from a leisure and culture background to explore ways to embed new creative and innovative approaches to tackling issues across the key needs identified in this document (including emerging family policy and community empowerment strategies). Recommendations for the future development of leisure and culture activities within Knowsley are as follows;

- Develop arts and physical activity programmes that;
  - Engage reception and year 6, age 15/16 (girls aged 14/15), disabled children and adults, ethnic minority groups, single mums, males 30-40, older people and those with specific long term medical conditions or at risk,
  - Bring together different generations and support greater community cohesion,
  - Reduce the gap between targeted provision and the universal offer by enhancing universal programmes. (e.g. Family Futures)
- Increase access to mainstream opportunities for people with physical and learning disabilities
- Include informal personalised community sport and physical activities for those deemed inactive or unengaged.

- Continue to develop structured programmes for volunteering in arts, heritage and sports to increase skills and access to quality engagement, training and employment opportunities.

- Provide access to training and development for coaches, sports professionals, arts practitioners and the voluntary and club sector, and also provide pathways to local employment in this growth sector.

- Support the development of more leisure and cultural opportunities that will have a regenerative effect on Knowsley communities

- Support the development of a coordinated programme of cultural and sporting events that increase the positive profile of the borough and support the tourism economy

- Consider specific target groups when promoting local leisure facilities: (price, information, quality equipment, transport & child care).

- Ensure that programmes factor in measures for retention and re-engagement.

- Engage the Knowsley workforce and support employers to encourage their workforce to be healthy.

- Work with smaller organisations on co-production programmes that address local priorities.

- Work with partners in planning to integrate public art into future regeneration schemes, with an emphasis on generating work through community engagement.

- Utilise national initiatives (such as 2012 Olympics & Paralympics) to engage local people in activity for example Older Peoples Fun Olympics, supporting local athletes, international connections and Cultural Olympiad.

- Development a GP referral scheme to maximise impact of arts and heritage on health and wellbeing, particularly around mental health (learning from other successful models).

- Continued monitoring and implementation of quality standards for facilities and services e.g. Activity for life, to ensure a positive impact of those services on the Borough and its residents.
3.4.9 TRANSPORT (ACCESS TO KEY SERVICES AND FACILITIES)

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**Key Needs**

- Low car ownership could indicate an increased reliance on other transport modes such as public transport, walking and cycling to access jobs and services;
- Affordability of public transport may be an issue for some residents
- Availability of public transport services which run from north to south within the Borough - although they are regular (as per the timetable) they are infrequent (e.g. half hourly services after peak hours or stop completely in the evening)
- The need to contribute to carbon reduction by providing access to sustainable modes of transport.

**Description of Where / Who the Issue Affects**

The Department of Health Guidance on Accessibility Planning (2006) defined accessibility as ‘whether people, particularly those from disadvantaged groups and areas, are able to reach the jobs and key services that they need, particularly health care, education and food shops, either by travelling to those services or by having those services brought to them’.

Accessibility has links to health, as if it is difficult for people to access the health care services they need, or other services which can affect wellbeing such as the ability to reach job or leisure opportunities, then there may be wider implications for the health sector.

Local Transport Plan 3 for Merseyside, (a long term transport strategy from 2011-2024) is currently in development and, includes a goal to ensure the transport network supports equality of travel opportunity by ensuring people can connect easily with employment, services and social activities. This reinforces the message that equality of travel opportunity (which incorporates accessibility) remains central to local transport planning, and an associated Knowsley implementation plan will be developed, to capture how Knowsley intends to deliver the long term strategy goals.
Low Car Ownership

According to the County Wide Survey (2010), 37% of households in Merseyside have no access to a vehicle. However, when considering the Merseyside Disadvantaged Communities Study (2010) this figure rises to 59% in disadvantaged areas, which could indicate an increased reliance on alternative transport modes such as walking, cycling and public transport in these areas.

Affordability of Public Transport

Public Transport fares have increased steadily, and this trend is likely to continue. Latest figures show that commercial bus fares on Merseyside have risen by 10% over the last 12 months and continue to rise at a faster rate than associated rail and motoring costs (LTP3 Evidence base, 2010). In addition, The Knowsley Young People’s Commission, in their report, Unlocking the Potential of Young People in Knowsley (2010), highlights the high cost of public transport as the single biggest issue identified by young people as the barrier that affects them most in accessing services and opportunities.

Public Transport Access within the Borough

Work has been taking place to consider accessibility by public transport to key employment locations in Merseyside. Access to work is a City Region Priority as well as an aspect of the Knowsley Sustainable Communities Strategy. This work showed that residents in parts of the Borough (mainly south of the Borough) may have to travel for 30 minutes to reach an employment site by public transport during the peak hours.

What is not clear is if the employment sites in question actually have suitable job vacancies. In addition, public transport availability at times outside of the peak periods may be less frequent, so those who work shifts in the early morning or late night may not have access to these sites in less than 30 minutes.

There is limited evidence to suggest that north/south movements within the Borough, for example Halewood to Kirkby may take in excess of 45 minutes to complete by bus. For some residents, anecdotal evidence would suggest that for Halewood residents it may be quicker to travel into Liverpool City Centre and then back out again to a destination such as Kirkby or Prescot using the train. This of course has financial implications for the user.

This issue can be demonstrated by the Map below which shows public transport access to Boulevard Industrial Park (allowing for 1 change of bus) between the hours of 7am – 9am. Residents living in Halewood are likely to reach the industrial park in less than 30 minutes, but those living in areas north of Huyton such as Kirkby could not make this journey in under 60 minutes, which for some job seekers may be a barrier to employment here. When reversing the journey, in the evening period, journey times are similar.
In keeping with the accessibility theme, access to healthcare must also be considered. In Knowsley, the Merseyside Disadvantaged Communities Study
(2010) suggests that over 68% of residents who have no access to a car (labelled risk groups in below graph 1 below) could walk to the surgery to access a GP, which fares well compared to those residents who do have access to a car, but also suggests that 32% of residents need to use alternative transport modes such as public transport or taxis. Again public transport and taxis both incur a fare, so affordability may be an issue. This also does not take into account the level of physical mobility of individuals or the availability of suitable bus routes/ appropriate times.

(Graph 1, extracted from Merseyside Disadvantaged Communities Study, 2010)

However, when considering secondary care in hospitals (see graph 2 below) the figure of people who could walk to their nearest hospital was much lower, at just over 40% (Merseyside Disadvantaged Communities Study, 2010). This would indicate an increased reliance on public transport to get to the hospital sites, but concerns over the reliability of public transport at certain times e.g. for early morning appointments, or having to change buses as opposed to a direct service, are just some of the reasons cited why current public transport is not the easiest option in many cases to access this service.

(Graph 2 extracted from Merseyside Disadvantaged Communities Study, 2010)
Equality and Diversity

Transport access presents greater challenges for different groups in Knowsley. Some examples of groups have been identified and listed below:

Young People

The Knowsley Young People’s Commission, in their report ‘Unlocking the Potential of Young People in Knowsley’ (2010) highlights the high cost of public transport as the single biggest issue identified by young people as the barrier that affects them most from accessing services and opportunities. Transport is also an issue which forms part of the Knowsley Youth Parliament campaign entitled ‘Fares – fair’.

Expectant Mothers

An interesting perspective was highlighted by mums who lived in Huyton and Kirkby during interviews conducted for the Merseyside Disadvantaged Communities Study (2010). They indicated that there were very few options for maternity services in these areas with expectant mothers travelling into Liverpool and sometimes Ormskirk to access maternity services. Participants felt that it was not always easy to access these hospitals as they can be a considerable distance away, or incur multiple changes of bus. This can be further exacerbated if the woman already has other older children and no access to childcare. However, it is worth noting that antenatal care is often delivered within the community.

Older People

Transport is a key priority for the Older Peoples Partnership Board in Knowsley, and has an associated action plan to aid improvement. Older people without access to a car may be reliant on public transport to access the key services they require.

Limited Physical Mobility

Similarly, those of any age with limited physical mobility without access to a car may be reliant on public transport to access the key services they require.

Links to Other Issues / Topics

Adequate transport access is central to many aspects of daily life, including education, employment and social activities. It is also important for reaching services such as shops, health care and financial services.
Links to Existing Strategies (incl. Policies / Services)

Existing Transport Strategy

The second Local Transport Plan for Merseyside comes to an end in March 2011. The replacement plan (LTP3) is currently in development and will be implemented from April 2011. A Knowsley Implementation Plan will be developed once the overall strategy has been agreed, of which accessibility will be a core consideration under goal 4, equality of travel opportunity.

Knowsley Metropolitan Borough / NHS Knowsley Travel Plan

A joint travel plan has been developed which considers staff travel within the borough. This is closely linked to the Good Corporate Citizenship Scheme which NHS Knowsley is working towards, which considers transport impacts and patient access to health care sites.

Transport Access to Employment

Limited transport options are sometimes considered as a barrier to those seeking employment. There are therefore clear links between this issue and the aims of both the City Region Employment Strategy and the developing Knowsley Child Poverty Strategy. This issue will also be considered in Knowsley’s Economic Regeneration Strategy which is currently being refreshed.

Transport Affordability

There are also links to the Knowsley Financial Inclusion Strategy, which helps residents to understand and manage their money in ways which minimise the impact of low income and limited access to bank accounts and affordable credit. This will be increasingly important if plans currently under discussion in relation to electronic payment go ahead. Such smart cards will need to make travel cheaper without the need to pre-pay large amounts and without the need for a credit or debit card.

Transport and Planning

The Local Development Framework for Knowsley and associated guidance documents will inform identification of future employment and housing areas. A supplementary planning document ‘Ensuring a Choice of Travel’ intends to show how development can satisfy the requirements of accessibility policies contained within Knowsley’s Development Plan. It will assist developers in ensuring that their proposals are accessible, promote sustainable travel patterns and minimise the congestion and pollution caused by vehicles.

For those who live in existing developments Knowsley’s Housing Strategy will also consider transport and its future interaction with housing delivery.
Climate Change Strategy

Knowsley’s Local Strategic Partnership has developed a climate change strategy for the Borough. There is a need to reduce the reliance on our use of vehicles and encourage more sustainable options such as public transport and active travel.

Future Implications (Modelling / Projections)

With potential changes to the way public services are delivered, following the reduction in public sector budgets, there may be a shift to more centralised services, which in turn may require increased travel for some residents. At the time of writing, the situation is very uncertain and future projections are difficult to make. Recently, secondary schools in Knowsley have become more centralised – this has meant in some circumstances that the journey to school has increased for pupils. It has been important to incorporate the facilities to encourage sustainable travel such as secure parking for bicycles, and allowing pupils the opportunity to swap bus passes for a bicycle.

A reduction in the Bus Service Operators Grant is also expected to increase demand for subsidised services. Subsidised services are usually those services that bus operators find unprofitable to run, and subsidies are already limited, therefore it is likely that there may be unmet need in some areas. Bus fares may also continue to rise, which further alleviates affordability of using public transport. For those residents who use rail to travel it is very likely that fares will increase in the future.

As described earlier, proposals for smart ticketing could disadvantage those with limited disposable income and no credit or debit cards.

Evidence of What Works

There is much evidence of the benefits to health and wellbeing of active forms of travel (walking and cycling). Most recently, promoting and facilitating cycling and walking are included as a recommendation in the NICE Guidance on prevention of heart disease. Active Travel is an element of the future Local Transport Plan and this type of activity will be promoted accordingly. It must also be recognised that active travel will not be a suitable choice in all circumstances.

Under LTP2, there have been a number of initiatives to help overcome transport barriers to employment for those seeking work. These included free cycles, scooter loan, new bus routes (part demand responsive, part fixed routes), travel passes and Neighbourhood Travel Teams to provide tailored information on existing transport options. There are reported successes, but no formal evaluation is available to date.

In relation to health services, there is anecdotal evidence that moving some hospital clinics closer to the community has increased take-up of referrals and
appointments. Examples include paediatric services from Alder Hey and cardiology clinics from Liverpool Heart and Chest Hospital.

Gaps

Work is underway to identify areas within the borough where there may be gaps in public transport provision. Geographically, Knowsley has good connectivity by road; however, anecdotal evidence does suggest gaps in public transport access in some areas of the Borough. Some communities, such as Knowsley Village, have few off-peak bus services when compared to other areas within the borough, and for some residents this is seen as a barrier. A recent travel survey undertaken by the Prescot, Whiston, Cronton and Knowsley Village Area Partnership Team supports the above. Rail travel is not an option for residents in the Knowsley Village area and it is unlikely that active travel such as walking and cycling would also be realistic all journeys.

Gaps have also been identified in the transport access to key employment sites in Knowsley, particularly the industrial park in Kirkby. The Kirkby Industrial Park Review undertaken in 2010 has considered transport options, and it is hoped recommendations for future improvements will be made. Where bus services to this employment area are available, many do not run at times to meet shift patterns and working hours of the businesses based there.

A review of cycle infrastructure is also underway. It is hoped that this will identify gaps in the cycle infrastructure which may be a barrier to people using cycles to access services. In the future, it is likely that we will have an awareness of where further work is needed to develop the cycle network.

Recommendations for Commissioners

- Provide comprehensive and co-ordinated responses to help with the development of Local Transport Plan 3, and work in partnership to develop a Knowsley implementation plan which takes current transport issues into account.
- Work together on initiatives to encourage walking and cycling activities for members of the community and for staff.
- Ensure new health sector buildings have adopted the principles suggested in the Knowsley ‘Ensuring a Choice of Travel’ Supplementary Planning Document and have considered travel to the site by staff and patients by adopting a travel plan.
- Where changes to service delivery exist, providers must take account of transport provision to the site. Where relevant, this should form part of a Health Impact Assessment and Equality Impact Assessment.
- Explore the potential for further studies to support the anecdotal evidence described above in relation to moving services closer to the community.
Links to Supporting Documents


http://www.letstravelwise.org/content188_LTP3-Consultation.html

Mott Macdonald (2010) Merseyside County Wide Survey

Mott Macdonald (2010) Merseyside Disadvantaged Communities Study – commissioned by Local Transport Plan Support Unit

Mott Macdonald (2010) Local Transport Plan 3 evidence base

The Knowsley Young People’s Commission (2010) Unlocking the Potential of Young People in Knowsley