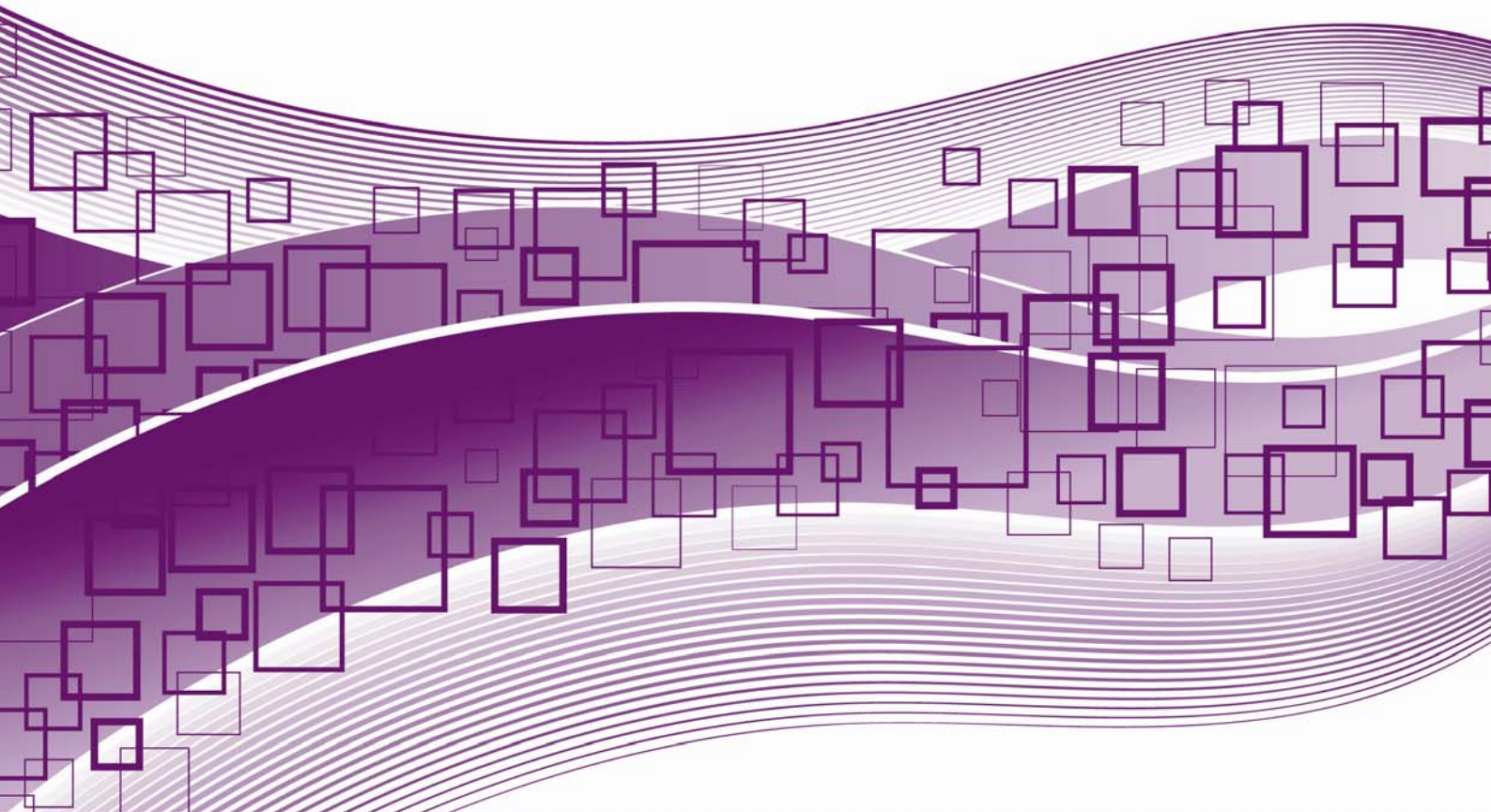


Good Health, Good Care in Flintshire

2011 – 2014

“Our vision for Flintshire is a healthy and caring community where people achieve the best possible levels of health and well-being”



INDEX

Foreword.....	1
Introduction	2
Local, Regional & National Context.....	2
Partnership Working in Flintshire	3
Links with other county partnerships and strategies	4
Challenges to the Health of Flintshire’s Population.....	5
What Else We Have Been Told – Consultation Responses	8
Achievements through the HSCWB Strategy 2008-11	9
Our Target Populations	9
Our Vision – Where We Want To Be	11
Our Contribution to This Vision.....	11
How We Will Know If We Are Getting There (Making Progress).....	11
Action Summaries.....	12
Outcome 1. That people do not smoke	13
Outcome 2. That people drink alcohol within recommended guidelines.....	14
Outcome 3. That people are a healthy weight for their height.....	15
Outcome 4. That older people do not fall	16
Outcome 5. That people do not deliberately harm or injure themselves	17
That people do not die by suicide	17
Outcome 6. That older frail people receiving health and social services	18
•are supported to remain at home	18
•have options and influence over their lives.....	18
Outcome 7. That people with specific long term or chronic conditions receiving health and social services.....	19
•have options and influence over their lives.....	19
•are supported to remain at home	19
Outcome 8. That young disabled people receiving health and social care, going through transition into adulthood	20
•have choice/control.....	20
•are supported to remain within their community where this is their choice.....	20
Outcome 9. That informal carers in Flintshire have options and influence over their lives	21
Monitoring and Review	22
Risk Assessment and Mitigating Actions	22
Workforce Development	22
Finance and Commissioning	23
Glossary.....	24



Foreword

Welcome to Flintshire's third Health, Social Care and Well-being Strategy (HSCWB). In developing *Good Health, Good Care in Flintshire 2011-2014*, the Health Social Care and Well-being Partnership Board¹ has continued to build on the success of, and respond to the experience and shared learning from previous strategies, the first of which was introduced in 2005

This strategy represents a shared vision for health, social care and well-being for the next three years.


Much has been learned by partner organisations about the value of working together with shared aims to maximise the benefit for residents. Experience tells us that success also depends on all of the organisations being able to actively contribute to those aims and in doing so, be able to demonstrate how the aims of their organisation have equally been met by working together.

There is a growing consensus that strategy documents should be concise, state clearly what is needed and why and then focus on what is going to be done about it. In response to this challenge, this document should be seen as a framework for action, where the overall aims and key tasks have been identified and where we have stated how we will measure success. However, throughout the 3 years of implementation, we will have to regularly review the work that takes place to ensure that we are moving in the right direction

The Partnership Board has used the Results Based Accountability methodology to develop this strategy. This approach has encouraged us to be very clear about what we want to change and why and what is needed to make a difference. It also helped us to be clear about how we will measure progress and to identify areas for future action.

One of the opportunities and challenges over the next 3 years is to ensure that locally identified needs are met within a regional context across North Wales. We will work towards ensuring that Flintshire's residents benefit from opportunities available through working together across the region whilst ensuring that meeting local needs remains our priority.

The Partnership acknowledge and are grateful for the many contributions made during the development of this strategy, including the responses received following the publication of the draft version of this strategy, and for all of the hard work that is now to come in order to "turn talk in to action".



Alan Butterworth
Joint Chair
Flintshire County Council



John Darlington
Joint Chair
Betsi Cadwaladr University Health Board

¹ The Partnership Board consists of senior managers from Flintshire County Council, Betsi Cadwaladr University Local Health Board, Public Health Wales, Betsi Cadwaladr University Community Health Council, Flintshire Local Voluntary Council and Independent Care Sector Providers

Introduction

Flintshire County Council (FCC) shares the statutory responsibility² with Betsi Cadwaladr University Health Board (BCUHB) to work with its partners to develop and implement a local strategy to meet the health, social care and well being needs of Flintshire's residents

Draft Guidance issued by the Welsh Assembly Government (WAG) to support the development of this, the third strategy, states that the strategies for 2011-2014, should focus on 2 main areas:

- (i) improving health and well-being and reducing inequities, that is inequalities in health that are unfair and avoidable
- (ii) improving the provision, quality, integration, and sustainability of 'overlapping services', that is in situations where the NHS, local government and their partners together provide a range of interlocking services to identifiable groups within their population.

In developing and delivering on the outcomes within the strategy, the partnership recognises and will respond to its statutory responsibilities within the Equality Act 2010.

In addition, the partnership will ensure that the commitments made within their own Welsh Language Schemes are complied with, and support the WAG vision for the Welsh language when it is published in 2011³ and the Welsh Language Measure (2010).

Local, Regional & National Context

Since the development of the second strategy (Good Health, Good Care 2008-2011), a number of policies and plans have been introduced which have influenced the development and will continue to influence the implementation of this strategy. These include:

Our Healthy Future, 2009.

Our Healthy Future (OHF) is the first strategic framework for public health in Wales. The OHF Technical Working Paper⁴ specifies ten priority outcomes and six themes in response to the biggest causes of preventable ill health across Wales.

In delivering against OHF, partners working in Flintshire will be working to develop and deliver activities against a wide range of local action plans. The OHF for example has been used to inform the development of the Local Authority Outcome Agreement with the Welsh Assembly Government.

A range of plans and policies are relevant to the development and implementation of this strategy at a national, regional and local level as illustrated in figure 1 below. The policy environment is evolving and we will be required to adapt and respond to these developments whilst still working towards the outcomes we have stated in this framework document.

² Section 40 of the National Health Service Wales Act 2006

³ [A Living Language: A Language for Living., Welsh Assembly Government, 2010 \(Consultation\)](#)

⁴ [Welsh Assembly Government | Our Healthy Future - technical working paper](#)

The purpose of the HSCWB Strategy, is to add value to existing planning arrangements, and the role of the Partnership Board is to lead where this is appropriate, not to duplicate existing, effective local mechanisms.

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ One Wales One Planet ▪ National Service Frameworks ▪ NICE Guidelines ▪ Obesity Pathway ▪ Community Strategy ▪ Children and Young Peoples Plan ▪ Community Safety Strategy ▪ Betsi Cadwaladr 5 year plan ▪ Air Quality Action Plans ▪ Creating an Active Wales ▪ Carers Measure | <ul style="list-style-type: none"> ▪ Talk to Me – The National Action Plan to Reduce Suicide and Self Harm ▪ Affordable Warmth Plan ▪ Fulfilled Lives, Supportive Communities and the associated commissioning framework guidance and best practice ▪ North Wales Spatial Plan ▪ Local Authority Service Plans ▪ Designed to Add Vale (Strategic Direction for the Third Sector) |
|--|--|

Figure 1 - Examples of national and local plans influencing the HSCWB development and delivery

Partnership Working in Flintshire

As previously stated, Flintshire County Council and Betsi Cadwaladr Local Health Board are jointly responsible for delivering on the commitments made within this strategy. The structures to take forward strategic level partnership working at a regional, sub regional and county level however are changing and will develop significantly during the lifetime of this strategy. It is anticipated that during 2012, a sub - regional board made up of key decision makers from each of the partner organisations will emerge to oversee and drive the implementation of the 2 HSCWB strategies for Flintshire and Wrexham.

Until this new sub-regional board is in place, the county Health, Social Care and Well being Partnership Board will continue in its current role to oversee and monitor the implementation of the strategy and to challenge partner organisations (with the support of the Local Service Board if needed⁵) where sufficient progress is not being made.

BCUHB, FCC and Flintshire Local Voluntary Council (FLVC) are currently developing a framework for locality working to further integrate community based services to meet the health and social care needs of residents. Within Flintshire there will be 3 localities of approximately 50,000 people. Locality working is delivered around “clusters” of GP practices, and aims to support residents to maintain

⁵ The Local Service Board (LSB) is made up of public and voluntary sector leaders who work collectively to improve the county and its services for the benefit of its residents, visitors and businesses.

independence and well being at home, including avoidance of unnecessary admissions to hospital and long-term care. They will also seek to:

- Improve the multi disciplinary care of people with chronic conditions
- Target and build community resources more effectively

The development of locality working is progressing through the work of the multi agency Locality Leadership Group which will report into the HSCWB Partnership Board.

The fundamental principle driving the development of local or regional structures will continue to be clear accountability and effective governance arrangements.

Links with other county partnerships and strategies

Good Health, Good Care compliments and adds value to other key strategies forming a basis for partnership working across the county. The relationship between these high level strategies/plans is illustrated in the diagram below:



Figure 2 - Key Strategies and Plans

Whilst there are links with a number of other strategies in Flintshire, particular mention should be made to the Children and Young Peoples Plan for 2011-2014. Many of the outcomes within this plan and *Good Health, Good Care* are complimentary and success in delivering against outcomes in each of the plans will require the partnerships to continue to develop strong working relationships.

Challenges to the Health of Flintshire's Population

Good Health, Good Care 2011-2014 sets out to improve the overall health of the population, to reduce unfair differences in health experience, and to improve the provision and quality of integrated services by NHS, local government and other providers to specific population groups. An important first step is to understand the current state of health amongst Flintshire's residents, and the particular issues of the identified population groups in relation to their need for health and social care services.

A review of the health profile⁶ for Flintshire conducted during 2010 showed that smoking, drinking excessive amounts of alcohol and obesity all contribute to the ill health conditions that result in deaths from these causes. If people were to stop smoking, drink alcohol within the recommended guideline amounts, eat a healthy diet and be physically active, there would be a major positive impact on the health of the population. This would lead to a reduction in the need for healthcare and social care services that support people managing these ill-health conditions.

Smoking is the single biggest avoidable cause of disease and early death in Wales. It is a major cause of cancer and many other serious chronic conditions including heart disease, stroke and lung disease.

- 24 % of adults in Flintshire smoke
- 1 in 6 boys, and 1 in 4 girls aged 15 in Wales reported smoking at least weekly
- Long term exposure to second hand smoke can also cause lung cancer.
- Smoking substantially increases the risk of poor outcomes after surgery.
- There is a substantially higher risk of miscarriage and complications in pregnancy and labour where the mother smokes.
- Employees who smoke are more likely to be absent due to ill health, and for longer.
- Smokers are 35% more likely to have a house fire than non smokers.

Excessive consumption of alcohol, binge drinking and alcohol dependence can cause serious social, psychological and physical health problems, and affect work, social and personal relationships. In young people, the negative social consequences include missing school, falling behind in schoolwork, unplanned and unprotected sexual activity, arguments with friends, destructive behaviour and trouble with the police.

Older people are far less likely to drink heavily compared to the younger age groups. However, it has been argued that alcohol consumption amongst older people is likely to be underestimated due to the fact that there is insufficient screening and other forms of detection which tend to focus on younger age groups.⁷

⁶ All primary sources of data are referenced within the health profile document are available on request from GoodHealthTeam@flintshire.gov.uk or 01352 702536

⁷ O'Connell et al cited in [A profile of the Health of Older People in Wales - National Public Health Service](#)

Adverse health outcomes also include intentional and unintentional injuries, both of which are related to patterns of drinking.

- 45% of adults in Flintshire report drinking alcohol above the recommended guidelines
- Excessive drinking in early pregnancy can lead to miscarriage, low birth weight and can affect the physical and mental development of the child

Overweight and obesity are risk factors for many serious chronic health conditions in adults, including circulatory disease, hypertension, diabetes, and some cancers.

- More than half of adults in Flintshire report being overweight or obese
- Women who are obese during pregnancy have significantly more pregnancy complications and a higher rate of Caesarean sections.
- Children who are overweight or obese risk exacerbation of asthma, and psychological problems as well as similar health consequences to those of adults.
- Weight loss in overweight and obese individuals can improve physical, psychological and social health, but being significantly **underweight** is also a risk factor for poor health

Preventing **injuries** or the impact that injuries can have would lead to a significant reduction in associated disability and death, again reducing the need for health and social care providers to provide long term care or support.

Unintentional falls are the most common form of injury amongst older people. Injuries and their consequences produce a heavy burden on individual, families and society in terms of short and long term disability, mortality, economic loss and health care and social care costs. Fear of falling can result in reduced levels of activity and social contact, leading to further physical and mental health problems.

- An estimated 35% of people aged over 65, and 45% of people aged over 80 will fall each year.

Every **suicide** is a tragedy, a life and family member lost. Although suicide is a relatively rare event, it is one of the highest causes of death among young people. Reasons are often very individual and complex, but suicide has been associated with many factors, including psychiatric and physical illness, and economic recession.

Deliberate self harm / self injury also has significant personal, social and economic consequences, and there is evidence to show that in many cases of suicide the person will have a history of harming themselves.

- In Wales over 70% more people die by suicide than in road traffic accidents
- People living in the most deprived fifth of Welsh areas are almost twice as likely to die from suicide as those in the least deprived fifth.
- Self harm - in Wales there are as many as 6,000 hospital admissions each year as a consequence of people harming themselves
- 7%-14% of adolescents will self harm at some time in their life
- Self harm is particularly prevalent in young people and is an indication of underlying social, relationship, emotional and psychological problems.
- Many people who die from suicide have harmed themselves in the past

Creating an equal and fair chance for good health and good care

In Flintshire, as elsewhere, some groups of people are known to experience poorer health and to have higher rates of harmful health behaviours than others of the same age and background, including

- People living in poverty or deprivation
- People with serious mental illness
- People with physical or learning disabilities
- Informal carers
- People from minority ethnic groups

This is also the case for people who live in areas where there is multiple deprivation and/or disadvantage. For example, the area of the Deeside coastal strip contains many of the worst rates of poor health in the county.

For many people, there is a double disadvantage: being poor and living in disadvantaged circumstances not only makes you ill, it also impacts on your ability to survive that illness.

Although reducing these unfair differences in health experiences presents a significant challenge, it is a clear focus in this Strategy.

In developing and implementing activities to improve the health of Flintshire's residents, the Partnership will pay particular attention to **improving health and wellbeing in groups who are known to experience the poorest health**

In response to one of the main themes identified during the consultation for this Strategy, **providing support for people to take responsibility for their own health is a clear priority**. A greater emphasis on providing accessible information, along with appropriate skills development and support to be able to act on that information is necessary. Targeting additional support to those who cannot otherwise take up available early prevention and protection services such as immunisation, screening and smoking cessation is also important.

The ability or an individual to be part of and to influence decisions being made about them or the person you provide care for is likely to help retain/develop individual responsibility, self worth and well being, thereby leading to improved outcomes for

them. The second theme within this strategy therefore seeks to ensure that individuals are able to influence (play an active part in) decisions, self care/management and to benefit from any options that are available to them.

What Else We Have Been Told – Consultation Responses

The consultation period for the strategy resulted in a total of 84 individual responses from members of the public and professionals, 11 group/organisational responses and attended 5 consultation events.

A number of the responses referred to activities that could only be taken forward at a national level. Where responses could be taken forward locally, these comments have been used to inform this strategy, to add detail to what the current situation is in Flintshire or what we should be doing. In addition, many of the comments received will become very relevant again when action plans begin to be developed.

The key or repeated messages which have influenced the development of the action summaries and key actions for 2011-2014 include:

- People should be encouraged to take responsibility for their own health, as well as being supported to do so.
- We should promote and strengthen community action.
- Whole families should be targeted for health improvement
- We should pay particular attention to ensuring children and young people develop healthy lifestyles but not forget that good health should be for life
- We need to use evidence to direct our resources over the longer term at interventions that will make a difference
- We need to make sure that we recognise and respond to the needs and difficulties that people have in maintaining a health promoting lifestyle.
- People with chronic conditions need an early diagnosis; supportive professional help and education and encouragement from carers and others to self manage their condition
 - Older frail people need timely access to a safety advice/checks of their home; timely provision of equipment and adaptations; support from friends and family, short term help when there has been a crisis for example
 - Carers need to be well informed and supported to benefit from all available options and to look after their own health and well being

Highlighted concerns were with regard to waiting times for appropriate occupational therapy equipment and adaptations and the need for GP practices to be able to respond more effectively to the needs of people with chronic conditions and carers.

A full report of all of the responses received is available upon request⁸.

⁸ Copies can be obtained from GoodHealthTeam@flintshire.gov.uk or 01352 702536

Achievements through the HSCWB Strategy 2008-11

Reflecting on the lessons we have learned collectively since the first strategy was implemented in 2005, the greatest achievements have occurred when:

- We have been clear about what we want to change and the contribution that each partner organisation must make
- There was clarity of purpose and effective local mechanisms in place.
- Effective prioritisation has enabled grant funding to be used to achieve change.
- Ongoing and proactive involvement of all partners has been maintained – reduced engagement rapidly results in lost momentum.

Examples of most effective impact include:

- The profile and recognition of the needs of informal carers has significantly improved. Examples of actions taken include the implementation of the carers commissioning strategy, carers in employment policies and support for carers to get back into work, greater recognition of the needs of carers in housing allocation policies, continuation of Carers Grant allocation to the voluntary sector and the focussed work to raise the profile of Young Carers.
- Development of improved services for Older People with Mental Health Needs in the west of Flintshire
- Development of the Living Well Project to support older people with dementia in a more flexible and person centred way in the community.
- Raising the profile of mental wellbeing, via a county – wide awareness campaign
- Focussing on reducing poverty and disadvantage
- Investing in smoking prevention and cessation in schools and youth service settings
- Health Challenge Flintshire awards made to local voluntary and community organisations who are supporting well being activities

Our Target Populations

The strategy relates to everyone who lives in Flintshire.

For the health improvement elements of the strategy, the outcomes are intended for everyone who lives in Flintshire, with a particular focus on population groups known to be at risk of poorer health experience as described above.

For the second element of the strategy i.e. to strengthen the planning and management of overlapping services between the local authority and the local health board where there is a joint responsibility and a duty to co-operate, we have identified groups of people for whom improvements can be made through the specific work of the Partnership.

- Older frail people
- People with long term conditions
- Informal Carers

- Young disabled people going through transition into adulthood who will require services

Within Flintshire there are already processes in place for integrating services for people with mental health problems, people with learning disabilities, and people with substance misuse problems. Therefore the Partnership has agreed to focus on how overlapping services can better meet the needs of the above.

Our Vision – Where We Want To Be

Our vision for Flintshire is a healthy and caring community where people achieve the best possible levels of health and well-being

Our Contribution to This Vision

Our vision is aspirational and achieving the vision will require longer term efforts of more than one strategy or partnership.

The Partnership has therefore stated that its contribution to the vision will be to work towards achieving the following outcomes:

1. That people do not smoke
2. That people drink alcohol within recommended guidelines
3. That people are a healthy weight for their height
4. That older people do not fall
5. That people do not deliberately harm or injure themselves
That people do not die by suicide
6. That older frail people receiving health and social services have options and influence over their lives and are supported to remain at home
7. That people with chronic conditions receiving health and social services have options and influence over their lives and are supported to remain at home
8. That young disabled people receiving health and social care, going through transition into adulthood have choice/control and are supported to remain at within their community where this is their choice
9. That carers have options and influence over their lives

How We Will Know If We Are Getting There (Making Progress)

For each of the above, we have either developed some measures to see if we are making progress or agreed that we must develop a new measure if this isn't currently available. These measures or "indicators" are not about services or organisations, but about whether we are moving in the right direction to achieve the overall outcome for the population.

In addition to these indicators at a population level, we will work with organisations and services who work towards these outcomes to measure their performance not by how busy they are or how many people they work with for example, but by the difference they make.

For each of these outcomes therefore, an action summary has been developed to summarise what trend we want to change, how we will measure progress at a population level and the key tasks or activities that will be undertaken during the implementation of the strategy.

These key tasks have been identified:

- through the consultation on the draft strategy with organisations, community groups and the public who were asked to tell us how we could achieve the outcomes we are working towards
- through evidence of effective interventions from local and national work
- in response to known gaps or where further work could improve effectiveness

Action Summaries

The following pages outline:

- our outcomes and why they are important
- measures we can already use to indicate whether progress is being made over time
- what is the current situation (or story) in Flintshire and where we need to focus
- What is known to work or has been recommended in the consultation
- What else we need to know

At the end of these summaries, we then provide details of the high level actions we are going to progress through the lifetime of the strategy.

Many of the action summaries are interlinked or can add value to each other and this will be considered in the development of activities during the implementation stage.

As stated above, this strategy should be considered as a framework for action and the Partnership will need to review and refine activity based on its monitoring and evaluation of progress.

Outcome 1. That people do not smoke

How we will measure progress	<ul style="list-style-type: none"> • Welsh Health Survey: Adults who reported smoking daily or occasionally. • Health Behaviour in School-aged Children (HBSC): % of 15 year olds reporting weekly smoking (All-Wales data only)
What is the situation in Flintshire, and where do we need to focus?	<ul style="list-style-type: none"> • Generally there is a downward trend in the overall proportion of adults in Flintshire who smoke – from 26% in 2003-2005, to 24% in 2008-2009. However, when compared to the best in the UK or Europe, this level is still high. • Nationally, there are strong links between smoking and deprivation: 36% of the adult population in the most deprived areas smoke compared to 14% in the least deprived. • The prevalence of smoking in some mental health service settings is 70%. • One in 6 boys, and 1 in 4 girls aged 15 in Wales reported smoking at least weekly.
What Works...	<ul style="list-style-type: none"> • Prevention, cessation and environmental actions are required to achieve maximum impact • Coordinated ‘whole school’ approaches, supported by policy development, curriculum material, peer led interventions, training and development • Evidence-based smoking cessation services • Simple, systematic brief interventions linked to smoking cessation interventions, particularly among those at high risk of cardiovascular disease; pregnant women and those undergoing elective surgery have the potential for significant health gain and reduction in healthcare and other costs. • Workplace smoke free policies promote a smoke free environment which encourages staff to quit smoking
What else we need to know	<ul style="list-style-type: none"> • More detailed local data on smoking in children and young people
What we are going to do	<ul style="list-style-type: none"> • Support actions in the Children and Young People’s Plan to address smoking through schools based approaches • Support staff members in all partner organisations who smoke (and who wish to stop) to access smoking cessation support services • Provide training to relevant front line staff to deliver brief intervention advice to people who smoke • Enforce legislation re age restricted sales and smoking in enclosed public places • Support No Smoking Day activities

Outcome 2. That people drink alcohol within recommended guidelines

How we will measure progress	<ul style="list-style-type: none"> • Welsh Health Survey: Adults who reported drinking above guidelines on at least one day in the past week • Welsh Health Survey: Adults who reported binge drinking on at least one day in the past week • HBSC : % 15 year olds reporting drinking alcohol in the past week (All-Wales data only) • Health Maps Wales: Hospital Admissions due to Alcohol-specific and attributable conditions
What is the situation in Flintshire, and where do we need to focus?	<ul style="list-style-type: none"> • 45% adults in Flintshire reported high levels of alcohol consumption, and this has increased over recent years, in line with the all-Wales picture. Unlike other health related behaviours, alcohol consumption above recommended guidelines is consistent across all socioeconomic groups. However, the most deprived areas experience alcohol-related mortality rates which are more than three times higher than those in least deprived areas. • Young people in Flintshire highlight alcohol use as a significant concern. • Flintshire has an aging population and there is evidence that this age group is less aware of the safe drinking limits than the general population
What Works.....	<ul style="list-style-type: none"> • Restricting the availability and affordability of alcohol • Protecting young people by test purchasing and application of appropriate sanctions. • Screening and brief interventions for people at risk of becoming harmful or hazardous drinkers (particularly children and young people and other high risk groups) • Alcohol Brief Advice training for Primary Care staff • Co-ordinated whole 'school' approaches, supported by policy development, curriculum material, peer led interventions, training and development
What else we need to know	<ul style="list-style-type: none"> • Information about alcohol use in older people • Information about 'drinking at home', and its associated risks to individuals and their family members
What we are going to do	<ul style="list-style-type: none"> • Support related actions in the Children and Young People's Plan and Community Safety Strategy • Focus on prevention work with children and young people, pregnant women and older people • Develop and deliver initiatives to raise awareness and understanding of the guidelines relating to alcohol consumption • Provide training to relevant front line staff to deliver brief advice to people drinking above the guidelines to reduce consumption • Enforce legislation re age restricted sales

Outcome 3. That people are a healthy weight for their height

How we will measure progress	<ul style="list-style-type: none"> • Welsh Health Survey (WHS): Adults who were overweight or obese / Adults who were obese • WHS: Adults who reported meeting physical activity guidelines in the past week • WHS: Adults who reported eating five or more portions of fruit and vegetables the previous day
What is the situation in Flintshire, and where do we need to focus?	<ul style="list-style-type: none"> • More than half of adults in Flintshire report being overweight or obese. • Preliminary all-Wales information from the Childhood Heights and Weights Study shows 22% children aged 4-5 years, and 26-28% children aged 8-9 years were overweight or obese. Without increased intervention, the situation is likely to worsen. • Levels of obesity in adults and children are higher in lower socioeconomic / socially disadvantaged groups.
What Works.....	<p>Interventions for prevention should focus on:</p> <ul style="list-style-type: none"> • Major socio-economic determinants of unhealthy eating and physical inactivity at the population level; • A combination of community (neighbourhood, workplace, school) and individual approaches; • Whole family approaches, including those targeting women planning to be or who are pregnant • A range of community and primary care weight management services should be available for children, young people and adults who wish to lose weight and have been identified as being at increased risk of obesity. More specialist interventions including dietary, physical activity and behavioural components are needed for those with co-morbidities (more than one condition) or more complex relationships with food
What else we need to know	<ul style="list-style-type: none"> • More detailed local data on physical activity levels in adults and children • Flintshire data from Childhood Heights & Weights Pilot, and subsequent annual data • Information on population groups at increased risk of being underweight
What we are going to do	<ul style="list-style-type: none"> • Provide opportunities across settings/age groups to develop skills/knowledge on healthy eating and physical activity, targeting people in lower socioeconomic / socially disadvantaged groups • Develop and implement a Creating an Active Flintshire Physical Activity plan • Deliver combined nutrition and physical activity programmes in key settings, including early years and schools • Identify people who are overweight/obese with risk factors, and assess their motivation to change • Develop a local response to the obesity pathway

Outcome 4. That older people do not fall

How we will measure progress	<ul style="list-style-type: none"> • eHealthShow: Hospitalisation for fractured neck of femur • eHealthShow: Hospitalisation for accidental falls
What is the situation in Flintshire, and where do we need to focus?	<ul style="list-style-type: none"> • The number of older people at risk of falling is increasing: the proportion of the Flintshire population aged 64-74 years is predicted to increase by 30%, and across North Wales, the proportion of people aged 75 or over is expected to increase by 50%. . An estimated 35% of people aged over 65, and 45% of people aged over 80 will fall each year. Increasing age is associated with frailty, disability and loss of independence which can lead to an increase in the risks associated with unintentional falls and hip fracture. • Women are more likely to be injured by falling than men • The home is the most common place for an older person to sustain an injury.
What Works....	<ul style="list-style-type: none"> • Multifactorial falls risk assessments that address and respond to both individual (e.g. visual assessment, medication review , nutritional assessment) and environmental factors (e.g. footwear, home hazards) • Diagnosis and management of osteoporosis, • Provision of strength and balance exercise opportunities throughout the life course, and specialist strength and balance exercises • Therapeutic interventions to reduce fear of falling • Specialist input where cognitive impairment is present
What else we need to know	<ul style="list-style-type: none"> • Locally generated information about who falls, and the causes of falls to support targeting of interventions
What we are going to do	<ul style="list-style-type: none"> • Provide information about relevant falls risk factors and the steps an individual can take to reduce them • Further develop and implement the multiagency Falls Pathway • Include a home environment / falls risk assessment as part of all assessments of need for older people • Support physical activity opportunities (including strength and balance training) for older people in a range of community based settings • Deliver specialist strength and balance exercise for people at high risk of falling, or who have already had one or more falls (e.g. via National Exercise Referral Scheme / Later Life Postural Stability)

**Outcome 5. That people do not deliberately harm or injure themselves
That people do not die by suicide**

How we will measure progress	<ul style="list-style-type: none"> • eHealthShow: Standardised rates for suicide and undetermined deaths • Hospital admissions for self harm
What is the situation in Flintshire, and where do we need to focus?	<ul style="list-style-type: none"> • In Flintshire, the number of suicide deaths is comparable to the average rate for Wales, and no overall trend is discernable. • In Wales, suicide accounts for around 300 deaths per year, and at least 6,000 people are taken into hospital each year because they have harmed themselves. The majority of people who self harm have no intent to end their life, but the process of self harming provides a way for them to cope with their distress. • In general, 7%-14% of adolescents will self harm at some time in their life. Self harm is more common among women than men • Three in four suicides in Wales are among males; the peak age for suicide is between 20-39 years of age., • Suicide accounts for almost one in five deaths among young men (aged 15 to 24), and almost one in ten deaths among young women (aged 15-24).
What Works	<ul style="list-style-type: none"> • Whole population approaches addressing public mental health and raising general awareness • Identification and delivery of targeted intervention to people at increased risk of suicide • Equip 'front line' service providers to address in a sensitive and effective manner the needs of people who self harm and people who are at risk of attempting suicide • Restricting access to the means of suicide
What we plan to do	<ul style="list-style-type: none"> • Provide information about steps individuals can take to look after their own (and others') mental wellbeing • Publicise sources of support, and information about treatments, for people with mental distress / mental health problems • Support relevant 'front line staff' to receive Mental Health First Aid Training, and Applied Suicide Skills Intervention Training, where appropriate. • Lead and monitor implementation of the local response to " Talk to Me" – the National Action Plan to Reduce Suicide and Self Harm 2009-2014
What else we need to know	<ul style="list-style-type: none"> ▪ More information about people who self harm in Flintshire

Outcome 6. That older frail people receiving health and social services

- are supported to remain at home
- have options and influence over their lives

<p>Existing Indicators to measure progress*</p>	<ul style="list-style-type: none"> • Rate of older people aged 65+ helped to live at home per 1000 population aged 65+ • % of clients supported in the community during the year who are aged 65+ <p>(*nb – it will be the “story behind” these indicators and what it means to residents which is important to assess)</p>
<p>What is the situation in Flintshire, and where do we need to focus?</p>	<ul style="list-style-type: none"> • Waiting times for OT assessments are causing delays in accessing equipment and housing adaptations. • Older people do not always require intense or long term support but would benefit from short term support e.g. following an illness. Early and flexible intervention can prevent deterioration and requirement for more intense support. • There is a need to consider the needs of and consequences to carers when providing options or influence to a service user. • The current and projected increase in older people with dementia will require services to adapt and be flexible if people are going to be supported to stay at home
<p>What Works.....</p>	<ul style="list-style-type: none"> • Flexible working within and across agencies and the whole system, to meet individual need • Collaborative, person-centred working between the voluntary sector and statutory agencies • Reablement approach • Informed, supportive and supported families and communities
<p>What else we need to know</p>	<ul style="list-style-type: none"> • Feedback from service users that services received have helped them: <ul style="list-style-type: none"> ○ to have options and influence over their lives ○ supported them to remain at home. • Feedback from service providers relating to how effective partner organisations are working together to meet the needs of service users/patients.
<p>What we are going to do</p>	<ul style="list-style-type: none"> • Develop a consistent approach to gain service user feedback as above • Ensure that the planning and delivery of community based services through locality working contribute to this outcome

Outcome 7. That people with specific long term or chronic conditions receiving health and social services.....

- **have options and influence over their lives**
- **are supported to remain at home**

Existing Indicators to measure progress	<ul style="list-style-type: none"> • number of emergency admissions for specific chronic conditions (Diabetes, Chronic Obstructive Pulmonary Disorder, Coronary Heart Disease) • number of readmissions to hospital within 30 days and 12 months
What is the situation in Flintshire, and where do we need to focus?	<ul style="list-style-type: none"> • People who are supported to self manage their conditions well (retain a “steady state”), will improve their quality of life and prevent the need for frequent admission into hospital. • The predicted demographic change and high risk behaviours impacted upon by life circumstances (e.g. sedentary living, tobacco and alcohol use), will contribute to a predicted increased number of people with chronic conditions and complex (or multiple) chronic conditions. • Health Service reorganisation, has resulted in a need to develop a standardised approach to the management of chronic conditions across the region. It will be necessary to respond to the impact on Flintshire’s residents from these changes when the model is finalised
What Works.....	<ul style="list-style-type: none"> • The patient and their needs must be “at the centre” of planning and delivery of services. Flexible and collaborate working across agencies at both an operational and senior management level will be required. It is vital that the “system” does not provide barriers to effective partnership working at the point of delivery. • Expert Patient Programmes • Dedicated support when needed from a health care professional who is known and trusted by the patient • Carers (informal and paid), health care professionals and others should be encouraged to support and give confidence to patients to manage their conditions in a consistent way • Supportive families and communities
What else we need to know	<ul style="list-style-type: none"> • Feedback from service users that services received have helped them: <ul style="list-style-type: none"> ○ to have options and influence over their lives ○ supported them to remain at home. • Feedback from service providers relating to how effective partner organisations are working together to meet the needs of service users/patients.
What we are going to do	<ul style="list-style-type: none"> • Develop a consistent approach to gain service user feedback as above • Ensure that the planning and delivery of community based services through locality working contribute to this outcome

Outcome 8. That young disabled people receiving health and social care, going through transition into adulthood ...

- **have choice/control**
- **are supported to remain within their community where this is their choice**

Existing Indicators to measure progress	<ul style="list-style-type: none"> • Number and % of disabled young people, who will require services from Social Services for Adults with their own single plan. • Number and % of disabled young people going through transition into adult services receiving a personal budget for services via either a direct payment or Citizen Directed Support (CDS). • % of young people leaving school supported to stay within their communities where this is their choice
What is the situation in Flintshire, and where do we need to focus?	<ul style="list-style-type: none"> • Young disabled people going through transition require a range of services from different agencies, all of whom develop separate plans • To give more control and choice to young disabled people and their families, the development of a single plan is a requirement in the NSF for Children, Young People and Maternity Services (5.35). • Despite the work of the Transition Implementation Group to develop the Single Plan, little progress in implementation has to date been possible. • Young people are often influenced by others in making choices about continuing education. Young people need to be supported to make their own choices based on information and experience.
What Works.....	<ul style="list-style-type: none"> • Single plan developed by 3 Mums from Monmouthshire has been held up as good practice
What else we need to know	<ul style="list-style-type: none"> • % of disabled young people going through transition into adulthood who report they had a smooth transition
What we are going to do	<ul style="list-style-type: none"> • Provide the necessary leadership to support development and evaluation of the single plan & monitor progress. This single plan, (or transition plan) which covers all the significant elements of the young person's life, is owned and controlled by that young person and their family and is produced in a format to meet their needs. From this plan, outlines of statutory plans can be completed. • Develop a mechanism to find out the views of young disabled people and their families – did they have a smooth transition? • Monitor the uptake of Personal Budgets for Services

Outcome 9. That informal carers in Flintshire have options and influence over their lives

Existing Indicators to measure progress	<ul style="list-style-type: none"> • Number (%) of identified carers of adult service users who were offered an assessment or review of their needs in their own right during the year (SCA/018a) • Number (%) of identified carers of adult service users who were assessed or reassessed in their own right during the year who were provided with a service (SCA/018c) • Number (%) of young carers known to social services who were assessed in the period.(SCC30a) • Number (%) of young carers identified in the period who were provided with a service
What is the situation in Flintshire, and where do we need to focus?	<ul style="list-style-type: none"> • The average age of over 65 age group receiving services from Social Care in 2010/11 is 87 indicating the age of carers is increasing. • There is a generation of carers that provide care for both older and younger people. These carers are effectively “sandwiched” between the older and younger generation. • Demographic changes and more complex health care needs place additional pressures on carers. • Support for carers to look after their own well being (often becomes secondary to needs of the cared for). • Some people may feel that professionals have assigned them a caring role without ever having received their consent
What Works.....	<ul style="list-style-type: none"> • Multi agency Carers Strategy Group leading a Joint Commissioning Strategy – ensuring we know our priorities and are able to direct service provision to meet those needs. • Carers recognise the role of the co-ordinating voluntary body who listen and advocate for their needs and act as an easy point of contact. • Focus separately on the needs of Young Carers. • Provision of timely, accurate information and training • Respite and crisis management to meet individual needs. • Promotion of good mental health for carers
What else we need to know	<ul style="list-style-type: none"> • Feedback from carers to identify whether services received have helped them to have options and influence
What we are going to do	<ul style="list-style-type: none"> • Continue to support work of Carers Strategy Group • Consider the impact of the Carers Measure • Promote the data development agenda across agencies

Monitoring and Review

To ensure effective monitoring and review of this strategy, the Partnership Board will develop a performance management framework which will include:

- More detailed action and commissioning plans
- Local performance, monitoring and review arrangements*
- Annual updates to Elected Members, the Local Health Board and Welsh Assembly Government
- Key achievements will be published annually on the websites of key partner organisations and in paper format on request⁹

*Local performance arrangements will challenge service providers and organisations to report on the contributions they are making towards the desired outcomes which is consistent with that used within Results Based Accountability methodology. This means that we will not measure success by “how busy” organisations are, but by the difference they are making.

The work of the Partnership Board is part of a wider governance framework set up by the Local Service Board. These arrangements provide the Partnership Board with opportunities to report on progress and to raise any issues preventing the successful delivery of the strategy and for the PB to be challenged where that is appropriate.

Risk Assessment and Mitigating Actions

Throughout the implementation of the strategy, the Partnership Board will need to identify, mitigate for and manage a number of risks, including:

- The current economic climate and the impact of this on individuals, families and carers.
- The implications of any reduction in public sector finance, including the withdrawal of key grants
- Potential increase in demand for services due not only to the above, but also as a result of demographic change
- Organisational change (including impact of regional working)
- Individuals being reluctant to exercise not only their rights, but also their personal responsibility to improving health and well being.

An assessment of risks and mitigations will be reported through the above mentioned governance arrangements with the LSB and as appropriate within partner organisations (e.g. via the Strategic Assessment of Risks and Challenges within the local authority)

Workforce Development

Partner organisations responsible for implementing this strategy will have to ensure that their workforce (including paid staff, volunteers and trustees) are able to deliver

⁹ Copies can be obtained from GoodHealthTeam@flintshire.gov.uk or 01352 702536

services to meet the current and future needs of Flintshire's residents. We will need to consider how to rebalance and further develop the way we work together to deliver more services away from hospital settings and support community based care.

The workforce will need to be responsive and flexible and have the required skills, experience, knowledge, cultural diversity and values to provide trusted care and support without duplication and in a way that puts the service user at the centre.

We also recognise that it is important that our workforce empowers service users and gives them the confidence and support to do what they can for themselves, to manage their chronic conditions well and to stay well and active for as long as possible.

Finance and Commissioning

This strategy is being published at a time when all partner organisations are facing significant challenges in relation to the funding of services.

Whilst it is true that the implementation of activities to support this strategy, will have to be undertaken within existing resources, this does not mean that we cannot consider how we currently use the resources available to us to make sure that they are focussed on delivering progress against the outcomes included in this strategy.

Partner organisations will therefore seek ways of achieving progress by the efficient and effective use of available resources. In meeting this challenge, the partnership will need to consider all available options, including for example provision made within the National Health Service Act (Wales) 2006 and the Children Act 2004.

Glossary

Applied Suicide Intervention Skills Training	A course which teaches people to recognise suicidal thoughts and gives them the confidence and the skills to intervene http://www.asist.org.uk/
Childhood Heights and Weights Study	A national programme under development to measure the height and weight of children to provide accurate and consistent information to inform policies to improve the health of young people. http://www.wales.nhs.uk/sitesplus/888/news/16488
Citizen Directed Support	Citizen Directed Support is about people being in control of the support they need to live their life as they choose. There are a number of components, one of which is Personalised Budgets http://www.ssiacymru.org.uk/index.cfm?articleid=4305
Expert Patient Programmes	The Expert Patients Programme Wales (EPP) provides a range of self-management courses and workshops for people living with long-term health conditions or for those who care for someone with a long term condition http://www.wales.nhs.uk/sites3/home.cfm?orgid=537
Health Behaviour in School-aged Children Study	A cross national study used to inform and influence health promotion and health education policy and practice at national and international levels. http://www.hbsc.org/countries/wales.html
Personal Budgets	See Citizen Directed Support
Results Based Accountability	Results Based Accountability is a disciplined way of thinking and taking action that can be used to improve the quality of life in communities and services. The methodology bans jargon and provides a simple toolkit for agreeing a common language, often blamed for the failure of joint working. The methodology requires those using it to start with the desired end results, and then plan backwards to means (what we will do). http://www.raguide.org/index.shtml
socio-economic determinants	Social determinants of health are the conditions in which people are born, grow up, live, work and age. These conditions influence a person's opportunity to be healthy, his/her risk of illness and life expectancy Source: World Health Organisation http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/socioeconomic-determinants
Welsh Health Survey	The Welsh Health Survey is a major source of <u>self reported</u> information about the health of people in Wales, the way they use health services, and the things that can affect people's health. http://wales.gov.uk/topics/statistics/theme/health/health-survey/?lang=en