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Blackpool Council

14 October 2014

All Members of the Health and Wellbeing Board are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 22 October 2014 at 3.00 pm
in City Learning Centre, Bathurst Avenue

A G E N D A

1 DECLARATIONS OF INTEREST

Members are asked to declare any interests in the items under consideration and in doing so state:

(1) the type of interest concerned; and

(2) the nature of the interest concerned

If any member requires advice on declarations of interests, they are advised to contact the Head of Democratic Governance in advance of the meeting.

2 MINUTES OF THE LAST MEETING HELD ON 3RD SEPTEMBER 2014 (Pages 1 - 4)

To agree the minutes of the last meeting held on 3rd September 2014 as a true and correct record.

3 STRATEGIC COMMISSIONING GROUP UPDATE (Pages 5 - 14)

To consider an update on the work of the Strategic Commissioning Group.

4 BETTER CARE FUND SUBMISSION (Pages 15 - 18)

To provide an update on the revised submission of the Better Care Fund.

5 TOBACCO CONTROL STRATEGY AND ACTION PLANS 2014-2016 (Pages 19 - 48)

To consider the Tobacco Control Strategy and Action Plan 2014-2016.

6 SOCIAL ISOLATION UPDATE (Pages 49 - 52)

To receive an update further to the meeting on the work from the thematic debate held on the 4th June 2014 regarding Social Isolation.

7 PUBLIC HEALTH ANNUAL REPORT (Pages 53 - 88)

To consider the Public Health Annual Report.

8 QUALITY PREMIUM (Pages 89 - 94)

To consider the quality premium.

9 OPERATIONAL RESILIENCE PLAN (Pages 95 - 98)

To provide an update on winter planning and the Operational Resilience Plan.

10 ADULT SOCIAL CARE- SECTION 256 MONIES TRANSFER (Pages 99 - 108)

To consider a report on the transfer of the Section 256 monies to Adult Social Care.

11 DUE NORTH REPORT (Pages 109 - 132)

To consider the Due North report.

12 DATE OF NEXT MEETING

To note the date of next meeting as the 3rd December 2014.

Venue information:

First floor meeting room (lift available), accessible toilets (ground floor), no-smoking building.

Other information:

For queries regarding this agenda please contact Lennox Beattie, Executive and Regulatory Manager, Tel: 01253 477157 , e-mail lennox.beattie@blackpool.gov.uk

Copies of agendas and minutes of Council and committee meetings are available on the Council's website at www.blackpool.gov.uk.

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 3 SEPTEMBER 2014

Present:

Councillors

Blackburn Collett Rowson

Simon Bone, David Bonson, Gary Doherty, Dr Amanda Doyle, Roy Fisher and Joan Rose

In Attendance:

Lennox Beattie, Executive and Regulatory Support Manager
Venessa Beckett, Corporate Development and Policy Officer
Stephen Boydell, Senior Public Health Analyst
Scott Butterfield, Corporate, Development Policy and Research Officer
Neil Jack, Chief Executive
Traci Lloyd-Moore, Health and Wellbeing Board Development Officer
Ibby Masters, Deputy Police and Crime Commissioner for Lancashire
Liz Petch, Public Health Specialist
Andy Roach, Blackpool Clinical Commissioning Group

Apologies

Apologies were submitted on behalf of Councillors Clapham and Taylor and Delyth Curtis, Richard Emmess, Jane Higgs, Ian Johnson, Dr Arif Rajpura and Professor Heather Tierney-Moore

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 9TH JULY 2014

Resolved:

That the minutes of the meeting held on the 9th July 2014 be approved as a correct record.

3 DEVELOPMENT UPDATE

The Board received an update on the four revised priorities identified at the Board's last Away Day. The four drivers identified were stabilising the housing market, substance misuse alcohol drugs and tobacco, social/isolation community resilience and early intervention. The update included a proposal setting out next steps which included a review of the current JHWS to support transitional arrangements from the current to a new version, finalising the improvement plan and undertaking a further development session to move forward into the new year with a clear plan of action.

Liz Petch updated board as to the views of the voluntary sector organisations and that these were broadly in line with the views of such organisations, with the exception of employment.

Neil Jack raised concern that the stabilising the housing market did not refer to selective licensing which was considered a key driver for change.

Resolved:
The Board agreed the revised priorities noting that the housing priority should include direct invention in the housing market and on the caveat that healthcare should remain a key focus as this is the central remit of the Board.

The Board agreed to undertake a review of the JHWS to determine progress and management arrangements against each of the existing priorities before formally moving forward with a revised set.

The Board agreed to hold a further development session in November to implement the improvement plan and initiate refresh of the JHWS in the new year.

4 STRATEGIC COMMISSIONING GROUP UPDATE

The Board received an update on the work of the Strategic Commissioning Group including the minutes of the meeting held on the 6th August 2014.

David Bonson summarised key aspects of the current work programme which include revising the Better Care Fund plan in light of changes to the policy framework affecting all local areas, a review of JHWS performance and the outcome of a mapping exercise to determine the groups and committees that currently have a connection with the Board. This information will be used to shape a partnership report which will describe the future interface between the Board and wider partners.

Resolved:
To note the update.

5 PERFORMANCE UPDATE QUARTER 1 2014-2015

The Board received a performance update on the key performance indicators identified by the Joint Health and Wellbeing Strategy, for the period of Quarter 1 2014/2015.

It was noted that due to time lag availability of data for many of the targets was not yet available but where it had been, this was supplied accompanied by commentary from the relevant performance lead.

Resolved:
To note the quarterly performance update.

6 DISABLED CHILDREN'S CHARTER

The Board considered the Disabled Children's Charter. It noted that it had previously

agreed and signed the charter at its meeting 3rd July 2013.

The progress since the last signing of the Charter was outlined in the report.

Resolved:

1. To note the progress made since the Charter was signed in 2013.

2. To agree that the Chairman on behalf of the Board sign the Disabled Children's Charter for the next twelve months.

7 PHARMACEUTICAL NEEDS ASSESSMENT

Liz Petch and Stephen Boydell from Blackpool Council Public Health provided a summary report on the Blackpool Pharmaceutical Needs Assessment.

Mr Boydell reminded board members of the statutory need for the Board to create a Needs Assessment which was consistent with the Joint Strategic Needs Assessment. He further explained the proposed contents of the Pharmaceutical Needs Assessment and that the document would be shortly circulated to Board members in advance of the formal consultation period between the 20th October 2014 and 19th December 2014. There was a planned stakeholder event on the 23rd October 2014.

It was agreed that the draft would be circulated by Mr Beattie to Board members in advance of the public consultation period.

It was noted that the Assessment would once approved be the subject of periodic reviews at least every six months or after significant changes. Members of the Board expressed a need for the assessment to be reviewed subject to the implementation of the Better Care Fund.

Resolved:
To note the summary of the main content and considerations of the Pharmaceutical Needs Assessment.

8 BETTER CARE FUND PLAN UPDATE

Andy Roach gave an update presentation to the Board on the Better Care Fund. He outlined the key recent changes in the guidance regarding the funding arrangements for the Better Care Fund.

A key feature was that the pay for performance framework now linked solely to the target of a 3.5% reduction in unplanned admissions. It was noted that the Better Care Fund Planning Leads had met with the NHS England Area Team and it had been agreed that the vision and core elements could remain unchanged but the new requirements will have to be addressed through the Better Care Fund Programme Board.

Resolved:

1. To note the presentation

2. To note the key policy changes underpinning the Better Care Fund and how these are being addressed locally.

3. To note the assurance that Blackpool's Locality Plan takes accounts of and robustly evidences the additional requirements set out in the new guidance.

4. That the authority to sign off any revisions to the Plan be delegated to the Chairman on behalf of the Board.

9 HEALTHWATCH ANNUAL REPORT

The Board received the first Healthwatch Blackpool Annual Report 2013-2014.

The report included the work undertaken over the first year including Care Home Enter and Views, Patient Led Assessments of Care Environments (PLACE), Dentistry Survey, and Open Events. Also the founding of the Patient Participation Group Network with over half he Blackpool practices now represented.

Resolved:

To note the Healthwatch Blackpool Annual Report.

10 DATE OF NEXT MEETING

The Board noted the date of next meeting as the 22nd October 2014.

Chairman

(The meeting ended at 3.55 pm)

Any queries regarding these minutes, please contact:

Tel:
E-mail:

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Delyth Curtis, Director of People, Blackpool Council
Relevant Cabinet Member	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Meeting	22nd October 2014

STRATEGIC COMMISSIONING GROUP UPDATE

1.0 Purpose of the report:

1.1 To receive a verbal update on issues related to the Strategic Commissioning Group.

2.0 Recommendation(s):

2.1 To note the update

3.0 Reasons for recommendation(s):

3.1 The Board has as a key responsibility to receive regular updates on the work programme of the Strategic Commissioning Group and to review future actions. The notes of the meeting of the Strategic Commissioning Group on 25th September 2014 are attached for information at Appendix 3a.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

There are no alternative options to be considered

4.0 Council Priority:

4.1 The relevant Council Priority is

"Improve health and well-being especially for the most disadvantaged"

5.0 Background Information

5.1 The Strategic Commissioning Group has a responsibility to regularly update the HWB on progress against its work programme and future planned activity. The notes of the meeting of the Strategic Commissioning Group on 25 September 2014 are attached for information at Appendix 3 (a).

5.2 Some of the items considered at the meeting include an update on the review of the Children's Trust; consideration of Blackpool's draft Tobacco Strategy; an update on the Better Care Fund submission; and an update on the Social Isolation task and finish group.

5.3 Does the information submitted include any exempt information? No

5.3 **List of Appendices:**

Appendix 3a – Strategic Commissioning Group Notes and Actions 25th September 2014.

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

Strategic Commissioning Group
Notes and Actions
25 September, 1:30-3:30pm
Boardroom, Stadium

Item 2

Present	Delyth Curtis, Director of People, Blackpool Council (Chair) Dr Amanda Doyle (OBE), Chief Clinical Officer, Blackpool CCG David Bonson, Chief Operating Officer, Blackpool CCG Helen Lammond-Smith, Head of Commissioning, Blackpool CCG Andy Roach, Director of Integration and Transformation, Blackpool CCG Dr Arif Rajpura, Director of Public Health, Blackpool Council Liz Petch, Public Health Specialist, Blackpool Council
Also present	Venessa Beckett, Corporate Development and Policy Officer Claire Grant, Integrated Commissioning Manager, Blackpool Council Val Raynor, Head of Commissioning, Blackpool Council Scott Butterfield, Corporate Development Manager, Blackpool Council
Apologies	Dr Mark Johnston, Associate Director Acute Commissioning and Service Redesign Blackpool CCG Wendy Swift, Director of Strategy/Deputy Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust Lynn Donkin, Public Health Specialist, Blackpool Council Jane Higgs, NHS England

	Apologies Apologies were noted.
	Welcome and Introductions. Del welcomed everyone to the meeting.
2.	**Notes and actions from previous meeting.** Notes from the previous meeting were agreed. **Actions from previous meeting:** The Partnerships and Sub-groups paper was deferred to the next meeting to enable greater clarity regarding the new Children's Partnership structure and terms of reference to be included. The Extensivist Model has been added to the October HWB agenda.
3.	**Better Start update.** Claire Grant, Integrated Commissioning Manager began by updating the SCG on the

	actions in the Action Plan, recognising that there had been some slippage in the project since the bid had been awarded. Delyth Curtis gave some context to Better Start to update the SCG on progress since the bid had been awarded. A meeting had taken place with Big Lottery the previous day to discuss the next stages in the process and set out three areas of focus for the coming months: 1. clear financial timescales and planning were required 2. a refreshed action plan was required 3. clear governance structures and arrangements would need to be put into place. This was the beginning of the implementation phase and the governance arrangements would be agreed at the Steering Group the following week. The Big Lottery were agreeable that there needed to be some flexibility in the delivery timescales of the projects given the size of the project and need to get good governance arrangements in place. Questions were raised regarding where Better Start 'fits' within existing governance structures, however it doesn't currently, the lead organisation is the NSPCC. It was recognised that once the Project Director has been recruited, it will be part of their role to co-ordinate the organisations involved and ensure the governance is reflective of our own organisational structures. Work is ongoing to establish how the projects will be monitored and evaluated and independent organisations including the London School of Economics and University of Warwick are working on PI's to measure outcomes. Del reiterated the importance of getting sound structures and governance in place before project delivery begins. **Action:** Helen Lammond-Smith to request that a Council Commissioner is included in the evaluation sub-group. **Action:** A full update to be brought to a future SCG meeting
5.	**JHWS Stocktake** Scott Butterfield, Corporate Development Manager presented a report describing the process for determining how the existing Health and Wellbeing Strategy priorities have progressed. This will allow it to determine whether there are areas it wishes to continue to monitor or provide ongoing support to. In considering the new priorities for the HWB, Dr Amanda Doyle stated that the priorities do not take on board operational and statutory duties for each organisation on the HWB. Dr Arif Rajpura suggested that tackling these four issues would help to deliver operational priorities. Del advised that the HWB and SCG need to consider what we do to collectively address these issues. Arif suggested that we need an incremental shift from downstream

	to upstream, with a focus on how we can shift resources and look at how we spend money collectively; and mature discussion about pooling budgets and a place-based approach. Amanda suggested that Council spending plans are brought to HWB alongside CCG's. Other comments were made about the wording of the priorities and Scott advised that further work was needed on the specifics. The purpose of the exercise was to tidy off the current strategy and tell the story focusing on the headlines for each area, its purpose being to provide assurance to the SCG and HWB that the previous priorities are not discounted.
5.	**Children's Trust** Scott presented a report setting out the proposed scope and membership of the new Children's Partnership. Membership is at senior, strategic level. Amanda pointed out that an officer from the CCG needs to be included in the membership in addition to the Chair; it was agreed that this would be David Bonson. Del stated that the Children and Young People's Partnership will be the health and wellbeing board equivalent for children and young people, and will have delegated authority. The terms of reference will be discussed and agreed at the Partnership's first meeting on 24 October. The Partnership will report to the HWB. **Action:** Venessa Beckett to invite David Bonson to the Children's Partnership meeting.
6.	**Improvement Plan** Venessa presented a brief report on the Improvement Plan; asking a number of questions as set out in the report. It was proposed that the actions from the plan are integrated into the forward plans for the SCG and HWB to enable reporting on actions and monitoring of progress as necessary. Andy Roach advised that some of the completion dates needed to be amended. **Action:** Venessa to update the Plan and integrate actions into the forward plan for SCG and HWB.
7.	**Draft Tobacco Strategy** Liz presented the draft Tobacco Strategy as described in the report. The strategy is adding value to the Lancashire Strategy and addressing three entrenched issues and areas where we can have an impact. A discussion followed regarding Public Health's view on e-cigarettes. Arif advised that the PH world is split; there are benefits in reducing harm caused by tobacco, however the long term effects are unknown and there are concerns that young people are being attracted to take it up therefore a precautionary approach is needed; also they are

	unregulated and research is still emerging. It was agreed that the strategy would be forwarded to the HWB as recommended.
8.	**Social Isolation Task and Finish Group update** Val circulated a report outlining progress since the decision at HWB to establish a task and finish group. Commissioners have been mapping work that reduces social isolation, identifying social care commissioned services. Val has also made contact with the voluntary sector, Fairness Commission, and community radio; and colleagues from neighbourhood policing have expressed a desire to be involved. The report recommends commissioning a third sector organisation to engage with the community, private and public sectors to develop a vision and strategy to reduce social isolation. Del advised that we need a step before this to ensure that the scope of the project is precise and links with our direction of travel, and that the working group should meet at least once to scope out what would be required. Representatives from the police and the Fulfilling Lives project should be invited. **Action:** Val to arrange the meeting and provide a progress report to the HWB.
9.	**Better Care Fund** Andy updated the group on the Better Care Fund, advising that the submission had been made and initial feedback was that the plan was good. The next steps involve the plan going to the moderator and then coming back through the area team. **Action:** Further updates to be given to the HWB and SCG as appropriate.
10.	**HWB development session** Venessa updated the group on the development session planned for November. Due to pressure on diaries, the session would take place before Christmas. The scope of the session has changed slightly and it will focus on a broader consideration of how the HWB can achieve its new priorities together; new arrangements to review how it meets its statutory responsibilities; and to consider the levels of involvement the Board wants in having oversight of the former priorities. **Action:** Venessa to progress with arranging the session.
12.	**EOL Fylde Coast Strategic Group minutes** The minutes were noted

13.	**AOB** **Future agenda items – HWB** Venessa listed the following items for the next HWB agenda: SCG update; BCF update, LAC action plan; Housing Market Rental Project update; Public Health Annual Report. Other items added include the Quality Premium measure (DB) and the Due North report into health inequalities (Dr AR).
14.	**DATES OF FUTURE MEETINGS** All meetings will run 1:30-3:30pm as follows : • Thurs 25 Sept (Boardroom) • Thurs 6 Nov 14 (Anteroom) • Thurs 11 Dec 14 (Anteroom) • Thurs 29 Jan 15 (Boardroom) • Thurs 26 Feb 15(Boardroom)

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Andy Roach, Blackpool Clinical Commissioning Group
Relevant Cabinet Member	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Meeting:	22nd October 2014

BETTER CARE FUND SUBMISSION

1.0 Purpose of the report:

1.1 To provide an update on the revised submission of the Better Care Fund.

2.0 Recommendation(s):

2.1 To note the current status of the revised Better Care Fund submission.

3.0 Reasons for recommendation(s):

3.1 The Board has a key role in monitoring the submission of the revised Better Care Fund.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None, the item is for information to keep the Board informed as to the Better Care Fund's progress.

4.0 Council Priority:

4.1 The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

5.1 The £3.8bn Better Care Fund (BCF) was announced in the June 2013 spending review. The key ambition of the Fund seeks to transform local services to ensure people are provided with better integrated care and support – which is joined-up, personalised and provided closer to home.

5.2 In order to access the Better Care Fund, every local area developed a locality plan aligned to the two-year operational and five year strategic plans of their Clinical Commissioning Group. Plans must also meet certain national conditions including a commitment to seven day working, better sharing of information and protection of social care services. Draft and final plans were approved by Health and Wellbeing Boards in February and April 2014 respectively before being take forward for ministerial sign off.

5.3 Following a ministerial review in April it was recognised that whilst many plans reflected the ambition of the Fund, certain aspects required further development as follows:

- More evidence of financial risk and performance metrics;
- Sufficient provider engagement and agreement on the impact of plans;
- Greater clarity around the alignment of the Better Care Fund plan to wider plans and policies, such as how Better Care Fund schemes will align with and work alongside primary care;
- More evidence of robust finance and analytical modelling underpinning plans.

5.4 To address these requirements, NHS England has published updated guidance, revised plan templates and extended the timetable for revising and submitting locality plans.

5.5 Further to the previous update at the meeting on the 3rd September 2014, a presentation will update the Board as to the resubmission of the plan.

5.6 Does the information submitted include any exempt information? No

5.7 **List of Appendices:**
None

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Liz Petch, Public Health Specialist
Relevant Cabinet Member	Councillor Collett, Cabinet Member for Public Health
Date of Meeting	22nd October 2014

TOBACCO CONTROL STRATEGY AND ACTION PLANS 2014-2016

1.0 Purpose of the report:

1.1 To formally endorse the Tobacco Free Lancashire Strategy 2014 – 2016, be in receipt of the Pan-Lancashire Smoking in Pregnancy Action Plan, and support the adoption of a Blackpool Tobacco Control Strategy and Action Plan 2014 – 2016 as a local tool for taking forward work to reduce the harms of tobacco use.

2.0 Recommendation(s):

2.1 To endorse the Tobacco Free Lancashire Strategy 2014 – 2016. This pan-Lancashire document has already been agreed by the Lancashire and Blackburn with Darwen Health and Wellbeing Boards.

2.2 To be in receipt of the Pan-Lancashire Smoking in Pregnancy Action Plan and agree work to develop local solutions to the actions identified.

2.3 To agree that the Blackpool Tobacco Control Strategy and Action Plan 2014 – 2016 focuses on a range of actions across three priority themes as we believe these to be the areas of greatest opportunity where the greatest differences can be made:

- ***Prevention*** - creating an environment where (young) people choose not to smoke
- ***Protection*** - protecting people from second-hand smoke
- ***Cessation*** - helping people to quit smoking

3.0 Reasons for recommendation(s):

3.1 Whilst figures in other areas of England have seen reductions in the numbers of adults who smoke, in Blackpool the figures have remained static over the last few years at around 29.5% of the adult population smoking as compared to the England

average at 20%. Smoking rates in the most deprived communities in Blackpool remain disproportionately high - 51% in the most deprived areas (e.g. Bloomfield) compared to less than 25% in the least deprived areas (e.g. Anchorsholme). This is a key factor in contributing to Blackpool's persistent health inequalities that result in the unfair differences in life expectancy between the richest and poorest of our communities. People in routine and manual occupations are around twice as likely to smoke as those in managerial and professional occupations. In Blackpool smokers from routine and manual groups comprise 44% of the overall smoking population; reducing smoking in this group is also critical to reducing inequalities in the town.

In addition to national initiatives, legislation and campaigns, locally various steps have been taken which go towards further reducing harm from tobacco within our population. These steps include:

- smoke free hospital and grounds to protect patients and visitors
- signage to encourage smoke free playgrounds and parks to protect our children
- working with midwifery services and pregnant women to reduce the rate of pregnant women smoking at the time of delivery giving babies a better start in life with initiatives including being the first are to introduce Carbon Monoxide monitoring at 36 weeks and a positive opt out referral to stop smoking services
- commissioning a smoking cessation service within GP practices in addition to the Specialist Stop Smoking Service ensuring wider more accessible services for those people wishing to stop smoking
- working closely with colleagues such as Trading Standards on various operations relating to proxy sales of tobacco to children, employing specialist sniffer dogs on illicit and illegal tobacco operations, and operations at Blackpool airport on smuggling
- commissioning a lung health check project to find the 'Missing Millions' – people who may be in the first stages of Chronic Obstructive Pulmonary Disease (COPD) with the aim of giving those people information that would encourage them to seek help to stop smoking
- an in-patient tobacco service at Blackpool Victoria Hospital offering unplanned admission access to NRT during their stay and referral to community services on discharge
- Supported social marketing projects to understand what pregnant need to encourage them to have a smoke free pregnancy and birth (e.g. BUMP magazine)

- Introduced an incentive scheme to encourage women in making a quit attempt

This Strategy builds on work already undertaken and recognises the need for a multi-faceted approach to local work, whilst balancing input and influence on a range of national, regional and sub-regional actions that complement and reinforce each other. Tobacco Free Lancashire is an important and influential forum whereby with work with wider partners to take forward some of this wider work.

In implementing decisive tobacco-control policies, Blackpool Council and our partners must show leadership in responding to the direction of travel set out in this Strategy. However, communities themselves also have a role to play. Whole population approaches such as regulation and investment in services must be supported by interventions which are driven by, and meet the needs of, local communities. We all need to consider, as individuals and communities, what we can do to support each other to make smoking a thing of the past and improve not only our own health but also the health of our local areas. Only by taking this approach can we achieve our ambition of a tobacco-free Blackpool and accelerate our efforts to tackle the underlying causes of health inequalities.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes
3.3	Other alternative options to be considered:	None

Not to endorse the strategy.

4.0 Council Priority:

4.1 The relevant Council Priority is "improve health and well-being especially for the most disadvantaged".

5.0 Background Information

5.1 Effective tobacco control is central to realising the right to life and the right to the highest attainable standard of health for everyone in Blackpool. It recognises that people deserve to live in a town free from the harms caused by tobacco, where people choose not to smoke and enjoy longer, healthier lives.

5.2 The Blackpool Tobacco Control Strategy has been developed with input from the

Blackpool Tobacco Alliance; which includes partners from Lancashire Fire and Rescue, North West Ambulance, Blackpool CCG, Blackpool Teaching Hospitals and local schools and colleges and sets out the next steps on Blackpool's journey to becoming tobacco-free.

5.3 England has come a long way in shifting cultural attitudes to smoking and are now seen as world leaders on tobacco control and smoking cessation. In recent years there has been:

- a ban on direct advertising of tobacco, followed by a ban of tobacco companies sponsoring sporting events and teams, especially Formula 1 from 2005
- the implementation of smoke-free legislation in 2007
- an increase in the age for tobacco sales from 16 to 18 in 2007
- an overhaul of tobacco sale and display law, including legislation to ban automatic tobacco vending machines and a ban on the display of tobacco and smoking-related products in shops at point of sale in large stores and supermarkets which came into force in 2012 and which will be in place for all other shops and stores in 2015
- comprehensive awareness-raising campaigns
- record investment in NHS smoking cessation services helping hundreds of thousands of people to attempt to quit smoking

5.4 Whilst there is clear evidence that action, such as the smoking ban, has led to a range of health benefits including: reduced heart attack admissions to hospital; reduced childhood asthma admissions to hospital; and fewer premature births, smoking still remains one of the most significant public health challenges.

5.5 Smoking is associated with a range of illnesses and is the primary preventable cause of ill health and premature death. Each year, there are over 403 smoking related deaths (around a quarter of all deaths in Blackpool every year) and 2,125 smoking related hospital admissions in Blackpool. Annual costs to Blackpool's health service associated with smoking-related illness are estimated to exceed £7m each year with an additional £744,000 as a result of second hand smoke.

5.6 Does the information submitted include any exempt information? No

5.7 **List of Appendices:**

Appendix 5a Tobacco Free Lancashire Strategy 2014 – 2016
Appendix 5b Pan-Lancashire Smoking in Pregnancy Action Plan

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 An Equality Impact Assessment (EIA) has been completed on the Tobacco Free Lancashire Strategy and is available on request. This assessment is currently being considered against Blackpool Tobacco Control Strategy and Action Plan 2014 – 2016.

9.0 Financial considerations:

9.1 Blackpool Tobacco Control Alliance currently holds a budget of £45,000 to take forward actions identified in the action plan - we must recognise that although some developments and interventions will be achieved by a different way of working, incorporating work into mainstream activities and in-kind contributions from the Council and its partners, not all work will be cost neutral.

9.2 This budget is held and administered by Blackpool Council Public Health, however all decisions on expenditure need to be agreed by a quorum Alliance meeting.

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 Both the Pan-Lancashire and Blackpool Strategies have multi-agency partnerships in place to ensure the consultation and involvement of relevant stakeholders in this work.

13.0 Background papers:

13.1 None

Tobacco FREE Lancashire

A Three-Year Tobacco Control Strategy for Lancashire 2014-2016

'Making tobacco less desirable, acceptable and accessible in Lancashire'

Tobacco FREE Lancashire

Foreword

As Lancashire Portfolio Leaders for Health, we are pleased to endorse this tobacco control strategy which has been developed in partnership with a wide range of stakeholder organisations and agencies interested in working together to reduce the devastating impact that tobacco has in Lancashire.

Tobacco smoking is the single largest preventable cause of ill health, premature death and health inequalities in the communities we serve. One in two long-term smokers die prematurely as a result of smoking, half of these in middle age. On average, each smoker loses 16 years of life and experiences many more years of ill-health than a non-smoker[1].

Smoking kills over 80,000 people each year in England and 2,212 adults aged 35 years and over in Lancashire alone[2,3]. This is greater than the total number of deaths from alcohol, obesity, illegal drugs, murder, suicide, road traffic accidents and HIV infection combined[3].

Reducing health inequalities resulting from smoking and protecting successive generations of young people from the harm done by tobacco therefore remains a public health priority in Lancashire. We are committed to this strategy and look forward to working with all partners to help in its delivery.

County Councillor Ali, Lancashire County Council

Councillor Khan, Blackburn with Darwen Council

Councillor Taylor, Blackpool Council

Tobacco FREE Lancashire

Tobacco Free Lancashire Membership

This Tobacco Control Strategy has been collectively developed and adopted by the following organisations:

Blackburn with Darwen Clinical Commissioning Group
Blackburn with Darwen Council
Blackpool Clinical Commissioning Group
Blackpool Council
Blackpool Teaching Hospitals NHS Foundation Trust
Burnley Borough Council
Cumbria and Lancashire Public Health Collaborative
Chorley Borough Council
Chorley & South Ribble Clinical Commissioning Group
East Lancashire Clinical Commissioning Group
East Lancashire Hospitals NHS Trust
Fylde Borough Council
Fylde and Wyre Clinical Commissioning Group
Greater Preston Clinical Commissioning Group
Hyndburn Borough Council
Lancashire Care NHS Foundation Trust
Lancashire Constabulary
Lancashire County Council
Lancashire Fire & Rescue
Lancashire North Clinical Commissioning Group
Lancashire Teaching Hospitals NHS Foundation Trust
Lancaster City Council
Pendle Borough Council
Preston City Council
Pennine Care NHS Foundation Trust
Ribble Valley Borough Council
Rossendale Borough Council
South Ribble Borough Council
Southport and Ormskirk Hospital NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
West Lancashire Borough Council
West Lancashire Clinical Commissioning Group
Wyre Borough Council

Together they build a strategic partnership within Lancashire to support Tobacco Control programmes and action to reduce smoking prevalence and niche tobacco use, protect adults and children from exposure to second-hand smoke and help all residents to live tobacco free lives.

Tobacco FREE Lancashire

1. Overview

Tobacco Free Lancashire

Tobacco Free Lancashire is a partnership made up of representatives from Local Authorities, the County Council, NHS Trusts and Clinical Commissioning Groups, Lancashire Constabulary, Lancashire Fire and Rescue and other partner organisations across Lancashire County, Blackburn with Darwen and Blackpool. It is chaired by elected members of Lancashire County Council, Blackpool Council and Blackburn with Darwen Council to ensure direct alignment and effective communication with the respective Health and Wellbeing Boards.

In Lancashire, we recognise that a variety of tobacco products are used by our population. The use of niche and smokeless tobacco products, such as shisha, pan, gutkha and nass amongst many others, remain a concern in communities such as Blackburn, Accrington, Burnley and Preston[4]. It is for this reason that we call ourselves 'Tobacco Free Lancashire', rather than 'Smokefree Lancashire'.

We work collaboratively across a multitude of organisations throughout the county to reduce the harm caused by tobacco.

Tobacco Use in Lancashire

Tobacco use remains one of the most significant public health challenges. While rates of smoking have continued to decline over the past decades, nationally one in five adults (20.2%) still smoke[5]. However as table 1 illustrates, smoking rates remain higher in Lancashire than England as a whole in adults[5], pregnant women[6] and young people[7,8]. There are around 268,308 current adult smokers in Lancashire[9]. However, two-thirds of smokers (63%) want to quit and welcome support to do so[10].

Table 1: Smoking Prevalence Rates in Lancashire

	Blackburn with Darwen	Blackpool	Lancashire County	England
Adult Smoking Prevalence[5]	27.9%	27.2%	22.3%	20.2%
Smoking at time of Delivery[6]	17.6%	30.8%	18.3%	12.7%
Young People Smoking Prevalence[7,8]			16%	11%

The vast majority of people who smoke become addicted as children before they are legally old enough to buy cigarettes; with two thirds initiating under the age of 18, the legal age of sale, and almost two-fifths under 16 years[11].

Smoking disproportionally affects those disadvantaged by poverty and is a major contributor to health inequalities, accounting for half of the difference in life expectancy between social classes I and V[12,13]. Adults in routine and manual occupations are around twice as likely to smoke as those in managerial and professional occupations (27% vs 13% respectively)[5].

People on low incomes start smoking at a younger age and are more heavily addicted, spending up to 15% of their total weekly income on tobacco[5]. Similarly, women who smoke in pregnancy are also more likely to be younger, single, of lower educational achievement and in unskilled occupations[14]. Smokers from routine and manual groups comprise 44% of the overall smoking population and reducing smoking in this group is critical to reducing inequalities.

Smoking rates are also higher among Bangladeshi and Irish males[15] (40% and 30% respectively), prisoners[16] (80%) and people living with a mental health condition. Nationally, a third (32%) of people with depression or an anxiety disorder and 40% for those with probable psychosis smoke[17]. Even higher rates are experienced in inpatient settings, where up to 70% of patients smoke and around 50% are heavy, more dependent smokers[18]. Reducing health inequalities resulting from smoking therefore remains a public health priority in Lancashire.

In recent years, smoking rates have remained somewhat stagnant and we need to take new and braver action to drive smoking rates down further[1].

Impact of Second-hand Smoke

Tobacco smoke contains over 4,000 chemicals, 69 of which are carcinogenic. Tobacco smoke not only damages a smoker's health but also the health of the people around them. Breathing other people's smoke is called second-hand smoking (SHS).

The World Health Organisation (WHO) has listed SHS as a human carcinogen to which there is no safe level of exposure[19]. Thirty minutes exposure to SHS reduces blood flow to the heart in fit, healthy adults. Long term exposure increases a non-smoker's risk of developing heart disease and lung cancer by a quarter and stroke by three-quarters[20,21].

Children are especially at risk from the effects of second-hand smoke because they have smaller vessels and their organs are still developing.

Therefore they breathe faster and breathe in more toxic chemicals than adults[22]. Children exposed to second-hand smoke are at increased risk of bronchitis, asthma symptoms, middle ear infections (glue ear), meningitis and sudden infant death syndrome (cot death) [22].

It is estimated that there are 3,902 additional incidents of childhood diseases each year within Lancashire, directly attributable to SHS [9,22]:

- 464 new cases of lower respiratory tract infection in children under two years old
- 2,890 new cases of middle ear infections in children of all ages
- 534 new cases of wheeze and asthma in children
- At least 14 new cases of bacterial meningitis

Financial Impact of Tobacco in Lancashire

Smoking is the primary cause of preventable ill health and premature death from respiratory diseases, circulatory disease and cancer (appendix 1) accounting for 2,212 deaths in adult aged 35 years and over each year in Lancashire alone[3]. One in 20 of hospital admissions are smoking related[23] and the estimated lifetime cost of treating a smoker with a smoking related disease in Lancashire is £15,121[24].

In Lancashire it costs the NHS a total of £53.77 million to treat smoking-related illnesses each year[24] (£29.51 million primary care and £24.26 million secondary care). A further £20.42 million is spent on treating the consequences of exposure to second-hand smoke[24] in children and adults.

The costs to the wider economy from sickness absenteeism, smoking breaks and reduced productivity are estimated at £19.61 million across Lancashire each year[24]. Every year 190,006 working days are lost through smoking related absence across the County.
Costs to the community are also significant. It is estimated that annual costs relating to smoking related house fires and clearing litter caused by smoking are £15.3 million and £9.3 million respectively[24].

A smoker of twenty cigarettes a day will spend around £2,800 a year on their habit. The more disadvantaged the smoker, the greater the burden high-cost tobacco imposes on their household income and the greater the impact smoking has on their family. Poorer smokers proportionately spend five times as much of their weekly household budget on smoking than do richer smokers. If poorer smokers quit they are more likely to spend the money they save in their local communities[25].

The scale of the tobacco epidemic needs to be clearly recognised in Lancashire if we are to significantly reduce smoking rates across the county.

Electronic Cigarettes

The use of electronic cigarettes is becoming more common, both locally in Lancashire and at a national level. However, these products are currently unregulated and unlicensed in the UK and therefore vary widely in their composition. They are currently undergoing thorough research by the UK's Medicines and Healthcare Regulatory Authority (MHRA) and will be licensed for public use in 2016.

Electronic cigarette use may retain some people smoking when they otherwise would have stopped. There is currently no medical evidence to support how they can be used to reduce or stop smoking and therefore should not be used as a cessation tool.

Electronic cigarette devices also replicate smoking. In addition to creating confusion and undermining compliance with smokefree policies, they also normalise smoking behaviour for children and young people. A 2013 Trading Standards Survey with 18,000 young people aged 14-17 years highlighted that 13% had tried e-cigarettes[8]. This could potentially facilitate a lifelong addiction to nicotine and provide a route into smoking conventional cigarettes.

The Role of this Strategy

This strategy outlines the areas of activity which Tobacco Free Lancashire and its collaborating partners will undertake to reduce smoking rates in Lancashire. It is supported at a sub-national level by Tobacco Free Futures, a Community Interest Company that develops tobacco control activity best delivered on a North West footprint, and in turn is intended to complement and support local plans for tobacco control. Tobacco Free Lancashire's three-year strategy mirrors the government's national tobacco plan[1], as well as local priorities. It will be supported by a detailed delivery plan which will be updated on a yearly basis to reflect progress. The unitary authorities of Blackburn with Darwen, Blackpool and Lancashire County Council are included within this plan, so any reference to 'Lancashire' includes all three Councils, unless otherwise stated.

A key aim of the strategy is to reduce the damaging impact of tobacco so that smoking is history for the children of Lancashire. As table 1 highlights, smoking rates in Lancashire are higher than the English average and this strategy aims to change that.

Funding and Commissioning Tobacco Control

Lancashire County, Blackpool and Blackburn with Darwen Borough councils currently have responsibility for commissioning tobacco control and stop smoking services in the community. There are Stop Smoking Services in

every area in Lancashire which are commissioned by the appropriate Authority. Clinical Commissioning Groups have responsibility for commissioning secondary care, including hospital, maternity and mental health, which includes smokefree programmes.

The national Tobacco Control Plan[1] identifies how the proposals in the White Paper Healthy Lives, Healthy People[26] place the responsibility for public health within upper tier local authorities. With ring-fenced funding this will enable tobacco control to be delivered locally to support national policy to reduce the prevalence of smoking. Local statutory Health and Wellbeing Boards play a vital role in steering the tobacco control strategy and in supporting tobacco control alliances. Tobacco Free Lancashire has therefore taken a lead in developing this strategy and subsequent annual action plan updates.

The national plan stresses that future ring-fenced funding should be used to support local comprehensive tobacco control activity, as well as other public health activities, according to local need. This strategy will therefore also help to identify those activities best delivered at a locality, Lancashire and sub-national basis.

2. Mission Statement, Aims and Ambitions

Mission Statement: To make smoking less desirable, acceptable and accessible in Lancashire to ensure all residents live tobacco free lives.

Aims

In line with the World Health Organisation's Framework Convention on Tobacco Control (FCTC)[27] and the national Tobacco Control Plan[1], Tobacco Free Lancashire adopts the six internationally recognised strands of comprehensive tobacco control measures as their core aims, which are to:

Aim 1) Stop the promotion of tobacco
Aim 2) Make tobacco less affordable
Aim 3) Effectively regulate tobacco products
Aim 4) Help tobacco users to quit
Aim 5) Stop exposure to second-hand smoke
Aim 6) Effectively communicate for tobacco control

Additionally, Tobacco Free Lancashire has also adopted the following aims:

Aim 7) To protect tobacco control policy from industry influence

Aim 8) To reduce health inequalities in Lancashire through reduced tobacco consumption

Aim 9) To ensure that tobacco control is prioritised in cross-cutting policies, guidance and funding

All of these aims relate to reducing tobacco consumption and exposure to second-hand smoke in both children and adults living in Lancashire.

Ambitions

Tobacco Free Lancashire will pursue the following ambitions, which will contribute to national targets within the Tobacco Control Plan[1] to:

Ambition 1) **Reduce adult (aged 18 or over) smoking prevalence to 18.5% or less by the end of 2015**

Ambition 2) **Reduce rates of regular smoking among 15 year olds to 12% or less by the end of 2015**

Ambition 3) **Reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015**

As table 1 outlines, for each local authority in Lancashire the challenge to achieve these ambitions will be different in scale as well as effort. These ambitions are therefore aspirational and should not be regarded as targets, which in many area of the county would be unachievable within the timescale of this plan. Rather they represent an overall direction of travel.

The strategy will also contribute to other ambitions within the Public Health Outcomes Framework:

- Low birth weight of term babies (2.1)
- Infant mortality (4.1)
- Mortality from causes considered preventable (4.3)
- Mortality from all cardiovascular diseases (including heart disease and stroke) (4.4)
- Mortality from cancer (4.5)
- Mortality from respiratory diseases (4.7)
- Excess under 75 mortality in adults with serious mental illness (4.9)
- Sickness absence rate (1.9)

This strategy provides some high-level aims which will inform more detailed action planning at both the pan Lancashire and local levels to achieve these ambitions, in line with both national and sub-national tobacco control policies. The Joint Strategic Needs Assessment for Drugs, Alcohol and Tobacco[28] informs action planning for tobacco control at local levels by highlighting local priorities for each district.

Achieving our Aims and Ambitions

The main areas of activity required to achieve these aims and ambitions fall into the following broad categories, around which detailed action plans can be built:

- Communication
- Training
- Advocacy
- Performance management
- Specialist support
- Regulation and enforcement

Progress towards achieving our ambitions will be measured by Tobacco Free Lancashire in line with the Public Health Outcomes Framework, and reported to the three Health and Wellbeing Boards.

3.Strategy

Aim 1) Stop the promotion of tobacco

Tobacco Free Lancashire will:

- Support partners to develop effective smokefree policies covering all buildings (not already covered by legislation) and grounds. This may include council premises, hospitals grounds, prisons and other criminal justice settings, children's playgrounds and sports stadia;
- Support agencies which work with children and young people to ensure that tobacco products and accessories, including shisha and niche[1], are not promoted to young people in Lancashire, and advocate for the introduction of standardised tobacco packaging at a national level;
- Support retailers with information and training to implement the provisions of all tobacco control legislation which affects them.

Aim 2) Make Tobacco less affordable

Tobacco Free Lancashire will:

- Advocate for the maintenance of continued tax increases for tobacco products;
- Support sub-national and local action to reduce the illicit tobacco market in Lancashire, including sharing intelligence, analysis, enforcement information, public education, and engagement on illicit tobacco;

[1] Products, such as pan, gutkha and nass. Access full directory at http://www.ntpd.org.uk

- Develop and promote local media campaigns and training packages on illicit tobacco with partners.

Aim 3) Effectively regulate tobacco products

Tobacco Free Lancashire will:

- Raise awareness of shisha and other niche tobacco products[2] and their impact through community education and training with partners, including retailers;
- Ensure that existing legislation in relation to shisha and other niche tobacco products is enforced;
- Advocate for strengthened legislation at both national and local level to license both mainstream and niche tobacco products.

Aim 4) Help tobacco users to quit

Tobacco Free Lancashire will:

- Continue to support the commissioning and development of specialist stop smoking services across Lancashire to assist adults and children to quit;
- Improve brief intervention training for all public, private and third sector frontline workers on tobacco control and smoking cessation;
- Promote the use of self help materials for people who want to stop smoking without the support of the Stop Smoking Service, ensuring that these materials are appropriate and accessible to local populations;
- Increase awareness of the current unlicensed status of electronic cigarettes with both the public and partners and monitor updates to national policy;
- Support primary, community and secondary care to ensure that all opportunities within care pathways are taken to encourage and support patients to quit, particularly in the case of pregnant women, mental health service users and pre-operative patients.

Aim 5) Reduce exposure to second-hand smoke

Tobacco Free Lancashire will:

- Ensure compliance with the existing smokefree legislation in workplaces and public places[29,30] is enforced;

[2] Products, such as pan, gutkha and nass. Access full directory at http://www.ntpd.org.uk

- Support measures to stop second-hand smoke exposure for children (in playgrounds etc), including the provision of smokefree homes and cars programmes;
- Support media campaigns on second-hand smoke;
- Support public, private and third sector frontline workers to deliver second-hand smoke brief interventions during routine contacts with clients through training;
- Advocate for strengthened legislation to ban smoking in cars when children under 18 years are present at national level.

Aim 6) Effectively communicate for tobacco control

Tobacco Free Lancashire will:

- Develop a communications plan for this strategy;
- Use social marketing principles to inform tobacco control communications and campaigns to ensure they are appropriately targeted;
- Use every opportunity to promote tobacco control at both pan-Lancashire and local level through all social media;
- Ensure that Stop Smoking Services are consistently and effectively advertised across Lancashire;
- Support and amplify national tobacco control campaigns.

Aim 7) Protect tobacco control policy from industry influence

Tobacco Free Lancashire will:

- Ensure all local authorities commit to the Local Government Declaration on Tobacco Control.

Aim 8) Reduce health inequalities through reduced tobacco consumption

Tobacco Free Lancashire will:

- Use commissioning processes to ensure support is targeted to those who want to quit from all hard -to-reach or under-represented population groups in all settings, ensuring services are accessible and meet the diverse needs of these groups.
- Use commissioning processes to develop and support the full implementation of smoke-free legislation in mental health and criminal justice settings;

- Encourage partners to use their own policies and contacts with clients to maximise their potential to support tobacco control, taking particular

account of the needs of hard -to-reach or under-represented population groups.

Aim 9) Ensure that tobacco is prioritised in cross-cutting policies, guidance and funding

Tobacco Free Lancashire will:

- Work to embed the actions in this strategy into appropriate local authority, Health and Wellbeing Boards and Clinical Commissioning Groups action plans to ensure this strategy is implemented;
- Ensure membership of Tobacco Free Lancashire includes appropriate elected members and representatives of the third sector and Clinical Commissioning Groups;
- Develop a performance and governance framework for this action plan with Health and Wellbeing Boards.

Tobacco FREE Lancashire

References

1. Department of Health (2011). *Healthy Lives, Healthy People: A Tobacco Control Plan for England.* www.dh.gov.uk/publications
2. London Health Observatory (2011). *Local Tobacco Control Profiles for England – Public Health Observatories in England Nov 2011.* http://www.lho.org.uk/Download/Public/17712/1/Tartan%20Rug_FINAL_Nov2011%20v2.pdf
3. The Information Centre for Health and Social Care (2012). *Statistics on Smoking: England, 2012 and Census 2011 all population aged 35 and over.*
4. A full directory of niche tobacco products is available at: http://www.ntpd.org.uk
5. Office for National Statistics (2012) General Lifestyle Survey Overview. A Report on the 2010 General Lifestyle Survey. www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2010
6. NHS Information Centre for Health and Social Care (2013). *Statistics on women's smoking status at time of delivery: England.* http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking
7. The Information Centre for Health and Social Care (2012) *Smoking, drinking and drug use among young people in England in 2011.*
8. Trading Standards (2013). *Young Persons Alcohol and Tobacco Survey 2013, North West Results.* TSNW, June 2013.
9. Tobacco Free Futures (2012) *Locality Tobacco Briefings September 2012: Lancashire.* TFF 2012.
10. Office for National Statistics (2009). *Smoking and Drinking Amongst Adults.* Office for National Statistics.
11. Robinson S & Bugler C (2010). *Smoking and drinking among adults, 2008.* General Lifestyle Survey 2008. ONS, 2010.
12. Wanless D. (2004) *Securing good health for the whole population.* London: TSO
13. Marmot M et al (2010) *Fair Society, Healthy Lives: strategic review of health inequalities in England post 2010.* Marmot Review Secretariat London.
14. McAndrew F et al (2012). *Infant Feeding Survey – 2010. A survey conducted on behalf of the Information Centre for Health and Social Care.* Leeds: The Information Centre for Health and Social Care.
15. HSE (2004) *The Health Survey for England.*
16. Singleton N et al (1998) *Psychiatric morbidity among prisoners in England and Wales: the report of a survey carried out in 1997 by Social Survey Division of the Office of National Statistics on behalf of the Department of Health.* London: The Stationary Office
17. McManus S, Meltzer H & Campion J (2010) *Cigarette Smoking and Mental Health in England: Data from the Adult Psychiatric Morbidity Survey 2007.* National Centre for Social Research. www.natcen.ac.uk/study/cigarette-smoking--mental-health
18. Jochelson K & Majrowski W. (2006) *Clearing the Air: Debating Smoke-Free Policies in Psychiatric Units.* London: King's Fund.
19. World Health Organisation (2005). *WHO Framework Convention on Tobacco Control* http://www.who.int/fctc/text_download/en/index.html
20. Scientific Committee on Tobacco and Health Great Britain (SCOTH) (1998) *Report of the Scientific Committee on Tobacco and Health.* London: TSO 1998.
21. Scientific Committee on Tobacco and Health Great Britain (SCOTH) (2004) *Secondhand smoke: Review of evidence since 1998.* Scientific Committee on Tobacco and Health (SCOTH), November 2004.
22. Royal College of Physicians (2010). Passive smoking and children. A report by the Tobacco Advisory Group. London: RCP, 2010.
23. The Information Centre for Health and Social Care (2012). *Statistics on Smoking: England, 2012.* http://www.ic.nhs.uk/news-and-events/news/about-1260-hospital-admissions-a-day-due-to-smoking-new-figures-show
24. Health Economics Research Group, Brunel University; Queen's Medical Centre, University of Nottingham & London Health Observatory (2012) *Building the economic case for tobacco control: A toolkit to estimate economic impact of tobacco.* http://www.brunel.ac.uk/herg/research-programme/building-the-economic-case-for-tobacco-control
25. ASH (2013) *The Economics of Tobacco* http://www.ash.org.uk/files/documents/ASH_121.pdf
26. Department of Health (2010). *Healthy Lives, Healthy People: Our Strategy for Public Health in England.* www.dh.gov.uk/publications
27. World Health Organisation (WHO) (2011). *Framework Convention on Tobacco Control. Guidelines for implementation. 2011 edition.* http://www.who.int/gb/fctc/PDF/cop3/FCTC_COP3_DIV3-en.pdf
28. Intelligence for Healthy Lancashire (JSNA) (2012) *Alcohol, Drugs and Tobacco in Lancashire, Section 3:Tobacco.*
29. HM Government (2006) *The Health Act 2006 (c.28)* http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf
30. HM Government (2007) *The Smokefree (Exemptions and Vehicles) Regulations 2007.* Statutory Instruments 2007 No.765 http://www.legislation.gov.uk/uksi/2007/765/pdfs/uksi_20070765_en.pdf

Tobacco FREE Lancashire

Appendix 1: Smoking related mortality: 2008-10

	England	Lancashire		Blackburn with Darwen		Blackpool	
	Rate	No.	Rate	No.	Rate	No.	Rate
Smoking attributable mortality	210.57	6,810	**242.54**	792	**320.65**	1,215	**352.56**
Smoking attributable deaths from heart disease	30.30	900	**35.48**	118	**50.99**	163	**53.52**
Smoking attributable deaths from stroke	9.79	306	**11.47**	41	**17.29**	55	**17.07**
Deaths from lung cancer	37.73	2,301	**42.60**	285	**59.09**	398	**59.60**
Deaths from chronic obstructive pulmonary disease	25.78	1,800	**29.18**	232	**43.19**	304	**40.94**

Significantly **higher** than the national average
Source: Local Tobacco Control Profiles for England, Public Health England

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Pan Lancashire Tackling Smoking In Pregnancy Project Group

Tackling Smoking in Pregnancy Action Plan 2014 - 2016

Abstract: This action plan refers to the Tobacco Free Lancashire Three year Tobacco Control Strategy for Lancashire 2014 - 2016[1]and the NICE guidance on smoking in pregnancy[2]. A comprehensive Pan-Lancashire programme needs to be undertaken to systemise and embed organisational change to ensure all pregnant smokers are offered effective support in order to reduce the rates of smoking. This would include the following components:

Objective One: Standardised Opt Out Pathway across Lancashire

Definition – A 'Care pathway' is an agreed standardised approach to care of a pregnant woman which aims to reduce variability in practice and ensure a consistent approach by all those involved in her care. An 'opt out referral system' means that all women who smoke will automatically receive a referral to a stop smoking service unless she specifically states that she does not want one.

Activity/Action	Partners	Outcome/Outputs	Timescales – phased approach to completion
1. Standardisation of a clear smoking in pregnancy opt-out care pathway, including referral systems, raising the issue at every contact and protocols to reflect the evidence base and NICE guidance.	CCG's	Decrease in number of pregnant smokers opting out of referral process.	June – November 2014
2. Incorporation of stop smoking advice and CO monitoring at first maternity booking, CO monitoring at 20 weeks scan and CO monitoring at 36+ weeks gestation, supported by provision of CO monitors and CO screening information resources for pregnant women; ensuring every contact counts.	Stop Smoking Services Sonographers Maternity Services	Reduction in number of pregnant smokers not attending appointments at Stop Smoking Services.	November 2014 – April 2015
3. Implementation of immediate and direct electronic referral system for frontline workers into local Stop Smoking Services.	Commissioners of Stop Smoking Services	Implementation of electronic referral to Stop Smoking Services. Adoption of a standardised mandatory opt out pathway across Lancashire.	May 2015 – October 2015
4. Adoption of CO reading of 4ppm for opt out pathway to reflect the evidence of NICE smoking cessation secondary care guidance and Pregnancy Challenge Group recommendation[2,3].	Maternity Services Stop Smoking Services	Increase number of pregnant smokers referred to Stop Smoking Service to 100%, unless they opt out.	June – November 2014

5. Identification of reasons for Did Not Attend (DNA's) attendance for support at Stop Smoking Services. 6. Inclusion of niche tobacco smoking products e.g. shisha in smoking in pregnancy care pathway.	Maternity Services		June 2014 – October 2015 June – November 2014

Objective Two: Training Definition – This objective aims to ensure a consistent approach to training for all staff involved in the care of pregnant women.			
Activity/Action	**Partners**	**Outcome/Outputs**	**Timescales – phased approach to completion**
1. Consult and identify training requirements for midwives and maternity staff.	Maternity Services	Development and implementation of a consistent training package for maternity and frontline staff working with pregnant smokers.	November 2014 – April 2015
2. Development and delivery of mandatory brief intervention and CO monitoring training, including annual updates, with associated resources, for all maternity staff (including allied health professionals, neonatal staff and sonographers) to ensure routine delivery of advice and CO screening for all pregnant women; ensuring every contact counts.	Health Improvement Service (Lancashire) Public Health Team (Blackpool)	Monitoring of the number of maternity and frontline staff trained in brief advice and brief intervention training, including CO monitoring training. Establish a baseline of the services that have received training sessions.	November 2014 – October 2015
3. Delivery of Risk Perception training to	Maternity	Development and implementation of	November 2014 – April

Specialist Midwives and incorporation within the care pathway to reach out to pregnant smokers who do not engage with Stop Smoking Services.	Services	specialist training for specialist midwives.	2015
4. Deliver very brief advice training programme to allied frontline health and social care professionals e.g. children centre staff.	Children and Young People Directorate	Increase in the number of trained staff who are able to provide brief advice/intervention and specialist advice to pregnant smokers resulting in a reduction in SATOD figures.	November 2014 – October 2015
5. Inclusion of e-cigarettes and niche tobacco smoking products in training materials to increase knowledge and understanding of the impact in pregnancy to maternity and frontline staff in brief advice and brief intervention training.	CCG's Commissioners of services	Undertake an audit sample of the number of staff training and referring pregnant smokers into Stop Smoking Service.	November 2014 – April 2015

Objective Three: Information and Support Definition – This objective relates to the information and support provided to pregnant women, their partners, carers and families			
Activity/Action	**Partners**	**Outcome/Outputs**	**Timescales – phased approach to completion**
1. Development and provision of tailored promotional materials and information, in partnership with pregnant women and new mothers, regarding the risks of smoking and health benefits for pregnant smokers, including social media.	Hospital Communication Department	Evaluation of increased awareness of risks of smoking in pregnancy, through the use of targeted campaigns.	November 2014 – April 2015
2. Provision of a 'Supporting a Smokefree Pregnancy Scheme' to increase quit rates	Local Authority Communication	Utilising new marketing strategies to increase referrals and continued	June 2014 – April 2016

among pregnant smokers up to three-months post-partum.	Department Tobacco Free Futures	attendance to Stop Smoking Services. Increased quit rates 3 months post-partum.	
3. Provision of a Smokefree Homes and Cars scheme to reduce exposure to secondhand smoke and assist pregnant quitters and their families to remain smokefree.	Maden Centre Tobacco Free Futures	Increase the number of Smokefree Homes pledges.	June 2014– November 2016
4. Development and implementation of new marketing strategies to promote Stop Smoking Services, with possible longer sessions treatment sessions and use of one-minute video uploads.	Public Health	Monitor of number of one-minute video uploads in place and number of times accessed.	May 2015 – October 2015
5. Liaison and engagement with community leaders and forums, faith groups and childrens centres to raise awareness of Stop Smoking Services and smoking in pregnancy.	Community Faith Centres Public Health	Reduction in SATOD figures to 11% or less by 2015.	May 2015 – October 2015
6. Development of a smoking in pregnancy campaign to target under the 25 year age group.	Children's centres Jo McCullagh	Implementation and evaluation of smoking in pregnancy campaign for under 25 year age group.	June – November 2014
7. Increase in capacity through the breastfeeding peer mentors programme and/or children's centre staff to deliver stop smoking brief advice to pregnant women and new mothers.	Star Buddies (North & Blackpool) NCT in East Families and Baby (Central) Katie Wharton	Monitoring of the number of breastfeeding peer supporters trained.	May 2015 – October 2015

Objective Four: Performance Monitoring and Evaluation

Definition – This objective relates to the way data on smoking in pregnancy will be collected, monitored and used to evaluate the effectiveness of this plan.

Activity/Action	Partners	Outcome/Outputs	Timescales – phased approach to completion
1. Implementation of performance management systems to ensure effective evaluation of smoking in pregnancy care pathway.	Hospital - Information Governance	Implementation of monthly monitoring process, including CO validation at 36+ weeks data.	November 2014 – April 2015
2. Implementation of a Standard Operating Procedure and a monthly data validation to audit SATOD collection. This could be supported by the distribution of monthly performance stop smoking update to maternity services.	Hospital IT Departments	IT fit for purpose and inclusion of SATOD at 36+ weeks in addition to booking.	May 2015 – October 2015
3. Implementation of SATOD at 36+ weeks to establish a consistent measure.	CCG's	SATOD KPI in secondary care contracts.	June – November 2014
4. Implementation of SATOD as a KPI in secondary care contracts held with Clinical Commissioning Groups.	Maternity Services	Information governance process agreed and implemented.	November 2014 – April 2015
5. Review governance procedures to enable information data sharing processes and develop agreements about information sharing.	Public Health	Reduction in SATOD figures to 11% or less by 2015.	June – November 2014

1. A Three-Year Tobacco Control Strategy for Lancashire, 2014-2016 *'Making tobacco less desirable, acceptable and accessible in Lancashire'* . Tobacco Free Lancashire
2. National Institute for Health and Clinical Excellence (2010). Quitting smoking in pregnancy and following childbirth. Public Health Guidance 26. London: NICE.
3. National Institute for Health and Clinical Excellence (2013) *Smoking Cessation in secondary care: acute, maternity and mental health services*. Public Health Guidance 48. London:NICE http://www.nice.org.uk/PH48
4. Action on Smoking and Health (2013) *Smoking Cessation in Pregnancy - A call to action*. http://www.ash.org.uk/pregnancy2013

Possible further developments – explore research proposals – E cigarettes in partnership with local universities

Glossary

CCG…… Clinical Commissioning Group
CO Validation…… Verifying whether someone is smoking using a Carbon Monoxide monitor
DNA …….. Did not attend
KPI…… Key Performance Indicator
NICE…… National Institute For Health and Care Excellence
SATOD…… Smoking status at time of delivery
IT…… Information Technology
NCT …… National Childbirth Trust
4ppm…….. A reading less than 4ppm (parts per million) is normally that of a non-smoker
Antenatal ……. Pre-birth; during pregnancy
Breastfeeding peer mentors …… Friendly help, information and support about breastfeeding.
Brief advice …… A short informal intervention delivered opportunistically giving information on the importance of behaviour change.
Brief Intervention …… A structured method to deliver advice and constitute a step beyond brief advice as it involves the provision of more formal help, such as arranging follow-up support. Brief interventions aim to equip people with tools to change attitudes and handle underlying problems.
E-cigarettes …… Battery-operated device that mimic cigarettes, contain nicotine, sometimes has flavors added.

Neonatal …….. Neonatal units in hospitals specialise in the care of babies born early, with low weight or who have a medical condition that requires specialised treatment.

Shisha …… Smoking tobacco, sometimes mixed with fruit or molasses sugar, through a bowl and hose or tube

Smokefree Homes and cars …… Campaign to raise awareness of the dangers of second hand smoke for babies and children, and to encourage their parents and carers to protect their children by making their homes and cars smoke free.

Sonographer …….. Specialist who uses specialised equipment to create images of structures and evaluation of the developing foetus and the female reproductive system during pregnancy.

Star Buddies …… Breastfeeding support for Blackpool mothers.

Supporting a Smokefree Pregnancy Scheme …… Incentive scheme to increase quit rates with pregnant smokers, up to 3 months post-partum.

Post-partum …… Period of time following childbirth; after delivery.

Risk Perception training…… An opportunity for specialist midwife to explore new ways to reach out to those women not engaged with the service - including implementation of a risk perception tool with women who decline support at booking

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Delyth Curtis, Director of People, Blackpool Council
Relevant Cabinet Member:	Cllr Kath Rowson, Cabinet Member for Adult Social Care
Date of Meeting:	22nd October 2014

SOCIAL ISOLATION UPDATE

1.0 Purpose of the report:

1.1 To provide an update on work undertaken following the thematic debate on Social Isolation at the Health and Wellbeing Board on 4 June 2014.

2.0 Recommendation(s):

2.1 That the Health and Wellbeing Board commission a third sector organisation to engage with the community, public and private sector to develop a vision and strategy to reduce isolation of people in Blackpool.

- The lead organisation will develop a partnership to work collaboratively to develop the plan.
- The partnership will comprise of third sector representatives and other stakeholders that may have a strong understanding of the needs of isolated people.
- There will be meaningful and genuine community engagement with groups representing isolated people.
- The strategy will produce a plan and recommendations to meet priority outcomes identified.

3.0 Reasons for recommendation(s):

3.1 The recommendation supports the Governments agenda of helping older people most at risk of longer-term loneliness and social isolation to remain active.

3.2 The reduction of social isolation is a priority for the Health and Wellbeing Board for all ages. Social isolation and loneliness can cause people's health to deteriorate and the need more intensive forms of support from health and social services in the long term.

3.3a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.3b Is the recommendation in accordance with the Council's approved budget? Yes

3.4 Other alternative options to be considered:

Not to commission services

4.0 Council Priority:

4.1 The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

5.1 At the Health and Wellbeing Board on the 4 June 2014 a thematic debate on Social Isolation in Blackpool took place.

5.2 Val Raynor, Head of Commissioning and Contracts for Children's and Adult Social Care and Judith Mills, Public Health Specialist led the debate, presenting an overview of the effects of social isolation and a summary of the current situation.

5.3 The debate highlighted the need for a multi-agency approach to driving this agenda forward with the community at the heart of this.

5.4 It was agreed that a small sub group (task and finish) should be set up to explore the way forward. This sub group was to include:

- Val Raynor – Blackpool Council
- Richard Emmess – CVS
- Arif Rajpura – Public Health
- Sue Harrison – Blackpool Council, Childrens
- Andy Roach - due to the need to link to the Better Care Fund

5.5 Since then Commissioners have continued with mapping the work which is already happening in Blackpool and have identified Social Care Commissioned Services that reduce social isolation either directly or indirectly. The Blackpool4Me website continues to be developed. Val Raynor has made contact with the Voluntary Sector, Fairness Commission and Community Radio to further understand how Blackpool is working to address social isolation. Colleagues from Neighbourhood Policing have made contact and expressed a desire to be involved.

5.6 There is still work to be done with regards to mapping services provided by other departments within the Council including Public Health, private enterprise and Clinical Commissioning Group.

5.7 Val Raynor has met with members of the sub group along with other key stakeholders in order to agree the scope of the work to be commissioned as described in 2.1

5.8 Does the information submitted include any exempt information? No

6.0 Legal considerations:

6.1 Procurement legislation will be adhered to.

7.0 Human Resources considerations:

7.1 Resource requirement from Commissioning and Contracts to monitor the project.

8.0 Equalities considerations:

8.1 Equality Impact Analysis is not required at this stage. The project will contribute to ensuring fair access to community, private and statutory services which support the social isolation agenda.

9.0 Financial considerations:

9.1 Funding for the project £25,000. Operational Resilience.

10.0 Risk management considerations:

10.1 None identified

11.0 Ethical considerations:

The recommendation is in line with the Council's values.

12.0 Internal/ External Consultation undertaken:

12.1 Not applicable

13.0 Background papers:

13.1 None

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Arif Rajpura, Director of Public Health
Relevant Cabinet Member	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Meeting	22nd October 2014

PUBLIC HEALTH ANNUAL REPORT

1.0 Purpose of the report:

1.1 The Public Health Annual Report.

2.0 Recommendation(s):

2.1 To receive the Public Health Annual Report 2013.

3.0 Reasons for recommendation(s):

3.1 The Director of Public Health has a statutory duty to write an annual report on the health of the local population.

3.2 The Local Authority has a duty to publish the annual report of the Director of Public Health (section 73B (5) and (6) of the 2006 Act, inserted by section 31 of the 2012 Act).

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None, as outlined above it is a statutory requirement for the Director of Public Health to write an annual report.

4.0 Council Priority:

4.1 The relevant Council Priority is

'Improve health and well-being especially for the most disadvantage'

5.0 Background Information

5.1 The purpose of the Public Health Annual Report is to present the Director of Public Health's independent assessment of local health needs, determinants and concerns.

5.2 This year the report focuses on lifestyles and considers the role of smoking, drinking alcohol, lack of exercise and unhealthy diets on the health, and looks at what can be done to promote and enable people in the town to make healthier lifestyle choices.

5.3 Does the information submitted include any exempt information? No

5.4 **List of Appendices:**

Appendix 7a: Public Health Annual Report: An independent assessment of the health of the people of Blackpool 2013.

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

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Blackpool Council

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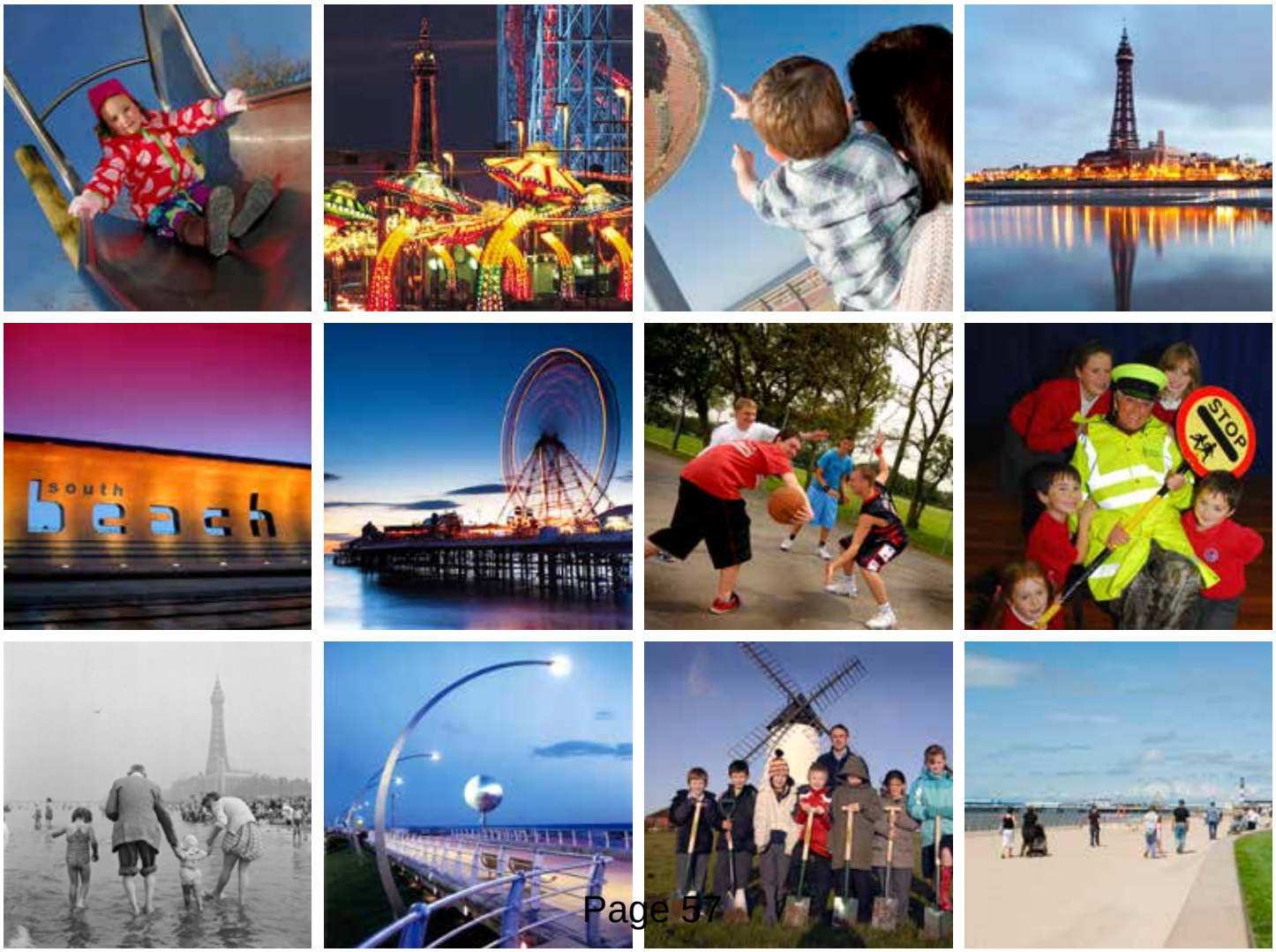
An independent assessment of the health of the people of Blackpool 2013

a better tomorrow



Public Health Annual Report
An independent assessment of the health of the people of Blackpool 2013

Acknowledgements

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Public Health Annual Report
An independent assessment of the health of the people of Blackpool 2013

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Foreword

I am pleased to present to you this my sixth annual report on the health of the people of Blackpool. Although this is my sixth report in the series, it is the first report to be published since the public health team joined the local authority in April 2013. These changes were part of a wider set of health reforms from the coalition government and have brought a major new set of responsibilities for the local authority to improve health and wellbeing. I hope that council colleagues in particular will find this report helpful in explaining where I can see real opportunities to improve the health and wellbeing of the people of the town.

The organisation changes I've alluded to have come as a result of the Health and Social Care Act 2012 which took effect on the 1st April 2013. The changes were wide reaching for the NHS locally and have seen the creation of Blackpool Clinical Commissioning Group, a consortium of local GPs which now commissions health and community services for the town as well as the public health team's transfer to Blackpool Council. In my view the local authority is uniquely placed to create the conditions required for significant improvements in the health of our population.

Without doubt this will need strong political leadership and the creation and maintenance of effective local partnerships across the town. A key means of achieving this will be through the Health and Wellbeing Board, a new statutory board introduced through the 2012 Act. Another opportunity is offered by Blackpool's Fairness Commission which I now chair and which brings together a wide group of partners and community representatives to focus on practical action to address social needs within the town.

In this year's report I take a look at lifestyles, some of which I'm pleased have already been the topic of debates at the Health and Wellbeing Board. I will consider the current impact of smoking, drinking, lack of physical activity and unhealthy diets on our health, and look at what can be done to promote and enable people to make healthier lifestyle choices across the whole population of the town. Over the last few years my annual reports have centred on the theme of inequalities and have explored the differences that we see in health between people in Blackpool and the national average.

These differences still persist and are continuing to widen. Lifestyle choices are particularly putting individuals at increased risk. The benefits to be gained from leading healthier lifestyles for the whole population go far beyond improving individuals' health, but can have a wider impact on organisations and society for example through reducing sickness absence and reducing drug and alcohol related harm. I look forward to the Health and Wellbeing Board holding members to account for delivering action plans arising from these debates.

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It's clear that real action could help us to make healthier choices and lead healthier lives. This will require us all as individuals to make healthier choices, but we also need an environment around us that makes these choices easy. For example we need safe play areas for children, walking and cycling routes, smaller portion size options, lower salt options, smokefree areas and access to good quality, affordable food. From individuals to health service commissioners, employers, town planners, café owners and caterers, leisure service providers, licensing and enforcement to community groups; we all have a part to play.

Finally this has been a year of major change for the public health team. It is entirely to the team's credit that they have continued to deliver their day to day roles throughout the transition period in addition to making all the necessary preparations that such a change requires and I thank them for their commitment and dedication. On behalf of the team I want to extend my thanks to council colleagues who have worked with the team to achieve the smooth transfer. My team and I look forward to working with you all to deliver the council's new responsibilities to safeguard and improve the health and wellbeing of the people of Blackpool.

Dr Arif Rajpura
Director of Public Health

Further reading:

The DH factsheet 'Public Health in Local Government' offers a succinct summary for those readers wishing to learn more about the new arrangements and responsibilities.

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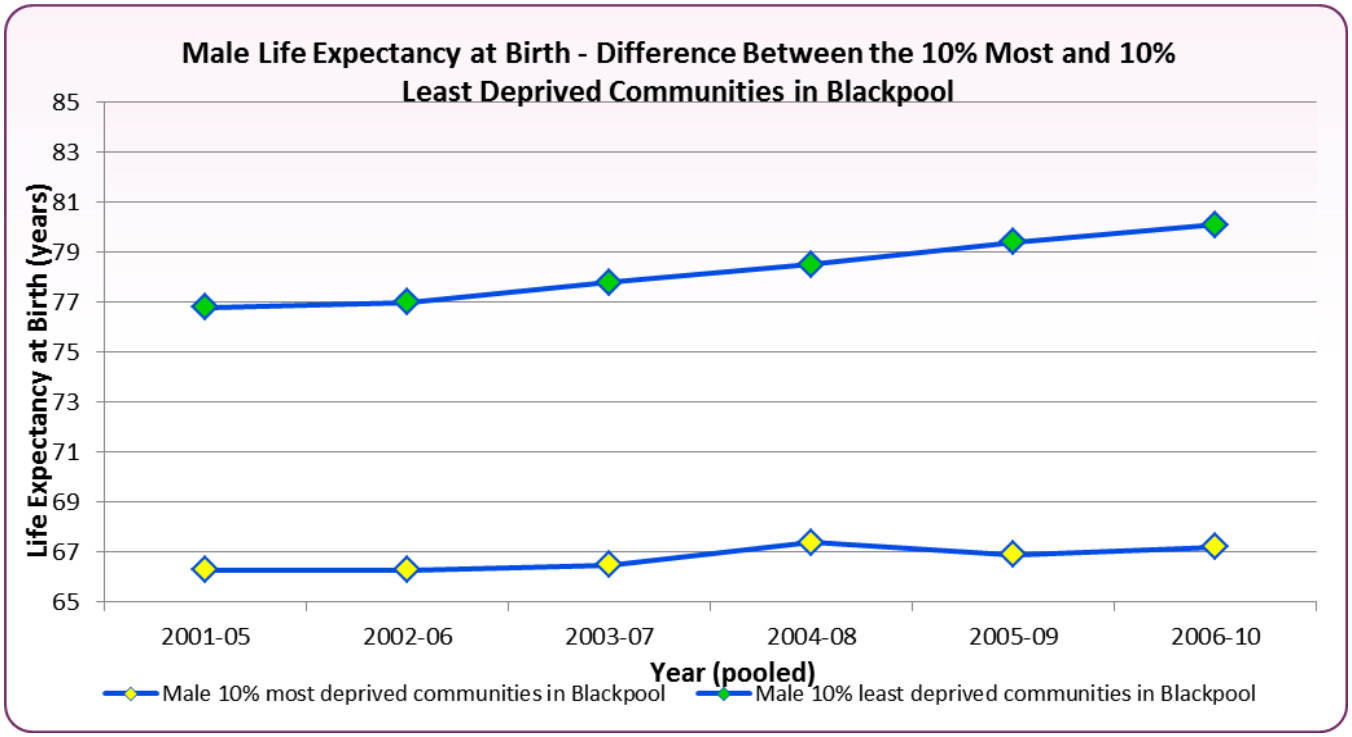
Introduction

The population of Blackpool experiences poorer health and lower life expectancy than much of the rest of the country and this is seen across a range of health indicators including the prevalence of chronic conditions, hospital admissions for self-harm and alcohol related harm, and early deaths from heart disease and cancer. Things are improving and over the past 10 years average life expectancy has increased by almost 2.8 years for men and two years for women. Although this is in the right direction, it's lower than average – for England and Wales the improvement has been almost double at 4.7 years for men and 3.4 for women. Worryingly, men in the most disadvantaged areas of the town have seen very little change at all, in fact an increase of just 0.9 of a year. Even men in the least disadvantaged group in Blackpool only experienced 3.3 years improvement, which is less than the England average.

Lifestyles are a major determinant of health and are considered to account for 30-50% of what makes us healthy (or unhealthy), alongside our genetics, our environment (including social, economic and physical environment), and access to health care. We know that this is certainly the case in Blackpool. Last year's Public Health Annual Report looked closely at the causes of shorter life expectancy in Blackpool finding that major causes of early deaths were:

- higher levels of harmful drinking and drug use
- smoking
- unhealthy diets and excess weight, and
- inactive and sedentary lifestyles

Figure 1:



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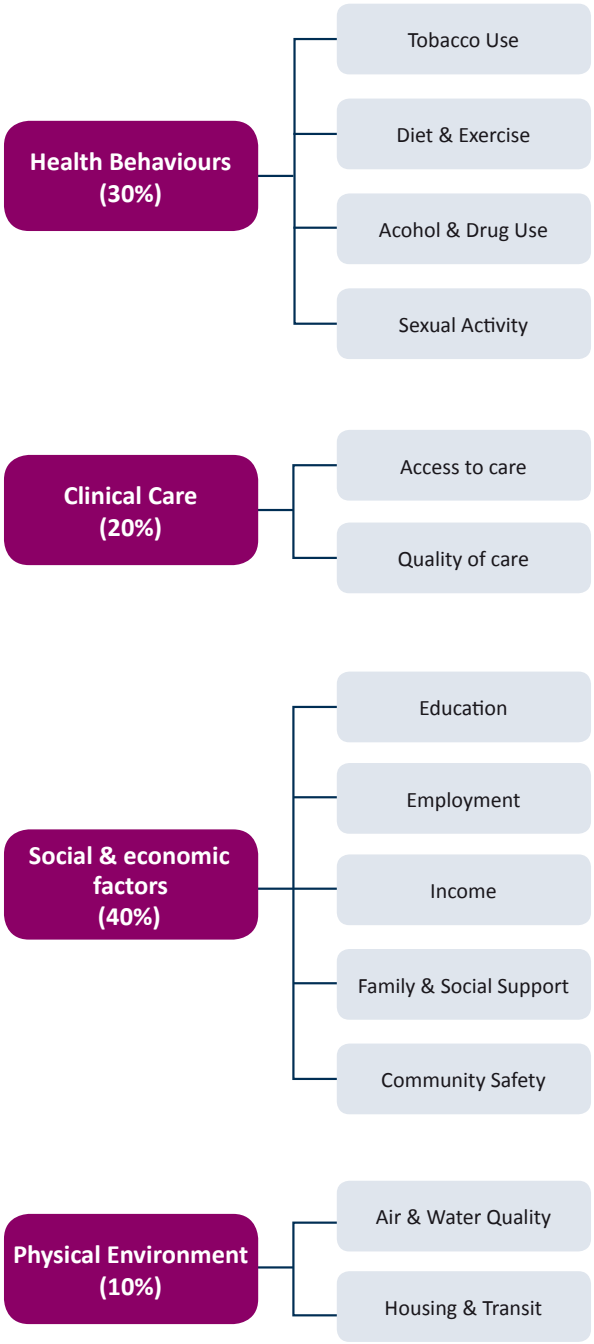
Major causes of early death in Blackpool (taken from Public Health Annual Report for Blackpool, 2012)

Men
Violence, self-harm and, overdose and poisoning
Digestive diseases including cirrhosis
Circulatory diseases (heart disease and stroke)
Women
Digestive diseases including cirrhosis
Cancers, chiefly lung cancer
Respiratory conditions

Lifestyles are already recognised as a priority in Blackpool and feature amongst the priorities identified by Blackpool's Health and Wellbeing Board in their Health and Wellbeing Strategy. Over the past year the Board has held thematic debates on a number of these priorities including alcohol, healthy weight and smoking.

Fig 2. What affects our health?



(Source: Adapted from the County Health Ranking and Roadmaps)

Public Health Annual Report
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Lifestyles in Blackpool

Alcohol

Blackpool has amongst the highest levels of alcohol related harm in England for the size of the population, including direct health effects for individuals and wider impact on the community from disorder and violence. Residents in the town experience the highest death rate in England for liver disease in people under 75. Between 2010 and 2012 there were 161 deaths from liver disease amongst people under 75 in the town. 148 of these deaths could be considered preventable (Source: PHOF). The impact on NHS services is startling with over 4,000 admissions to hospital and over 16,000 attendances at A&E every year related to alcohol. In fact Blackpool sees the 10th highest rate of alcohol related hospital admissions in the country and has one of the highest rates of people entering specialist treatment services. 52% of people having specialist treatment for alcohol problems are registered long term sick at the time of entering treatment compared to 20% nationally.

Drug misuse

There are significant levels of drug misuse within Blackpool. The town has the 4th highest number of opiate and crack users (OCU) for its population size in the country. In 2012/13 there were just under 2,000 OCU in the town, which is more than two and a half times the national average. There were just under 1,000 injecting drug users in this same period, almost four times the national average.

Prevalence Estimates (aged 15 – 64)	Local Number	Local Rate per 1000 population	National Rate per 1000 population
OCU	1,946	21.89	8.67
Opiate	1,802	20.27	7.59
Crack	721	8.11	4.95
Injecting	958	10.77	2.71

Source: Public Health England (2013): Alcohol and Drugs JSNA support pack

The number of young people in treatment has reduced. In 2011/12 the number of young people in treatment was 140, which fell to 76 in 2012/13. Whilst this decline might seem good news, the reasons are not fully understood and there is concern that this does not reflect the true underlying need for treatment. Young people access specialist treatment from various routes:

- 34% from youth justice
- 28% from education services
- 10% either by self/family/friends
- 10% from children and family services, and
- 7% from mental health services

Many young people who are accessing specialist treatment have a range of vulnerabilities. In the treatment system 70% of the young people have between 2-4 risk factors identified. This is slightly above the national average of 69%.

In relation to the risk factors:

- 98% of those in treatment began using their main substance under the age of 15, compared to 81% nationally
- 21% are looked after children compared to 12% nationally, and
- 40% in treatment have been involved in offending

Those young people entering into treatment in 2012/13 who stated that they had been sexually exploited was 4%, which is similar to the national average.

Excess weight and healthy eating - children

Levels of excess weight (overweight and obesity) amongst children in Blackpool are similar to the national average both for:

- Reception class (4-5 year olds) - Blackpool 26%, England 22.2%, and
- Year 6 children (10-11 year olds) - Blackpool 35.4%, England 33.3%

(Period: 2012/13, Source: PHOF)

Even though levels of excess weight are similar to the national picture, the figures themselves are extremely worrying. One in five Reception children and one in three Year 6 children are overweight or obese.

A survey of school children in the town has found that only around a quarter of children eat five or more portions of fruit and vegetables each day, and 8% don't eat any at all (School Health Education Unit Survey, 2009 Blackpool Council).

The dental health of children in Blackpool is considerably worse than average. Tooth decay is associated with eating diets that are high in carbohydrate, particularly sweet and sticky food and drinks such as chocolate, sweets, sugar and fizzy drinks as well as with poor dental hygiene (not brushing your teeth regularly). A useful way of assessing dental health is to look at the number of decayed, missing and filled teeth using the:

- dmft index for baby teeth, or
- DMFT index for permanent teeth

In Blackpool:

- more than one in three five year olds (37%) has at least one dmft. The average number of dmft amongst these children is 3.85. This is higher than the national average of 31% having an average of 3.45 dmft
- almost half of twelve year olds (43%) in Blackpool have at least one DMFT. The average number of DMFT these children have is 2.49. Again this is higher than the national average of 33.4% having an average 2.21 DMFT.

Excess weight and healthy eating - adults

A greater proportion of the Blackpool population are overweight or obese, that is body mass index (BMI) over 25, compared to the England average (72.1% in Blackpool, 63.8% England) (Period: 2012, Source: PHOF). Approximately 29,000 adults across Blackpool are clinically obese, that is have a BMI of over 30 (modelled estimates based on 2001 HSE data).

In Blackpool Teaching Hospitals' maternity unit, one in twelve (8%) pregnant women are clinically obese at booking (approx 12th week of pregnancy), almost double the national average of one in twenty (4.9%).

Body mass index (BMI) is your weight in kilograms divided by your height in metres squared (for adults).

- If your BMI is under 20, you would be considered underweight
- if your BMI is between 25 and 29, you would be considered overweight
- if your BMI is between 30 and 40, you would be considered obese
- if your BMI is over 40, you would be considered very obese (known as "morbidly obese")

You can check your BMI using the NHS Healthy Weight calculator at www.nhs.uk.

In Blackpool consumption of fruit and veg is lower than average with only a fifth of adults eating the recommended five or more portions each day, which is lower than the national average (Period 2006-2008, Source: 2013 LA Health Profiles).

Physically inactivity in children

Physical activity is important for the health of children of all ages, irrespective of their weight. In the Schools and Student Health Education Unit survey (SHEU 2012) approximately eight out of 10 (78%) of primary pupils indicated that they enjoyed physical activities 'quite a lot' or 'a lot'. This compares to figures of 86% in 2009 and 83% in 2007. This trend is also seen amongst secondary school pupils, of which six out of ten (60%) indicated that they enjoyed physical activities 'quite a lot' or 'a lot', compared to 84% in 2009 and 72% in 2007.

The PE and Sports School Survey ran from 2005 to 2010 and provided an indicator of five-16 year olds participating in at least two hours PE per week. Data for Blackpool showed an increase from 51% in 2005 to 78% in 2010, though still falling short of the overall level for all pupils nationally at 86%.

Physical inactivity in adults

Blackpool residents are slightly less physically active than elsewhere:

- Just under half of adults in the town (48.2%) achieve the recommended 150 minutes of physical activity per week, compared to 56% across England
- Around a third of adults in Blackpool (34.9%) are physically inactive, doing less that 30 'equivalent' minutes of at least moderate intensity physical activity per day in bouts of 10 minutes or more, compared to a quarter (28.5%) for England.

(Period: 2012, Source: PHOF)

Smoking

An estimated 29.5% of adults aged 18 or over in Blackpool smoke compared to 19.5% for England. Within the routine and manual group an estimated 44.3% of adults in Blackpool smoke compared to 29.7% for this group in England.

(Period: 2012, Source: PHOF).

Approximately 37,000 people registered with Blackpool GPs are known to be living with long term conditions such as high blood pressure, coronary heart disease, stroke, diabetes or chronic obstructive pulmonary disease (COPD), conditions which can be caused or made worse by smoking.

Respiratory diseases are one of the top causes of death in Blackpool. Smoking is a major cause of COPD, one of the major respiratory diseases. Blackpool residents experience the highest death rate in England for respiratory disease in people under 75. Between 2010 and 2012 there were 310 deaths from respiratory disease amongst people under 75 in the town. 145 of these deaths could be considered preventable.

(Source: PHOF).

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Building a healthier relationship with alcohol

What's behind the stats?

Alcohol related problems and addictions have led to an abundance of both small and large providers of cheap and strong alcohol to meet the demands of the customer.

A total of 1,900 licensed premises exist in the entire town: approximately one for every 72 residents. One particular ward (Bloomfield) has an off-licence for every 150 residents. This ward is amongst the most disadvantaged wards in the country and has the lowest life expectancy of all the wards in the town. Whilst the alcohol industry brings some economic prosperity through employment, paradoxically 105,000 working days a year are lost in Blackpool due to alcohol misuse, at an estimated cost upwards of £10.5mn per year. This equates to £618 per resident per year.

The NHS recommends:

- Men should not regularly drink more than 3-4 units of alcohol a day.
- Women should not regularly drink more than 2-3 units a day.
- If you've had a heavy drinking session, avoid alcohol for 48 hours.

'Regularly' means drinking this amount every day or most days of the week.

In Blackpool violent crime, including domestic abuse, is associated with the areas with the highest levels of alcohol availability, however where interventions have been focussed on licensed premises and the surrounding area, violent crime has reduced in recent years. 15% of all recorded crime in Blackpool takes place in the night time economy (NTE) which constitutes 37% of all of the town's violent crime. On a peak Saturday night over 80% of Accident and Emergency (A&E) visits can be alcohol related predominantly originating in the NTE. There can be up to 150 A&E attendances every Saturday night between 8pm Saturday and 8am Sunday.

What's being done in Blackpool at present?

There are a variety of activities, interventions and services ranging from prevention, through to harm reduction, and specialist treatment.

Modr8 and altn8

Modr8 and altn8 campaigns raise awareness of alcohol harm and give messages about simple ways to minimise harm. The modr8 campaign is supported by workplace visits and information sessions at community venues and shops, and aims to raise awareness of lower risk levels and units. The altn8 campaign uses various methods including polycarbonates, posters and mobile phone apps across the pubs and clubs of Blackpool. It is used to advise revellers and young people to drink water alongside any alcohol to help reduce the harm that alcohol causes.

Policies for a safer night time economy

Current initiatives and policies that aim to improve safety in the NTE include:

- Nightsafe Haven which provides a place of rest, support and emergency care within the town centre on a Saturday during busy periods.
- Cumulative Impact Policies – a range of policies that aim to reduce the availability of alcohol by limiting the number of outlets and opening hours in areas considered to be saturated.
- Designated Public Place orders (drinking bans) – allows police and council enforcement officers to stop drinking in public places if this contributing to anti-social behaviour.
- Introducing the use of plastic glasses (polycarbonate drinking vessels) in town centre pubs and clubs.

Since the introduction of this suite of activities, police incidents recorded as anti-social behaviour reduced by 21% between 2009/10 and 2001/12 (Source: MADE).

Policies to improve safety in the night time economy are coordinated by the BSafe group. BSafe is a group of the key agencies with responsibilities for reducing crime and disorder in the town including that related to alcohol. This group consists of representatives from the Police, Probation, Blackpool Council's Directorate of Public Health, Blackpool Teaching Hospitals NHS Foundation Trust, Blackpool Clinical Commissioning Group, Lancashire Police and Crime Commissioner, North West Ambulance Service and the Lancashire Fire and Rescue Services.

Treatment services for people with alcohol problems

Public Health Blackpool commissions an integrated drugs and alcohol specialist treatment service known as Horizon Community Services which is described more fully in the drugs section of this report. The key focus of the treatment system is to support individuals in achieving recovery. Horizon helps individuals address their wider health and needs such as housing issues, benefits advice, employment and training.

Alcohol liaison in hospital

In response to the growing numbers of patients presenting in hospital for alcohol related treatment, Blackpool has introduced a harm reduction programme, 'a better tomorrow', across the hospital trust. The programme is aimed at patients, staff and visitors through the development of policies and interventions such as information leaflets, posters, training, and bedside support. In addition, a team of four alcohol liaison nurses work with patients who have been admitted to hospital who present with alcohol related symptoms. They provide specialist pharmacological and psychosocial support to reduce consumption and ultimately hospital admissions. These nurses are supported by in-reach workers to link patients to the Horizon Community Services.

What's planned for the coming year?

We will continue to provide the existing services and seek further opportunities for improvement. Over the next year we will:

- Carry out a community engagement project including involving local residents in developing their own alcohol policies to advise the public sector services
- Develop a responsible traders scheme to include training for staff serving alcohol in shops and pubs to ensure they comply with the current legislation and to professionalise the occupation
- Increase enforcement of legislation including test purchases to ensure alcohol is not sold to under 18s and that all retailers operate as safely as possible
- Develop a new physical, health and social education (PHSE) package to raise awareness of the wider impact of alcohol to be used by schools and youth organisations
- Open Supported Housing for recovering alcoholics who will benefit from an alcohol free environment

Recommendations

1. The evidence base for Minimum Unit Pricing (MUP) is growing and becoming widely accepted as effective in reducing harmful consumption. Therefore we should continue to lobby for national legislation to introduce a minimum unit price of 50 pence (index linked) and talk with residents about the need and benefits of such legislation. In the event of no national policy being brought forward, we should look to introduce local legislation.
2. Blackpool Council should look to implement local restrictions on the advertising and promotion of alcohol to protect our children from the harms of alcohol.

Drug misuse - working towards a recovery community

What's behind the stats?

Drug addiction is not only associated with a wide range of problems beyond the health consequences for the individual but also their families and wider community for example crime, violence and neglect. Drug addiction has a significant impact on family life and on children in the household. Over half of Blackpool residents in treatment have children living with them, and a further 5% have children living elsewhere (Period: 2012/13).

What's being done in Blackpool at present?

The 2010 Drug Strategy called for the provision of good quality education and advice to young people and their parents, and for targeted support to prevent drug and alcohol misuse and early interventions when problems first arise.

Education in schools

Lessons for school children during PHSE sessions to talk about drugs and alcohol are being refreshed and updated. Workers delivering these sessions will be trained in giving brief advice and early interventions to children identified as potentially having drug or alcohol misuse problems.

Needle Exchange Programme

Blackpool has a Needle Exchange Programme run by a dedicated team along with local pharmacies that provides those who need it with access to safe disposal facilities of used equipment and a supply of clean needles ensuring reduced risks of cross infection from blood borne viruses.

Horizon – integrated drug and alcohol treatment service

The key focus of the treatment system is to support individuals in achieving recovery. This offers support for overcoming addiction alongside support to help resolve housing issues, employment, training, education and family needs. Employment is a key factor in successful recovery. In 2012/13:

- 73% of people in treatment were unemployed
- 5% were long term sick or disabled
- less than one in 10 (8%) were in regular employment

Supported housing

Individuals in Blackpool who require detoxification often find themselves on their own with no support to detox in the community. Public Health has commissioned a pilot for supported housing, which provides a safe environment for individuals to detox in the community.

What's planned for the coming year?

Recovery housing

Social relationships and peers are key to supporting individuals recovering in the community. A way to support the development of these social relationships is to develop Recovery Housing in Blackpool. As part of the scheme, individuals in recovery will be offered the opportunity to gain training and education through the development of the properties i.e. renovation work, as well as providing suitable housing for those still requiring support from the treatment system. The project will also look to develop social enterprises.

Big Lottery Fulfilling Lives Complex Needs project

Blackpool has recently been awarded funding from the Big Lottery's Fulfilling Lives Complex Needs initiative. This project will bring in £10 million over seven years to support individuals who are living with mental health or drug/alcohol problems, in contact with the criminal justice system or who are homeless. The project will supplement the work already being done by existing services, and will improve service delivery to people with these very complex needs.

Recommendations

1. Continue to commission a specialist treatment service that meets the changing drug trend demands, and responds to the arising issues from alcohol.
2. To build a recovery community, as it is recognised that social relationships have a bigger impact on individuals achieving recovery. Offering volunteering opportunities for people in recovery is one way to support this. Commissioners and providers should work together with volunteering groups to identify opportunities.
3. Commissioners of drug and alcohol treatment services should ensure that the 5 ways to wellbeing are achieved in treatment delivery i.e. connect, be active, keep learning, take notice and give.

Healthier eating and healthier weight

What's behind the stats?

Excess weight (overweight and obesity) and poor diet are related to many major diseases including cardio-vascular disease (heart disease), diabetes, cancer (particularly bowel cancer), falls and fractures, low birth weights, child morbidity and mortality and dental decay (adapted from Faculty of Public Health 2005). In addition to direct health impacts for individuals, excess weight is also linked with mental health, bullying and low self-esteem. As with other lifestyles, there are significant impacts for society more widely for example through the economic consequences for employers of sickness absences, and the burden on NHS services of treating the ill health arising from carrying excess weight, obesity and poor diet.

Over the last 20 years there has been a massive growth in processed foods and ready meals in response to demands for convenience. Processed foods tend to be higher calorie and less nutritious compared with home-made meals. We now eat out more too - nationally the average person eats one in six meals outside the home. This excludes snack food and quick 'on the go meals' (FSA 2010).

Our perceptions of healthy weight and overweight have changed. In a recent survey, 7% of people considered themselves to be overweight when in fact 26% were clinically obese (Our Life, Pfizer and DHNW 2010).

Despite the abundance of food, a number of recent national reports have drawn attention to the fact that some people are struggling to adequately feed themselves and their families, for example The Trussell Trust suggests that there has been a three-fold increase in people visiting food banks in the period from 2011 to 2013 (The Trussell Trust April 2013).

How much is a portion of fruit or veg?

A portion of fruit (80g)
is roughly equivalent to:

- a slice or half a large fruit e.g. a slice of melon or half a grapefruit
- 1 medium size fruit e.g. an apple
- 2 small size fruits e.g. 2 plums or satsumas

A portion of dried fruit (30g)
is roughly equivalent to:

- a heaped tablespoon of dried fruit

A portion of vegetables (80g)
is roughly equivalent to:

- 3 heaped tablespoons of peas, beans or pulses
- 2 broccoli spears
- a dessert bowl of salad

The amount that kids should eat depends on their size and age – there are no set rules. But a good guide to a portion for them is the amount they can fit into the palm of their hand.

Source: Change4Life www.nhs.uk/change4life

What's being done in Blackpool at present?

There is a wide range of activities and services within the town that will support people to eat more healthily and to reduce weight. These include education, prevention and awareness activities, through to treatment services.

Free school breakfast scheme

This unique scheme offers every child in Blackpool primary schools a free breakfast and free school milk on every day of the school term. Providing a nutritious breakfast has the potential to make a significant impact on children's health and wellbeing. Breakfast can play an important part in reducing dietary deficiencies and may improve school outcomes. The scheme was introduced in January 2013 following concerns relating to poverty and deprivation and the impact this has on children, particularly that some children might be going hungry. The scheme now delivers in excess of 11,000 breakfasts daily with children having the opportunity to have a drink and two food items from a selection.

School Food Ambassadors

Using the Leeds model we have trained staff and pupils to become ambassadors which enables an understanding of healthy eating and encourages pupils to be involved with decisions about food across the school.

Health Buddies

The Health Buddy Service, provided by Blackpool Wellness Service, supports people who lack the confidence or motivation to make the changes and healthier choices needed for a healthier lifestyle by attending various activities and appointments with the individual.

Health Works Award

The Health Works Award has been operational since 2009 and has helped to improve the mental and physical wellbeing of employees by encouraging and supporting local employers to include health promotion/wellness programmes to create healthier working environments and business advantage through sustainable organisational change.

Breastfeeding Out and About Scheme

Breastfeeding mothers want to know that they can go and feed in comfort, safe in the knowledge that they will not be asked to leave, or made to feel unwelcome. Increasing breastfeeding is one of the key interventions to tackle health inequalities. The 'Out and About' scheme encourages new mums to feel confident about breastfeeding away from home by providing them with the certainty that the premises they are in are breastfeeding friendly environments.

Weight management services

A range of weight management services are available to support people to reach and maintain a healthier weight which includes:

- Children's weight management services for 5 – 13 year olds
- Energise Blackpool community weight management service for adults
- Energise Blackpool Teens is a pilot service for teens aged 14-18
- Choose to Change is a specialist weight management service for adults with a BMI of 35+ with certain health conditions or BMI 40+ available via referral from a healthcare practitioner

What's planned for the coming year?

A comprehensive Healthy Weight Action Plan for the town has just been approved by the Health and Wellbeing Board. The plan includes a wide range of actions that are all aimed at making healthier eating choices easier to make in Blackpool, and providing services to support people to reach and maintain a healthier weight. Amongst the activities planned are:

- Healthier Catering Award – criteria developing and 10 places to have the award by October 2014 and increase access to healthier food options across public buildings such as the hospital and health centres
- Consider ways in which to limit access to food of low nutritional value
- Working with Early Years services to promote appropriate physical activity and nutrition for preschool children
- Supporting front line staff to help their clients to recognise and take action to achieve and maintain a healthy weight

Recommendations

1. Blackpool Council and the Public Health Team should continue to support the work of the Food Bank Partnership and the Fairness Commission to explore ways of providing more choices for affordable healthy food within the town.
2. Establish a steering group with appropriate representation from relevant directorates within the council and partner organisations to oversee delivery of the healthy weight action plan.

Physical inactivity – sit less, move more

What's behind the stats?

Physical activity is simply defined as any body movement that uses energy and includes activities undertaken whilst working, playing, carrying out housework, travelling and leisure activities. In contrast, 'exercise' is a subcategory of physical activity that is planned, structured, repetitive and aims to improve or maintain one or more components of physical fitness.

In recent years physical activity levels have dropped. This drop is partly due to us being more sedentary at work and in the home, and an increase in the use of 'passive' types of transport, mainly cars. Built up areas can often discourage people from being active through fear of violence and crime in outdoor areas, high-density traffic, low air quality and pollution and lack of parks, pavements and sports/recreation facilities.

People who are inactive have a 20-30% increased risk of death compared to people who engage in at least 30 minutes of moderate physical activity on most days of the week. Physical inactivity is the main cause of more than a fifth of breast and bowel cancers (21-25%), a quarter of diabetes cases (27%) and more than a quarter of heart disease cases (30%) (Physical activity Fact sheet No 384, WHO, Feb 2014).

Both moderate and vigorous intensity physical activity brings health benefits. At all ages, the benefits of being active outweigh potential harm and even a little physical activity is better than doing none at all.

Sit less, move more

- Adults need to be active for at least 150 minutes each week
- Kids aged five to 16 need to be active for at least 60 minutes each day
- Kids under five need three hours of activity a day
- Everybody should try to minimise the amount of time spent sitting for long periods of time

(Adapted from Chief Medical Officer guidelines Start Active, Stay Active, 2011)

What's being done in Blackpool at present?

Wellness Service

The Wellness Service aims to empower health behaviour and lifestyle changes, and is designed to gain life years by reducing morbidity and mortality rates associated with poor health choices. With a full range of activities throughout the week, individuals can access groups including cycling at a leisurely pace around Stanley Park, ten pin bowling, boccia, swimming and creativity & walking groups. All groups actively encourage individuals to connect with others and take in their surroundings ensuring they improve their mental health and wellbeing.

Active Blackpool

The Council's Active Blackpool Programme offers a range of activity opportunities to suit different needs. The programme includes a number of elements:

- GP Referral Programme - The Active Blackpool Team take referrals for anyone who the GP or practice nurse believes would benefit from becoming more physically active
- Steps to Health - A volunteer led community walking programme
- Cardiac rehabilitation - Delivered jointly with the Cardiac Rehabilitation Team at Blackpool Teaching Hospitals to provide a progressive pathway for patients who have suffered a cardiac event. The Cardiac Rehabilitation nurses deliver the first stage of the community based education and exercise sessions after which patients have the opportunity to attend a supervised exercise session three times a week delivered by the Active Blackpool team.
- Respiratory rehabilitation - Dedicated respiratory classes for patients referred from The Respiratory Rehabilitation Team
- Falls Prevention/OTAGO - Delivered in partnership with the NHS Falls Programme for clients who would benefit from targeted exercise to help prevent, manage and rehabilitate common problems in old age such as stroke, falls and depression. Includes the OTAGO exercise programme which helps to strengthen muscles and retrain balance
- Chair Based Programme - Provides an opportunity for adults with learning disabilities who attend Day Care Centres to take part in a chair based exercise class
- Ankylosing Spondylitis (AS) Group - A dedicated exercise class for patients who suffer from AS to increase flexibility, movement, posture and sleep, and help reduce stiffness

Walk to School Project

This project, led by an officer from Living Streets organisation, encourages children across all of Blackpool's primary and secondary schools to walk to school. Average walking rates have increased by 11% since the project began in Sept 2012.

Bikeability Cycle training

This training is offered to children in years 5 or 6 at Blackpool primary schools. In 2013-14, 904 children completed the training to Level 2 demonstrating their competence in cycling in a road environment.

Fit2Go project

Fit2Go is a healthy lifestyle project, which is delivered by Blackpool Football Club Community Trust, as part of the Altogether Now initiative with Blackpool Council, Blackpool CCG and Blackpool Teaching Hospitals NHS Foundation Trust. The project has worked with over 10,000 young people and their parents in the past three years. The project has involved all 30 primary schools in Blackpool, offering a six week project for Year 4 pupils. The project combines classroom activities on healthy eating and exercise with physical activity sessions to allow children to try out a range of sports. At the end of the six weeks a family workshop is delivered at school, to raise the awareness to parents of what their children have learnt over the six weeks.

What's planned for the coming year?

Sport and Physical Activity strategy

The vision for this strategy is to encourage everybody in Blackpool to move more. The strategy has identified four key themes for the development of sport and physical activity in the town:

1. Physical activity – encourage more people to be physically active as part of their everyday lifestyle;
2. Urban environment and facilities – develop high quality and accessible facilities for sport and physical activity;
3. Clubs, coaches and volunteers – support the development of an accessible, inclusive and sustainable community sport infrastructure;
4. Events – develop an annual programme of sporting events.

Green Infrastructure Plan

In November 2013 the Town and Country Planning Association published 'Planning Healthier Places – report from the reuniting health with planning project' to maximise the impact of the transfer of Public Health to Local Authority. Blackpool will be building on this, together with the recommendations of the King's Fund document 'Improving the Public's Health a Resource for Local Authorities', to ensure that Blackpool is reducing health inequalities through designing a healthy urban environment that promotes health. Key amongst this work will be the development of the Green Infrastructure Strategy that supports the Council's Core Strategy.

Leisure Services developments (Town centre gym, fitness factory)

The council's leisure services team have a number of developments planned for the coming year. Funding has been secured for the development of a second Feel Good Factory in the town providing a ladies only facility with easy to use equipment. May 2014 will see the council's leisure services open a new gym, Gateway Fitness, located on the ground floor of the council's new office building at Number One, Bickerstaffe Square, Talbot Gateway providing state of the art facilities for residents and workers in the centre of the town.

Recommendations

1. The council should ensure that it continues with action to improve the urban environment to support healthy lifestyle. Key amongst this action will be delivery of a Green Infrastructure Strategy for the town.

Public Health Annual Report
An independent assessment of the health of the people of Blackpool 2013

A healthier, longer and smoke-free life

What's behind the stats?

Smoking remains the single biggest contributor to health inequalities. It is associated with many of the major diseases and causes of early death, particularly: respiratory disease, heart disease and many cancers. Social deprivation is associated with high levels of smoking and low rates of quitting. There is a strong link between cigarette smoking and occupation and smoking rates are much higher among people with mental illness, and among prisoners.

Tobacco use also varies widely according to race, sex, age, educational level and socio-economic status. In the UK, the last 25 years has seen cigarette consumption amongst adults (16 plus) fall steadily among both men and women, however the decline has been substantially smaller across Blackpool. The total prevalence figure for Blackpool is 29.5%, significantly above the England average at 19.5%.

Smoking during pregnancy is one of the most preventable causes of foetal and infant morbidity and mortality. Blackpool's prevalence for smoking during pregnancy is the highest in the country at 30.8% as compared to 12.7% in England. This does however show a decrease in recent years following substantial work undertaken to help reduce smoking during pregnancy.

What's being done in Blackpool at present?

- The Specialist Stop Smoking Service is well established in the town providing drop in clinics and appointments on a range of sites across the town
- Stop smoking support is available via many GP practices across the town
- A Local Nicotine Replacement Treatment (NRT) voucher scheme exists across Blackpool which allows residents using Blackpool's stop smoking services to have NRT on prescription
- Smokefree signage is continuing to roll out across schools, parks and health facilities
- A tobacco liaison service exists within Blackpool Victoria Hospital to offer patients access to NRT and stop smoking services
- Test purchasing and Trading Standards enforcement regularly takes place in order to tackle illicit and counterfeit tobacco
- Lung health checks have been made available to residents in order to encourage people to stop smoking and signpost to stop smoking services
- Blackpool Victoria Hospital is officially a smokefree site, and is one of the few hospitals in the country to have achieved this

What's planned for the coming year?

Tobacco control plan

A comprehensive tobacco control plan for Blackpool which aims to reduce tobacco use is scheduled to be developed during the year and will be presented to the Health and Wellbeing Board for approval. This will include initiatives to promote and support smokefree homes and cars. The action plan will be based on the latest evidence of effectiveness emerging from behaviour change science and research currently underway nationally.

Improvements for brief intervention training

The Public Health team will work to increase the availability of brief interventions by providing training for all public, private and third sector frontline workers on tobacco control and smoking cessation.

New tobacco products

Blackpool Council will raise awareness of the current unlicensed status of electronic cigarettes with both the public and partners and monitor updates to national policy.

Lobbying for standardised packaging

The Public Health team will continue to lobby for standardised packaging which serves to reduce the targeting of tobacco products at children and young people.

Recommendations

1. Local businesses should promote healthier lives by prohibiting smoking on their premises with supporting their staff to quit and protecting people from the harms of second hand smoke.
2. The Council will work with partners to ensure that tobacco products and accessories, including niche products, are not promoted to young people in Blackpool.

Public Health Annual Report
An independent assessment of the health of the people of Blackpool 2013

Appendix 1

Figure A1.1 Health Profile 2013: Blackpool

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

England Worst — England Average — England Best; 25th Percentile; 75th Percentile

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	68345	48.1	20.3	83.7		0.0
	2	Proportion of children in poverty	8270	31.1	21.1	45.9		6.2
	3	Statutory homelessness	30	0.5	2.3	9.7		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	719	47.9	59.0	31.9		81.0
	5	Violent crime	4203	30.0	13.6	32.7		4.2
	6	Long term unemployment	1512	16.9	9.5	31.3		1.2
Children's and young people's health	7	Smoking in pregnancy ‡	497	30.0	13.3	30.0		2.9
	8	Starting breast feeding ‡	939	57.4	74.8	41.8		96.0
	9	Obese Children (Year 6) ‡	244	18.0	19.2	28.5		10.3
	10	Alcohol-specific hospital stays (under 18)	34	113.8	61.8	154.9		12.5
	11	Teenage pregnancy (under 18) ‡	154	58.5	34.0	58.5		11.7
Adults' health and lifestyle	12	Adults smoking	n/a	25.9	20.0	29.4		8.2
	13	Increasing and higher risk drinking	n/a	22.0	22.3	25.1		15.7
	14	Healthy eating adults	n/a	22.6	28.7	19.3		47.8
	15	Physically active adults	n/a	48.2	56.0	43.8		68.5
	16	Obese adults ‡	n/a	25.8	24.2	30.7		13.9
Disease and poor health	17	Incidence of malignant melanoma	23	16.4	14.5	28.8		3.2
	18	Hospital stays for self-harm	677	519.1	207.9	542.4		51.2
	19	Hospital stays for alcohol related harm ‡	4903	2950	1895	3276		910
	20	Drug misuse	1946	21.2	8.6	26.3		0.8
	21	People diagnosed with diabetes	9336	6.6	5.8	8.4		3.4
	22	New cases of tuberculosis	18	12.9	15.4	137.0		0.0
	23	Acute sexually transmitted infections	2020	1422	804	3210		162
	24	Hip fracture in 65s and over	154	421	457	621		327
Life expectancy and causes of death	25	Excess winter deaths ‡	126	22.0	19.1	35.3		-0.4
	26	Life expectancy – male	n/a	73.8	78.9	73.8		83.0
	27	Life expectancy – female	n/a	80.0	82.9	79.3		86.4
	28	Infant deaths	10	5.7	4.3	8.0		1.1
	29	Smoking related deaths	381	327	201	356		122
	30	Early deaths: heart disease and stroke	171	98.4	60.9	113.3		29.2
	31	Early deaths: cancer	234	135.3	108.1	153.2		77.7
	32	Road injuries and deaths	69	48.3	41.9	125.1		13.1

Indicator Notes

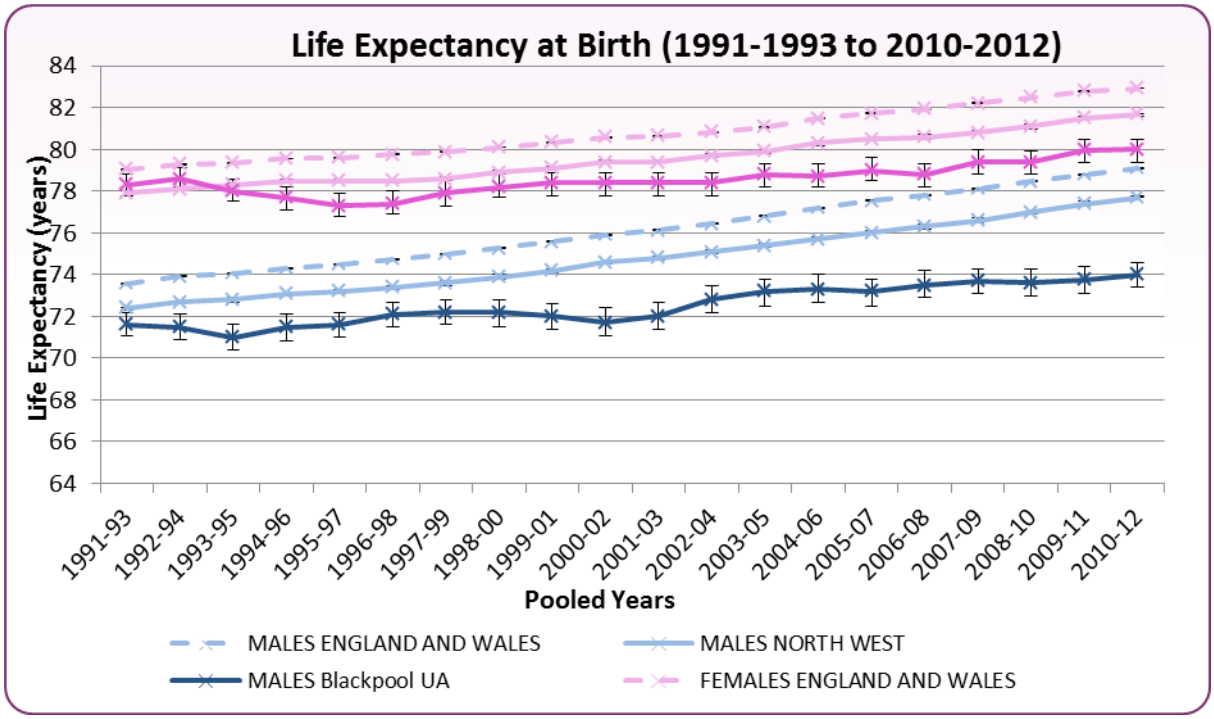
1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2010 3 Crude rate per 1,000 households, 2011/12 4 % at Key Stage 4, 2011/12 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2011/12 6 Crude rate per 1,000 population aged16-64, 2012 7 % mothers smoking in pregnancy where status is known, 2011/12 8 % mothers initiating breast feeding where status is known, 2011/12 9 % school children in Year 6 (age 10-11), 2011/12 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2009-2011 12 % adults aged 18 and over, 2011/12 13 % aged 16+ in the resident population, 2008-2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % adults achieving at least 150 mins physical activity per week, 2012 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2008-2010 18 Directly age sex standardised rate per 100,000 population, 2011/12 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 21 % people on GP registers with a recorded diagnosis of diabetes 2011/12 22 Crude rate per 100,000 population, 2009-2011 23 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2011/12 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.08-31.07.11 26 At birth, 2009-2011 27 At birth, 2009-2011 28 Rate per 1,000 live births, 2009-2011 29 Directly age standardised rate per 100,000 population aged 35 and over, 2009-2011 30 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 31 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 32 Rate per 100,000 population, 2009-2011

Appendix 2 Trends in life expectancy and mortality

Life expectancy

Life expectancy in Blackpool has improved in recent years. Despite this improvement, life expectancy in Blackpool has been increasing at a slower rate than the country as a whole, and the gap between life expectancy in Blackpool and the national average continues to widen.

Figure A2.1 Life Expectancy at Birth (1991-1993 to 2009-2012)



Source: Health and Social Care Information Centre Indicator Portal

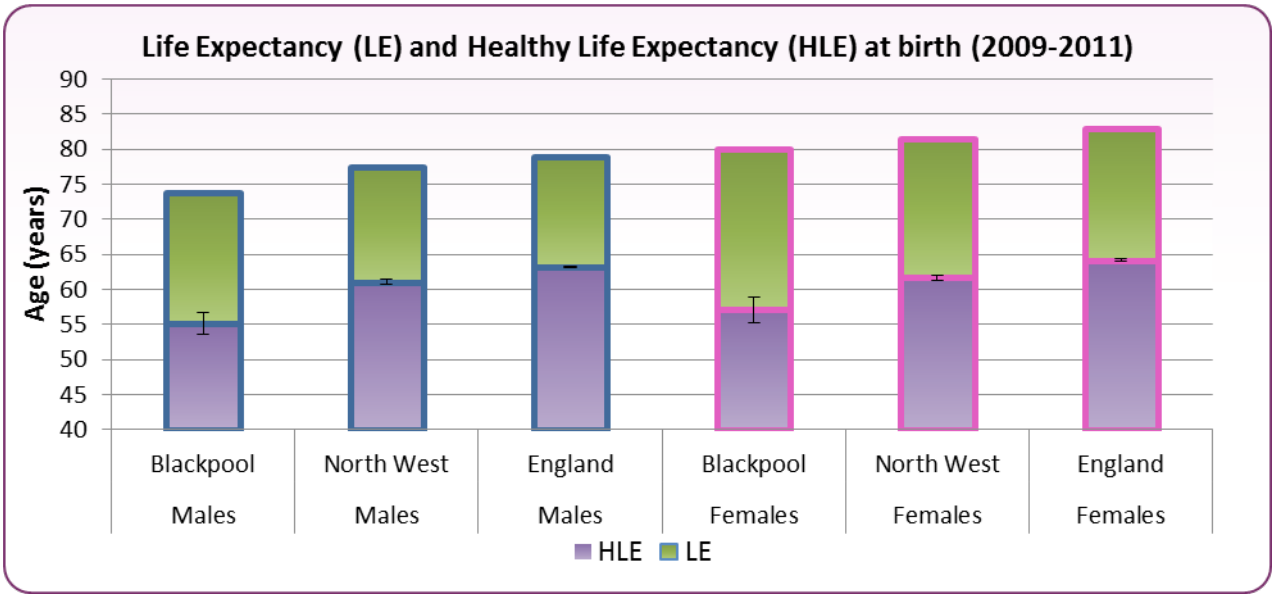
Table A2.1 Life Expectancy at Birth (1994-1996 to 2009-2012)

		1994-96	1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12
MALES	ENGLAND AND WALES	74.3	74.5	74.7	75.0	75.3	75.6	75.9	76.1	76.4	76.8	77.2	77.5	77.8	78.1	78.5	78.8	79.1
	NORTH WEST	73.1	73.2	73.4	73.6	73.9	74.2	74.6	74.8	75.1	75.4	75.7	76.0	76.3	76.6	77.0	77.4	77.7
	Blackpool UA	71.5	71.6	72.1	72.2	72.2	72.0	71.7	72.0	72.8	73.2	73.3	73.2	73.5	73.7	73.6	73.8	74.0
FEMALES	ENGLAND AND WALES	79.6	79.6	79.8	79.9	80.1	80.3	80.6	80.7	80.8	81.1	81.5	81.7	82.0	82.2	82.5	82.8	82.9
	NORTH WEST	78.5	78.5	78.5	78.6	78.9	79.1	79.4	79.4	79.7	79.9	80.3	80.5	80.6	80.8	81.1	81.5	81.7
	Blackpool UA	77.7	77.3	77.4	77.9	78.2	78.4	78.4	78.4	78.4	78.8	78.7	79.0	78.8	79.4	79.4	80.0	80.0

Source: Health and Social Care Information Centre Indicator Portal

Whereas life expectancy (LE) is an estimate of how many years a person might be expected to live, healthy life expectancy (HLE) is an estimate of how many years they might live in 'good' health. The HLE estimate was calculated using self-reported prevalence of 'Good' general health collected in the Annual Population Survey. Comparison of the HLE between England and Blackpool shows a greater difference than for LE alone. From this it can be observed that residents of Blackpool live shorter lives than the national average, and furthermore spend a smaller proportion of their shorter lifespan healthy.

Figure A2.2 - Life expectancy and Healthy Life Expectancy (2009 – 2011)

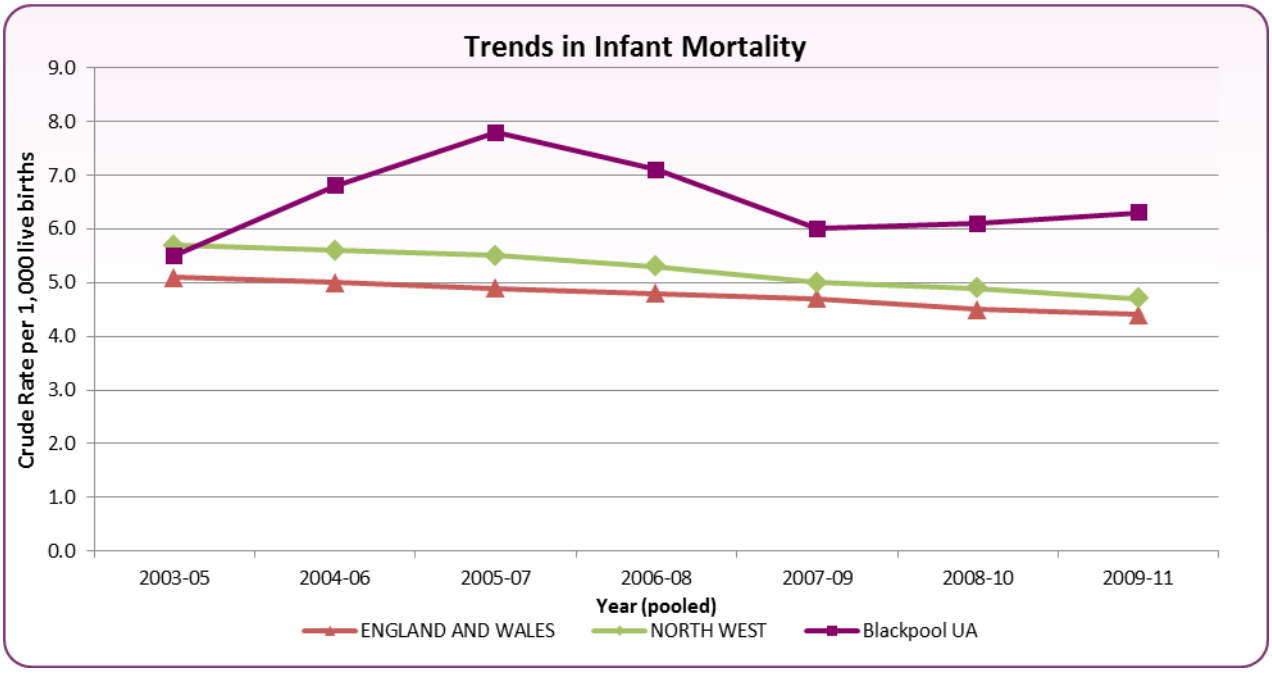


Source: ONS

Infant mortality

Infant mortality is an indicators of the general health of an entire population. Reducing infant mortality overall and the gap between the richest and poorest groups are part of the Government's strategy for public health. The rate of infant mortality within Blackpool has remained constantly higher than the North West and England rates.

Figure A2.3 – Infant Mortality (2003/05 – 2009/11)



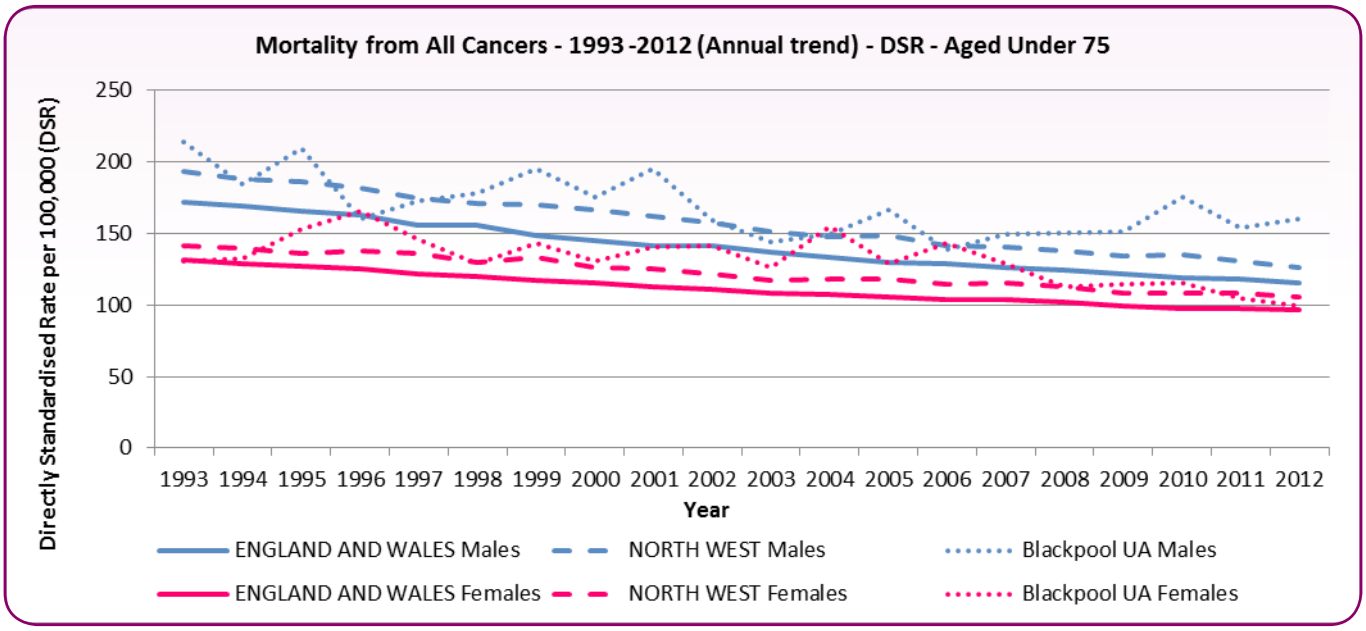
Source: Health and Social Care Information Centre Indicator Portal

Premature mortality

A number of indicator that focus on mortality in those aged under 75 are included within the Public Health Outcomes Framework. Many deaths in those aged under 75 are avoidable and the number of these deaths could be reduced through public health policy and interventions.

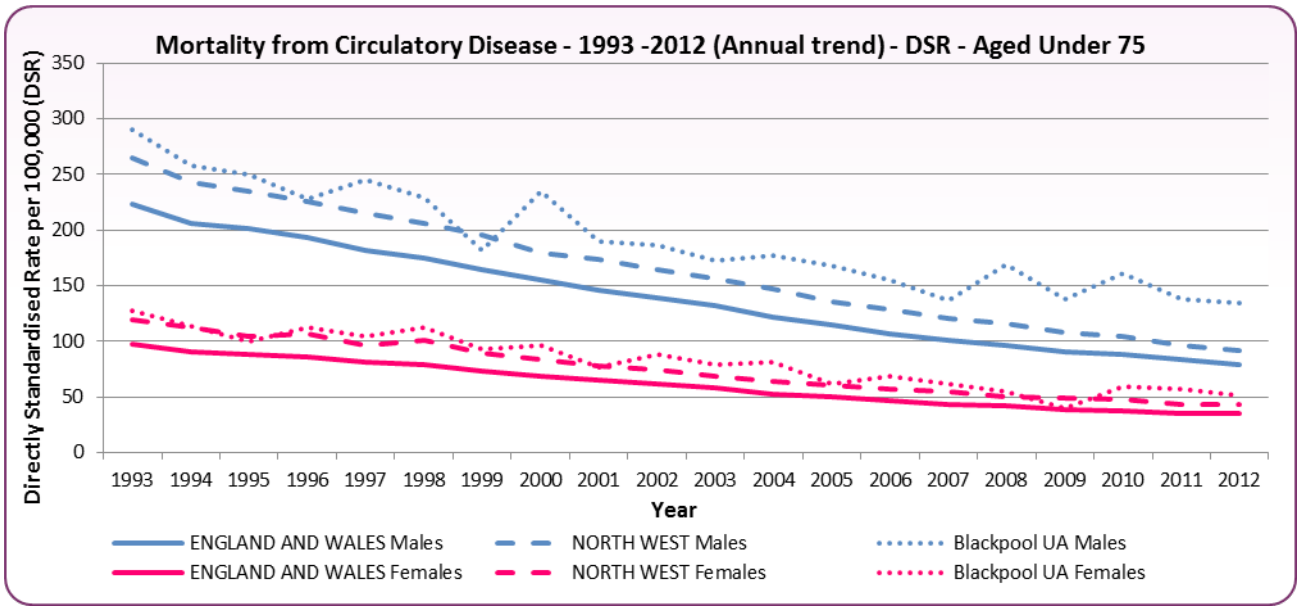
The trend in mortality from cancers and circulatory diseases amongst people under age 75 shows an overall pattern of improvement. However mortality rates remain higher than the regional and national average in both cases.

Figure A2.4 - Mortality from all cancers - 1993-2012 (Annual trends) - DSR - aged under 75 years



Source: Health and Social Care Information Centre Indicator Portal

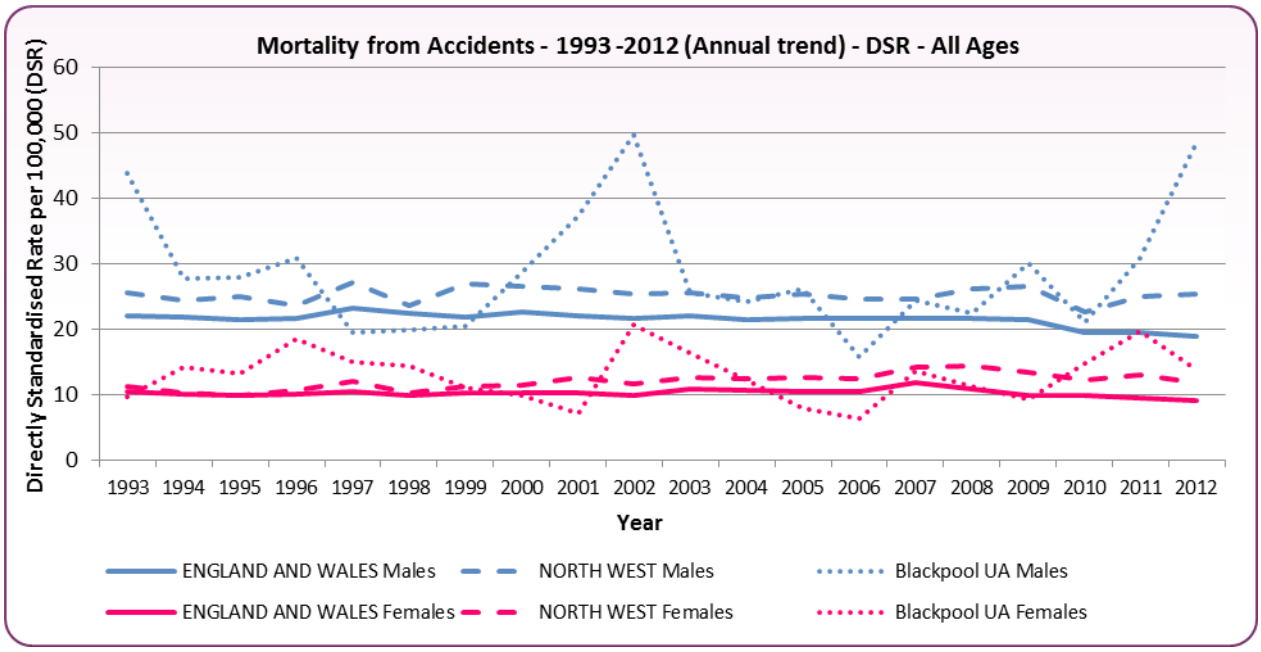
Figure A2.5 - Trends in mortality from circulatory diseases - 1993-2012



Source: Health and Social Care Information Centre Indicator Portal

Mortality rates from accidents amongst Blackpool people of all ages are similar to the North West average. Accident mortality rates are based on small numbers of actual deaths so rates are sensitive to natural variations in the actual number of cases and apparent spikes should be interpreted with caution.

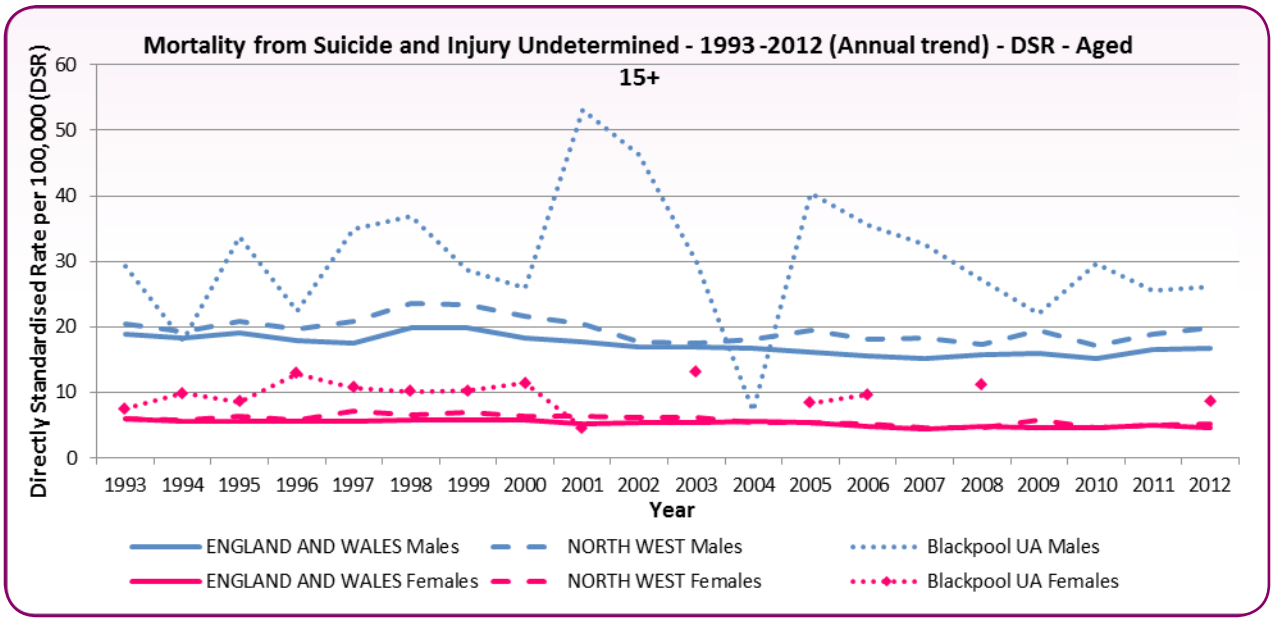
Figure A2.6 - Trends in mortality from accidents - 1993-2012



Source: Health and Social Care Information Centre Indicator Portal

Mortality rates from suicide and undetermined injury are also based on only a few actual deaths and figures for single years must be viewed with care. The overall trend shows rates in Blackpool tend to be higher than both the North West region and national average.

Figure A2.7 - Trends in mortality from suicide and injury undetermined - 1993-2012



Finding out more

Blackpool Joint Strategic Needs Assessment (JSNA)
www.blackpooljsna.org.uk

Blackpool Council
www.blackpool.gov.uk

Health Profiles from Association of Public Health Observatories
www.healthprofiles.info

National Statistics
www.statistics.gov.uk

NHS Choices
www.nhs.uk

Stop smoking
www.smokefree.nhs.uk

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www.blackpooljsna.org.uk

J109283 0714

Report to:	**Health and Wellbeing Board**
Relevant Officer:	David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Relevant Cabinet Member:	Councillor Eddie Collette, Cabinet Member for Public Health
Date of Meeting:	22nd October 2014

QUALITY PREMIUM

1.0 Purpose of the report:

1.1 To inform the Health and Wellbeing Board of Blackpool CCG's Quality Premium (QP) intentions for 2014/2015 and have agreement to the chosen target to 'improve on Quarter 4 2013/2014 Friends and Family Test score for patients in the Stroke Unit in Quarter 4 2014/2015'.

2.0 Recommendation(s):

2.1 To note the Clinical Commissioning Group's Quality Premium goals for 2014

2.2 To support the Clinical Commissioning Group with their choice of local metric for the Friends and Family Test element of Quality Premium

3.0 Reasons for recommendation(s):

3.1 To keep the Health and Wellbeing Board informed of the Clinical Commissioning Group priorities. To meet the national requirement to have the Health and Wellbeing Board support in choosing a local Quality Premium within the narrow parameters set in the Friends and Family Test.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	N/A

3.3 Other alternative options to be considered:

Other options for a "locally selected metric", part of the national quality premium

have been explored:

Patient Experience of GP out of hours services. Not recommended as Quality Premium due to High level of attainment

Patient experience of hospital care – Adult inpatient Survey.
Across the ten areas Blackpool Teaching Hospital scored average across all but one where Accident and Emergency results showed below average score. As the score is the average (mean) of five domain scores, and each domain score is the average (mean) of scores from a number of selected questions in the CQC Inpatient Services Survey not recommended as a Quality Premium.

- The emergency Accident and Emergency department 7.9/10 (below),
- Waiting Lists and planned admissions 8.8/10 (Average)
- Waiting to get to bed on ward 7.9/10 (Average)
- The hospital and ward 8.4/10 (Average)
- Doctors 8.2/10 (Average)
- Nurses 8.1/10 (Average)
- Care and Treatment 7.4/10 (Average)
- Operations and procedures 8.2/10 (Average)
- Leaving hospital 7.0/10 (Average)
- Overall views and experiences 5.2/10 (Average)

Other measures were also considered but there is not a means to monitor these:

Clinical Commissioning Group Outcomes indicator Set 2014/15 (December 2013). Status of this measure is "In development".

Patient Experience of outpatient services - Clinical Commissioning Group Outcomes indicator Set 2014/15 (December 2013). Status of this measure is "In development".

Improvement in hospitals' responsiveness to personal needs: Responsiveness to inpatients' personal needs - Clinical Commissioning Group CCG Outcomes indicator Set 2014/15 (December 2013). Status of this measure is "In development".

4.0 Council Priority:

4.1 The relevant Council Priority is

'Improve health and well-being especially for the most disadvantaged'

5.0 Background Information

5.1 The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission. In financial terms it relates to £5 per head of population = £860,000.

5.2 A Clinical Commissioning Group will not receive a quality premium if it:

a) Is not considered to have operated in a manner that is consistent with Managing Public Money during 2014/15; or

b) Incurs an unplanned deficit during 2014/15, or requires unplanned financial support to avoid being in this position; or

c) Incurs a qualified audit report in respect of 2014/15.

5.3 Achievement of the national conditions, subject to meeting the above pre-qualifying criteria, have been listed below with the percentage reward for each metric:

- Reducing potential years of life lost through amenable mortality (15%)
- Improving access to psychological therapies (15%)
- Reducing avoidable emergency admissions (25%)
- Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of Friends and Family Test FFT in 2014/15 and **showing improvement in a locally selected patient experience indicator (15%) (this is the metric that requires support from the Health and Wellbeing Board)**
- Improving the reporting of medication-related safety incidents based on a locally selected measure (15%)
- A further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies (15%)

5.4 **Friends and Family Test local measure**

Quality premium: addressing issues identified in the 2013/14 Friends and Family Test, supporting roll out of Friends and Family Test in 2014/15 and showing improvement in a locally selected patient experience indicator (15 per cent of quality premium), is in two parts:

To achieve the above national quality premium, the Clinical Commissioning Group need to demonstrate;

1. Support roll out of Friends and Family Test in 2014/15 – This monitored as part of CQUIN.
2. improvement in a locally selected patient experience indicator

5.5 Financial allocation for 15% of Quality Premium is £129,000. The Clinical Commissioning Group must demonstrate achievement for part 1 and 2 of this quality premium measure to ensure allocation for full amount.

5.6 Blackpool Clinical Commissioning Group locally selected patient experience indicator: Stroke Unit Friends and Family Test score.

5.7 Rationale

The Clinical Commissioning Group has reviewed the national list of most appropriate measures and excluded them as outlined in section 3.3 of this report.

The Acute Trust overall is a high achiever on "patient improvement indicators set" and as Stroke is a High Mortality at the Trust, there is currently a specific focus on the Stroke Unit / pathway. The rationale therefore for choosing the Stroke Unit Friends and Family Test is;

- Patients (generally) experience a range of services in an acute setting,
- An Friends and Family Test Pathway Pilot was undertaken specially around stroke patients in Feb 2013/2014.
- Stroke is a high mortality area (Keogh) for Blackpool Teaching Hospitals NHS Foundation Trust
- Both Blackpool Clinical Commissioning Group and Fylde and Wyre Clinical Commissioning Group are currently undertaking a "Deep Dive" on the Stroke Pathway.
- Focus on stroke unit includes collaborative work between Clinical Commissioning Group, Acute Trust and community based organisations.

Target: improve on Quarter 4 2013/2014 Friends and Family Test score for patients in the Stroke Unit in Quarter 4 2014/2015.
Date Source: Friends and Family Test Inpatient extract at "IP Ward Level".

Further local measure

'People with Chronic Obstructive Pulmonary Disease and Medical Research Council Dyspnoea scale $\leq$3 referred to a pulmonary rehabilitation programme'. Financial Allocation : £129,000

Rationale

The indicator measures a key component of high-quality care as defined in the NICE quality standard for Chronic Obstructive Pulmonary Disease.
Increasing Chronic Obstructive Pulmonary Disease prevalence was a local Quality Premium last year as such the proposed new indicator builds on that work.
The provider of the Pulmonary Rehabilitation service is incentivised with a stretch target to increase referrals to their service by 10% every year and they accept patients with MRC1 -2. Therefore they have a vested interest in increasing the referral rate on behalf of the Clinical Commissioning Group. Supports Clinical

Commissioning Group Outcome Ambition 2: Improving the health-related quality of life of the 15 million+ people with one or more long term condition.

5.8 Does the information submitted include any exempt information? No

5.9 **List of Appendices:**
None

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Relevant Cabinet Member:	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Decision:	22nd October 2014

OPERATIONAL RESILIENCE PLAN UPDATE

1.0 Purpose of the report:

1.1 To provide an update on winter planning and the Operational Resilience Plan.

2.0 Recommendation(s):

To note the update on winter planning and the Operational Resilience Plan.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priority is

"Safeguard and protect the most vulnerable"

5.0 Background Information

5.1 Urgent Care Working Groups have been tasked with developing operational resilience and capacity plans by involving all key local organisations in order to fulfil both planning requirements and ensure good system working in the future. The plan has been collaboratively developed and signed-off by all member organisations.

5.2 The Fylde Coast Operational Resilience Plan has now been signed off by the Local Area Team and the Clinical Commissioning Group commissioners are coordinating the completion of PIDs for each scheme and ensuring appropriate monitoring is in place.

5.3 A verbal update will be given on winter planning and Operational Resilience Plan.

5.4 Does the information submitted include any exempt information? No

5.5 **List of Appendices:**

None

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 The NHS England funding will be transferred to each Clinical Commissioning Group in October 2014. The Clinical Commissioning Group will be responsible for the monitoring of the schemes and arranging payment to providers. A financial monitoring template has been issued by NHS England to monitor the budgets.

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 The Urgent Care Working Group and Clinical Commissioning Group Urgent Care leads have been responsible for working with partner organisations and completing the plan.

13.0 Background papers:

13.1 None

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Karen Smith, Deputy Director of People
Relevant Cabinet Member:	Councillor Kath Rowson, Cabinet Member for Adult Social Care
Date of Meeting:	22 October 2014

ADULT SOCIAL CARE- SECTION 256 MONIES TRANSFER

1.0 Purpose of the report:

1.1 To consider an update on the proposed services and values in respect of the funding transfer for Adult Social Care from NHS England to Blackpool Council.

2.0 Recommendation(s):

2.1 To discuss and accept the proposed schedule, which is in accordance with the joint workingof Health and Social Care services

3.0 Reasons for recommendation(s):

3.1 Health and Wellbeing Boards are required to authorise the transfer of Section 256 monies

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

Not to authorise the transfer of Section 256 monies.

4.0 Council Priority:

4.1 The relevant Council Priority is

- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

5.1 In December 2012 it was announced (Department for Health Gateway reference 18568) that funding to support Adult Social Care had been passed to NHS England as part of the 2013/2014 Mandate.

5.2 For the 2014/2015 financial year, NHS England will transfer £1,100m from the Mandate to Local Authorities.

5.3 Payment locally will be made via a Section 256 of the 2006 NHS Act and equates to £4,141,888 for Blackpool.

5.4 Unlike previous years where the Section 256 schedule was signed off by the local Primary Care Trust and Local Authority, this year approval and discussion also has to take place with the Health and Wellbeing Board and NHS England local area team.

5.5 The funding must be used to support Adult Social Care services in each Local Authority which also has a health benefit. There will be a responsibility to link the funding proposals to joint commissioning plans with regard also to the joint strategic needs assessment for our local population.

5.6 NHS England will also make it a condition of the transfer that Local Authorities demonstrate how the funding transfer will make a positive difference to social care services and outcomes for service users, compared to service plans in the absence of funding.

5.7 The attached schedule at Appendix 4a summarises the analysis of spend that shall be attributed to each area and this has been agreed with Blackpool Clinical Commissioning Group.

5.8 Monitoring systems and outcome specific measurements can be determined in conjunction with NHS England once the domains have been agreed. It is suggested that these shall be brought back to the Health and Wellbeing Board for consideration.

5.9 Does the information submitted include any exempt information? No

5.10 **List of Appendices:**

Appendix 10 (a) - Summary analysis of spend
Appendix 10 (b) – Service allocation schedule

6.0 Legal considerations:

6.1 Payment locally will be made via a Section 256 of the 2006 NHS Act.

Approval and discussion also has to take place with the Health and Wellbeing Board and NHS England local area team.

The funding must be used to support Adult Social Care services in each Local Authority which also has a health benefit. There will be a responsibility to link the funding proposals to joint commissioning plans with regard also to the joint strategic needs assessment for our local population.

7.0 Human Resources considerations:

7.1 The funding pays for services, including employee costs

8.0 Equalities considerations:

8.1 None identified

9.0 Financial considerations:

9.1 Payment locally equates to £4,141,888 for Blackpool.

10.0 Risk management considerations:

10.1 Monies would not be transferred, services would cease, outcomes for people in Blackpool would not be achieved, and staff would be redundant

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 Discussion between relevant Health and Social Care Commissioners, senior managers, and finance officers

13.0 Background papers:

13.1 None

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Blackpool

Service description - staffing	Cost 2014/15	NHS England Description	Benefit to the health economy	Performance measures
Care and Repair	£138,635	Community equipment and adaptions	• Greater numbers of users and carers remaining independent in the community with equipment thus reducing or preventing hospital admissions and admission into residential care • Increase the life expectancy of service users • Single procurement of equipment resulting in increased efficiencies and cost- effectiveness across health and social care budgets • Tracking and traceability of equipment. This will include responsibility for ensuring maintenance is in place for all medium and high risk equipment and detailed up to date records are available to commissioners and the Health and Safety Executive as required. • Financial and activity management information at regular intervals • Good levels of communication and joint working between professional groups. • Appropriate and cost effective maintenance contracts for rented equipment • Monitoring the budget within agreed joint health and social care commissioning budgets	KPI's are collected monthly and contract reviews occur quarterly together with two anonymous case studies which describe how the service has met the agreed outcomes of the service: The Activity Performance Indicators can be seen below: - Delivery of Equipment within 7 days - Number of items supplied > £1,000 and the referrer of these - Number and costs of children's items supplied - Number of items collected with value of these - Numbers of delayed deliveries - Waiting time for specials or bespoke equipment - Number and cost of adult items supplied - Numbers of equipment fitted - Number of orders placed by referring organisation - Number of items requiring maintenance
Vitaline	£429,883	Telecare	• An increase in the number of older people and other vulnerable adults supported to remain safely in their own homes • To contribute to preventing or delaying admission into residential care or nursing care • To contribute to facilitating safe and timely discharge from hospital •To contribute to preventing admission or re-admission to hospital • To assist with the management of long term conditions • To reduce the costs of health and social care provision • To provide support to enable carers to continue to care • Improved health and well-being	KPI's are collected monthly and contract reviews occur quarterly together with two anonymous case studies which describe how the service has met the agreed outcomes of the service:. The Activity Performance Indicators can be seen below: • Total number of units being provided at the beginning of the period • Number of units installed during in the period : Silver, Gold, Platinum, Diamond • Number of units removed during the period • Total number of units being provided at the end of the period • Number of routine installations not undertaken within 48 hour and the reasons why: Silver, Gold, Platinum • Number of routine Diamond installations not undertaken within 72 hours • Number of emergency installations (Silver, Gold, Platinum) not undertaken within 6 hours • Number of emergency installations (Enhanced) not undertaken within 24 hours
Homecare Rapid Response	£100,000	Integrated crisis and rapid response services	• To support and care for adults in their own homes in an acute phase of illness and who without additional intensive support would normally be admitted to hospital or residential home. • To reduce inequalities in patient provision. • To reduce hospital admissions and facilitate early discharge from Secondary Care • To facilitate greater patient choice [on a risk assessed basis] • To provide a cost effective alternative to an inpatient episode • To provide timely and specifically targeted intensive Care Packages that are regularly reviewed • To develop partnerships and integrated working with both Social Services and third sector providers as outlined in "our health, our care, our say"	KPI's are collected monthly and contract reviews occur quarterly together with two anonymous case studies which describe how the service has met the agreed outcomes of the service: The Activity Performance Indicators can be seen below: - No of hours of Domicilary Care, day and night, provided per client and overall for the period -No of clients admitted to hospital during the 14 day/72hr domicilary care hour provision -Cost per client for domicilary care support and total cost per quarter -No of clients supported for 72hr and discharged without an increase to their package of care. - No of referrals by referral source to social worker for full assessment. -No of people allocated social care packages split by new package, or enhanced package. -Cost of/additional cost of social care package per client and total per quarter.

Primary Night Care	£461,114	Integrated crisis and rapid response services	• To contribute to preventing hospital admission • People are able to remain living in their own homes • People retain dignity and control when requiring support in their own home • Carers are supported • Reduction in delayed discharges, once a person is medically fit for discharge	The following Key performance information is provided by the Service Provider on a quarterly basis together with two anonymous case studies which describe how the service has met the agreed outcomes of the service: Total number of hours provided • % clients living in their own home • Reason for packages ending • Number of clients who have used the unplanned service more than 3 times • Number of planned / unplanned referrals •Source of referral •Total hours of provision
Social Care - Mental Health Team	£965,049	Maintaining eligibility criteria	Contribution to the reduction of hospital readmissions. Enhances the Intermediate Care pathways established through joint working arrangements with health and social care.	Regular supervision of social care practise by Care Management. Health and Wellbeing Performance framework measures i) delayed transfers of care and ii) Delayed transfers of care attributable to social care. Both indicators are currently showing improved performance. iii) Proportion of adults in contact with secondary mental health in paid employment.
Social Care - Other Teams	£100,000	Maintaining eligibility criteria		
Homecare - Reablement	£584,041	Re-ablement services	• To support independent living by minimising the dependence people have on care support services. • To support and encourage reintegration into community life • To support timely and early discharge from acute care. • To contribute to preventing admission or re-admission into hospital via the provision of reablement support • Improved health and well-being and quality of life • Increase the life expectancy of service users	The following Key performance information is provided by the Service Provider on a quarterly basis prior to each quarterly contract review together with two anonymous case studies which describe how the service has met the agreed outcomes of the service: • Number of referrals received in the period • Number of referrals accepted in the period • Percentage of accepted referrals where the service commenced within 72 hours • Number of people who successfully completed an episode of reablement in the period • Number of people who ceased receiving a service prior to completing an episode of re ablement period • Total number of hours per week reduced from care packages as a result of reablement support • Annualise saving (hours per week x contracted care rate of £11.35ph x 52 weeks)
ARC	£500,000	Bed-based intermediate care services	• To contribute to facilitating early discharge from hospital, the prevention of a hospital admission or inappropriate long term residential care • To maximise independence, enabling service users to resume living at home • To contribute to a reduction in avoidable hospital admissions • Improved quality of life for service users • Increased choice and control for service users • Service users develop new skills in order to maintain self-sufficiency • Service users are fully informed in the definition and assessment of their needs and actively involved them in the development of their multi–disciplinary care plan	The following Key performance information is provided by the Service Provider on a quarterly basis prior to each quarterly contract review together with two anonymous case studies which describe how the service has met the agreed outcomes of the service: • Number of beds utilised for intermediate care during the month • Number of bed nights utilised for recuperation per month • Number of service users with a personalised structured care plan within 7 days of admission to the service • Number of service users participating in falls prevention activities – education and chair-based exercise • Number of service users who receive a period of re-ablement of more than 6 weeks • The number of service users where follow-up contact has taken place within 4 weeks • Number of inappropriate referrals including reasons why inappropriate • Number of referrals to the service

Hospital Discharge Team	£300,000	Early supported hospital discharge schemes	To facilitate safe and early discharge of patients, To minimise delays in discharges Support patients to access appropriate care and ensure safe discharge	Health and Well Being Performance Framework measure: Delayed Transfers of Care and Proportion of patients (65+) still at home 91 days after discharge from hospital into reablement/rehabilitation services
Phoenix Centre	£398,166	Mental health services	• To prevent admission or re-admission into hospital • To support social integration within local communities • To assist with the management of long term mental health conditions • To support reintegration into community life • To prevent admission or re-admission into hospital • To reduce the costs of health and social care provision • To provide support to carers and enable carers to continue to care • Improved health and well-being and quality of life • Effective working with and signposting to health, social care and other agencies	The following Key performance information is provided by the Service Provider on a quarterly basis prior to each quarterly contract review together with two anonymous case studies which describe how the service has met the agreed outcomes of the service: - Number of referrals - Bed occupancy levels
Richmond Fellowship	£100,000	Mental health services	• To enable people to have valued and satisfying lives • To support people to access existing opportunities in their local community rather than creating segregated activities • To provide people with opportunities to extend their social networks and form relationships • To offer opportunities for people to support each other • Users are supported in accessing resources, which support them in maintaining physical and mental health. • To provide support to carers, enabling carers to continue to care • To support individuals who wish to develop skills and confidence to engage in employment	KPI's are completed quarterly and contract reviews are undertaken 6-monthly across all levels of the service • Number of referrals, with reasons • Number of discharges, with reasons • Service input i.e. what has been provided • Number of group sessions and activities provided • Movement between levels of service • Number supported in training, employment, education • Number supported into other community activities
Volunteers Service	£50,000	Other preventative services	• To help the carers to continue to care and so enable them to delay or avoid the person they care for having to go into respite care or hospital. • Provide vital social contact for the carers and the person they look after to reduce isolation. Promote inclusion in the Community and reduce social exclusion for carers, service users and those who wish to volunteer. • Provide volunteers with the opportunities to gain new skills, make friends and gain confidence. Provide volunteers with opportunities to access employment through confidence building/new skills acquisition. • Reduce the increasing demands on health services by providing a preventative service which enables people to live independently and healthier for longer in the community.	Information is provided quarterly on: Volunteers and training of volunteers, number of service users supported through Out and About and Sitting Service, other volunteer activity, number of Carers receiving a break, outcomes for carers and the cared for person. Case studies are provided quarterly.
Advice & Information	£15,000	Other preventative services	To provide effective and efficient advice and information to elderly people in Blackpool. To support the health and wellbeing of Blackpool residents through the delivery of a comprehensive information and representation service to older people and their carers/relatives.	Number of enquiries (personal), Number of enquiries (phone) demographics of service users, analysis of the type and resolution of enquiries, number of sessions provided, staffing information, Outcome case studies.

Total	£4,141,888	

NHS England Description	Subj. Code	Value
Community equipment and adaptions	52131015	£138,635
Telecare	52131016	£429,883
Integrated crisis and rapid response services	52131017	£561,114
Maintaining eligibility criteria	52131018	£1,065,049
Re-ablement services	52131019	£584,041
Bed-based intermediate care services	52131020	£500,000
Early supported hospital discharge schemes	52131021	£300,000
Mental health services	52131022	£498,166
Other preventative services	52131023	£65,000
Other social care (please specify)	52131024	£0
Other Intermediate Care (please specify)	52131025	£0
Housing Projects	52131026	£0
Employment Support	52131027	£0
Learning Disabilities Services	52131028	£0
Dementia Services	52131029	£0
Support to Primary Care	52131030	£0
Integrated Assessments	52131031	£0
Integrated Records Or IT	52131032	£0
Joint Health And Care Teams/Working	52131033	£0
		£4,141,888

S256 Service Allocation Schedule

Category Description	2014/15 Social Care Allocation £'000	Comments
Community Equipment and Adaptations	139	Care and Repair
Telecare	430	Vitaline
Integrated Crisis and Rapid Response Service	561	Primary Night Care and Rapid Response
Maintaining Eligibility Criteria	1,065	Mental Health Team and Other Social Care
Re-ablement Services	584	Out of Hospital Care
Bed Based intermediate Care Services	500	Arc
Early Supported Discharge Schemes	300	Hospital Discharge Team
Mental Health Services	398	Phoenix Centre
Other Preventative Services	165	Volunteers/Richmond Fellowship/Advice and Info
Total	4,142	

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Meeting	22nd October 2014

DUE NORTH REPORT

1.0 Purpose of the report:

1.1 This is a report of the inquiry on health equity for the North. The aim of the inquiry has been to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England.

2.0 Recommendation(s):

2.1 To consider the recommendations detailed within the Due North report

2.2 To discuss the best way to implement the recommendations.

3.0 Reasons for recommendation(s):

3.1 This is an important report with recommendations for both local government and central government and it is particularly relevant at this time because of the austerity measures and poverty-generating welfare reforms which are hitting the disadvantaged areas in the North the hardest.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered: None

None

4.0 Council Priority:

4.1 The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

5.1 The aim of the inquiry has been to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England. Further background information is available in the body of the report.

5.2 Does the information submitted include any exempt information? No

5.3 **List of Appendices:**

Appendix11a Due North Executive Summary

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 N/A

13.0 Background papers:

13.1 Due North Full Report

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DUE NORTH

Executive summary report of the Inquiry on Health Equity for the North

Due North: The report of the Inquiry on Health Equity for the North

Inquiry Chair: Margaret Whitehead

Executive summary report prepared by the Inquiry Panel on Health Equity for the North of England

First published in Great Britain in September 2014 by University of Liverpool and Centre for Local Economic Strategies

ISBN: 1 870053 76 1

Aknowledgements

We thank the many people who contributed to the Inquiry's work. This Inquiry was carried out by a panel chaired by Margaret Whitehead and supported by a secretariat from the Centre for Local Economic Strategies (CLES). The review was informed by 18 policy makers and practitioners, with expertise in the relevant policy fields (see appendix 1) and four discussion papers prepared by Ben Barr, David Taylor-Robinson, James Higgerson, Elspeth Anwar, Ivan Gee (University of Liverpool), Clare Bambra and Kayleigh Garthwaite (Durham University) and Adrian Nolan and Neil McInroy (CLES). This report was prepared by the Inquiry Panel supported by CLES (Neil McInroy, Adrian Nolan and Laura Symonds) and the WHO Collaborating Centre for Policy Research on Social Determinants of Health (Ben Barr). Public Health England provided financial support for the conduct of the Inquiry and the gathering of evidence but played no part in the decisions or conclusions of the Inquiry Panel.

PREFACE

Life is not grim up North, but, on average, people here get less time to enjoy it. Because of poorer health, many people in the North have shorter lifetimes and longer periods of ill-health than in other parts of the country. That health inequalities exist and persist across the north of England is not news, but that does not mean that they are inevitable.

While the focus of the Inquiry is on the North, it will be of interest to every area and the country as a whole.

This has been an independent inquiry commissioned by Public Health England. We particularly wanted and welcome fresh insights into policy and actions to tackle health inequalities within the North of England and with the rest of the country, in the context of the new public health responsibilities locally and nationally, and the increasingly live debate about greater economic balance.

I would like to thank Professor Whitehead, her panel, witnesses to the Inquiry and the Centre for Local Economic Strategies for the time, energy and commitment that has resulted in this report

PHE's own interim response to the issues and recommendations from this inquiry is published alongside this report and we will produce a fuller response at a later date, when we have had time to explore and consider the issues in greater depth. We look forward to contributing to stimulating discussion and debate with partners over the coming months.

Paul Johnstone
Public Health England
August 2014

FOREWORD

We have lived with a North-South health divide in England for a long time, illustrated by the shocking statistic that a baby girl in Manchester can expect to live 15 fewer years in good health than a baby girl in Richmond. This gap is not static but has continued to widen over recent decades. This regional health divide masks inequalities in health between different socio-economic groups within every region in England which are just as marked: health declines with increasing disadvantage of socio-economic groups wherever they live in the country.

By and large, the causes of these health inequalities are the same across the country – and are to do with differences between socioeconomic groups in poverty, power and resources needed for health; exposure to health damaging environments; and differences in opportunities to enjoy positive health factors and protective conditions, for example, to give children the best start in life. It is, however, the severity of these causes that is greater in the North, contributing to the observed regional pattern in health. It also marks out the North as a good place to start when inquiring into what can be done about social inequalities in health in this country. There may be lessons to be learnt for the whole country.

There are more pressing reasons, however, for setting up this Inquiry on Health Equity for the North at this point in time. The austerity measures introduced as a response to the 2008 recession have fallen more heavily on the North and on disadvantaged areas more than affluent areas, making the situation even worse. Reforms to the welfare system are potentially increasing inequalities and demand for services. At the same time, there are increasing calls for greater devolution to city and county regions within England. There is a growing sense that now is the time to influence how the process of devolution happens, so that budgets and powers are decentralised and used in ways that reduce economic and health inequalities.

It is against this background that the Inquiry Panel developed its' recommendations – recommendations that are based on an analysis of the root causes of the observed health inequalities. A guiding principle has been to build on the assets and agency of the North. There are plenty of ideas, therefore, about what agencies in the North could and should do, made stronger by working together, to tackle the causes of health inequalities. These are centred around the twin aims of the prevention of poverty in the long term and the promotion of prosperity, by boosting the prospects of people and places. They are also about how Northern agencies could make best use of devolved powers to do things more effectively and equitably.

The Panel is keen to stress, however, that there are some actions that only central government can take. Government policy is both the cause and the solution to some of the problems analysed by the Inquiry. The report therefore sets out what central government needs to do, both to support action at the regional level and to re-orientate national policies to reduce economic and health inequalities. There is an important role too for national health agencies, including the NHS and Public Health England. The aim of this report is to bring a Northern perspective to the debate on what should be done about a nationwide problem. We are optimistic that something can be done to make a difference and that this is the right time to try.

Margaret Whitehead
Chair, Inquiry on Health Equity for the North
August 2014

EXECUTIVE SUMMARY

Why have an inquiry into health inequalities and the North?

The North of England has persistently had poorer health than the rest of England and the gap has continued to widen over four decades and under five governments. Since 1965, this equates to 1.5 million excess premature deaths in the North compared with the rest of the country. The latest figures indicate that a baby boy born in Manchester can expect to live for 17 fewer years in good health than a boy born in Richmond in London. Similarly, a baby girl born in Manchester can expect to live for 15 fewer years in good health, if current rates of illness and mortality persist.

The so called 'North-South Divide' gives only a partial picture. There is a gradient in health across different social groups in every part of England: on average, poor health increases with increasing socio-economic disadvantage, resulting in the large inequalities in health between social groups that are observed today. There are several reasons why the North of England is particularly adversely affected by the drivers of poor health. Firstly, poverty is not spread evenly across the country but is concentrated in particular regions, and the North is disproportionately affected. Whilst the North represents 30% of the population of England it includes 50% of the poorest neighbourhoods. Secondly, poor neighbourhoods in the North tend to have worse health even than places with similar levels of poverty in the rest of England. Thirdly, there is a steeper social gradient in health within the North than in the rest of England meaning that there is an even greater gap in health between disadvantaged and prosperous socio-economic groups in the North than in the rest of the country. It is against this background that this Inquiry was set up.

Aims of the inquiry

In February 2014, Public Health England (PHE) commissioned an inquiry to examine Health Inequalities affecting the North of England. This inquiry has been led by an independent Review Panel of leading academics, policy makers and practitioners from the North of England. This is part of 'Health Equity North' - a programme of research, debate and collaboration, set up by PHE, to explore and address health inequalities. This programme was launched in early 2014, with its first action to set up this independent inquiry.

The aim of this inquiry is to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England.

The Inquiry Panel

The Inquiry Panel was recruited to bring together different expertise and perspectives, reflecting the fact that reducing health inequalities involves influencing a mix of social, health, economic and place-based factors. The panel consisted of representatives from across the North of England in public health, local government, economic development and the voluntary and community sector. The members of the Inquiry Panel were:

- Professor Margaret Whitehead (Chair), W.H. Duncan Chair of Public Health, Department of Public Health and Policy, University of Liverpool;
- Professor Clare Bambra, Professor of Public Health Geography, Department of Geography, Durham University;
- Ben Barr, Senior Lecturer, Department of Public Health and Policy, University of Liverpool;
- Jessica Bowles, Head of Policy, Manchester City Council;
- Richard Caulfield, Chief Executive, Voluntary Sector North West;
- Professor Tim Doran, Professor of Health Policy, Department of Health Sciences, University of York;
- Dominic Harrison, Director of Public Health, Blackburn with Darwen Council;
- Anna Lynch, Director of Public Health, Durham County Council;
- Neil McInroy, Chief Executive, Centre for Local Economic Strategies;
- Steven Pleasant, Chief Executive, Tameside Metropolitan Borough Council;
- Julia Weldon, Director of Public Health, Hull City Council.

The process

Recommendations were developed through 3 focused policy sessions and 3 further deliberative meetings of the panel over the period February to July 2014. The policy sessions involved the submission of written discussion papers commissioned by the panel, as well as a wider group of experts and practitioners, with expertise in the relevant policy fields, who were invited to these sessions (see Appendix 1 for a list of participants). During the three further deliberative sessions held by the Inquiry the panel refined the recommendations, drawing on the discussions and written evidence from the policy sessions, and the experience and knowledge of the panel members.

This report sets out a series of strategic and practical policy recommendations that are supported by evidence and analysis and are targeted at policy makers and practitioners working in the North of England. These recommendations acknowledge that the Panel's area of expertise is within agencies in the North, while at the same time highlighting the clear need for actions that can only be taken by central government. We, therefore, give two types of recommendations for each high-level recommendation:

- What can agencies in the North do to help reduce health inequalities within the North and between the North and the rest of England?
- What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

What causes the observed health inequalities?

The Inquiry's overarching assessment of the main causes of the observed problem of health inequalities within and between North and South, are:

- Differences in poverty, power and resources needed for health;
- Differences in exposure to health damaging environments, such as poorer living and working conditions and unemployment;
- Differences in the chronic disease and disability left by the historical legacy of heavy industry and its decline;
- Differences in opportunities to enjoy positive health factors and protective conditions that help maintain health, such as good quality early years education; economic and food security, control over decisions that affect your life; social support and feeling part of the society in which you live.

Not only are there strong step-wise gradients in these root causes, but austerity measures in recent years have been making the situation worse – the burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South; on disadvantaged than more affluent areas; and on the more vulnerable population groups in society, such as children. These measures are leading to reductions in the services that support health and well-being in the very places and groups where need is the greatest.

Policy drivers of inequalities and solutions

1. Economic development and living conditions

The difference in health between the North and the rest of England is largely explained by socioeconomic differences, including the uneven economic development and poverty. One of the consequences of the uneven economic development in the UK has been higher unemployment, lower incomes, adverse working conditions, poorer housing, and higher unsecured debts in the North, all of which have an adverse impact on health and increase health inequalities.

The adverse impact of unemployment on health is well established. Studies have consistently shown that unemployment increases the chances of poor health. Empirical studies from the recessions of the 1980s and 1990s have shown that unemployment is associated with an increased likelihood of morbidity and mortality, with the recent recession leading to an additional 1,000 suicides in England. The negative health experiences of unemployment are not limited to the unemployed but also extend to their families and the wider community. Youth unemployment is thought to have particularly adverse long term consequences for mental and physical health across the life course.

The burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South;

The high levels of chronic illness in the North also contribute to lower levels of employment. Disability and poor health are the primary reasons why people in the North are out of work, as demonstrated by the high levels of people on incapacity benefits. Strategies to reduce inequalities need to prevent

people leaving work due to poor health, enable people with health problems to return to work and provide an adequate standard of living for those that cannot work.

A great deal of evidence has demonstrated an inverse relationship between income and poor health, with falls in income and increases in poverty associated with increased risk of mental and physical health problems. Poor psychosocial conditions at work increase risk of health problems, in particular cardiovascular conditions and mental health problems. More precarious forms of employment, including temporary contracts, are also increasing and these have been associated with increased health risks.

Poor housing has been shown to have numerous detrimental effects on physical and mental health. Living in fuel poverty or cold housing can adversely affect the mental and physical health of children and adults. It is estimated that this costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes. For infants, after taking other factors into account, living in fuel poor homes is associated with a 30% greater risk of admission to hospital or attendance at primary care facilities.

This calls for a strategy that not only ameliorates the impact of poverty but also seeks to prevent poverty in the future

People in debt are three times more likely to have a mental health problem than those not in debt, the more severe the debt more severe the health difficulties. In terms of physical health, debt has been linked to a poorer self-rated physical health, long term illness or disability, chronic fatigue, back pain, higher levels of obesity and worse health and health related quality of life.

What could be done differently?

The evidence reviewed by the panel has outlined a number of actions that have the potential to address the economic and employment causes of health inequalities. This calls for a strategy that not only ameliorates the impact of poverty but also seeks to prevent poverty in the future, not least by investing in people (improving skills and health and hence employment prospects), as well as investing in places. This strategy links public service reform to economic development in the North, to refocus services on preventing poverty and promoting prosperity.

2. Early childhood as a critical period

The UK has some of the worst indicators for child health and well-being of any high-income country. In 2007 a UNICEF study found that the UK had the worst levels of child well-being of any developed country and a recent study found that it had the second worst child mortality rate in Western Europe. Within England, the health of children is generally worse in the North, reflecting the higher levels of child poverty.

There is a large body of evidence demonstrating that early disadvantage tracks forward, to influence health and development trajectories in later life, and that children who start behind tend to stay behind. For example, children living in poverty and experiencing disadvantage in the UK are more likely to: die in the first year of life; be born small; be bottle fed; breathe second-hand smoke; become overweight; perform poorly at school; die in an accident; become a young parent; and as adults they are more likely to die earlier, be out of work, living in poor housing, receive inadequate wages, and report poor health.

Whilst the higher levels of child poverty and disadvantage in the North of England are potentially storing up problems for the future, none of this is inevitable. Numerous reviews of evidence have repeatedly shown that providing better support early in children's lives is the most effective approach to significantly reduce inequalities in life chances. In the North of England, where large proportions of children are growing up in poverty, it is critical that action to improve early child development takes place on a scale that is proportionate to need.

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Some progress has been made over the past decade; however these gains are now under threat. The UK was the first European country to systematically implement a strategy to reduce health inequalities. In particular, the Government set targets to reduce inequalities in infant mortality and to cut and eventually 'eradicate' child poverty. To address these targets, a raft of well-funded policies were implemented including changes to the tax and benefits system that led to a reduction in child poverty and the establishment of Sure Start centres, which aimed to reduce child poverty through the targeted provision of pre-school education. Child poverty did reduce dramatically and inequalities in infant mortality also fell during this period. Unfortunately, we are now seeing signs that these achievements are being undone. For the first time in more than 17 years, child poverty in the United Kingdom increased in absolute terms in 2011 and the reduction in inequalities in infant mortality ceased with the onset of the financial crisis in 2008. The Social Mobility and Child Poverty Commission has estimated that by 2020 3.5 million children will be in absolute poverty, about 5 times the number needed to meet the Government's legal obligation to end child poverty.

What could be done differently?

Children are often not in a position to speak out for themselves and for this reason are offered special protection under the UN charter on human rights. The arguments are not just about the evidence, but also that investing in children is morally and legally the right thing to do. A rights-based approach to addressing inequalities in the health and well-being of children has the potential to engender a new commitment to investment in the early years.

The evidence indicates that two strands of action are required to significantly reduce child health inequalities at a population level. Firstly, a universal system of welfare support is needed that prioritises children, in order to eliminate child poverty. Well-developed social protection systems result in better outcomes for children and protect them against shocks such as economic crises. Those countries in Europe that do have more adequate social protection experience better child health outcomes. The recent analysis of the Social Mobility and Child Poverty Commission has shown that the Government's current strategy for reducing child poverty is not credible. They conclude that 'hitting the relative poverty target through improved parental employment outcomes alone is impossible' and recommend that increases in parental employment and wages are supplemented by additional financial support for families.

Secondly, a system of high quality universal early years child care and education support is also necessary. In Nordic countries, a child's life chances are not so dependent on how privileged their

parents were than they are in other developed countries. One reason for this is the provision of universal and high-quality early years intervention and support, which can have a powerful equalising effect.

There is a great deal of agreement that providing good quality universal early years education and childcare proportionately across society would effectively reduce inequalities. Providing any education is not enough, though, since it is the quality of preschool learning that appears to be critical for longer-term beneficial effects. This needs to be supported by routine support to families through parenting programmes, key workers, and children's centres with integrated health and care services and outreach into communities. The evidence base for these early interventions is strong.

3. Devolution: having the power to make a difference at the right spatial scale

The evidence suggests that there are three ways through which levels of community control and democratic engagement have an impact on health. Firstly, those who have less influence are less able to affect the use of public resources to improve their health and well-being. The Northern regions, for example, have had limited collective influence over how resources and assets are used in the North of England and this has hindered action on health inequalities. Secondly the process of getting involved, together with others, in influencing decisions, builds social capital that leads to health benefits. Thirdly, where people feel they can influence and control their living environment, this in itself is likely to have psychological benefits and reduce the adverse health effects of stress.

Northern regions have had limited collective influence over how resources and assets are used and this has hindered action on health inequalities.

There is a growing body of evidence indicating that greater community control leads to better health. Low levels of control are associated with poor mental and physical health. A number of studies have found that the strength of democracy in a country is associated with better population health and lower inequalities. Countries with long-term social-democratic governments tend to have more developed preventive health services. US states with higher political participation amongst the poor have more adequate social welfare programmes, lower mortality rates and less disability. There is evidence indicating that the democratic participation of women is particularly important for the health of the whole population.

When community members act together to achieve common goals there are indirect benefits resulting from improved social support and supportive networks which can reduce social isolation and nurture a sense of community, trust and community competence. Research indicates that community empowerment initiatives can produce positive outcomes for the individuals directly involved including: improved health, self-efficacy, self-esteem, social networks, community cohesion and improved access to education leading to increased skills and paid employment. Evidence from the 65 most deprived local authorities in England shows that, as the proportion of the population reporting that they can influence decisions in their local area increases, the average level of premature mortality and prevalence of mental illness in the area declines.

A constraint on the capacity of local government to make a difference is the highly centralised nature of the political system in England. England has one of the most centralised political systems in Europe, both political and economic power are concentrated in London and the surrounding area and this has contributed to the large inequalities between regions. The disproportionate cuts to local government budgets currently being implemented are exacerbating the problem. Successful regions will have control over the prerequisites of growth, such as skills, transport and planning.

What could be done differently?

Increasingly, the new combined authorities and core cities are demanding greater devolution of powers and resources to cities and local government. There is also a growing consensus across political parties that this is needed to drive economic growth and reduce regional inequalities in England. Simply devolving power to city regions and combined authorities, however, will not, on its own, address inequalities. Giving local areas greater control over investment for economic development will only reduce health and economic inequalities if local strategies for economic growth have clear social objectives to promote health and well-being and reduce inequalities, backed by locally integrated public services aimed at supporting people into employment. The public health leadership of local authorities will need to play a central role if devolution to cities and regions is going to reverse the trend of rising inequalities. Devolution of power and resources to local administrations needs to be accompanied by greater public participation in local decision-making. Decisions in Whitehall may seem distant and unaccountable to people living in the North, but decisions made by combined authorities or local economic partnerships will seem no more democratic unless there is greater transparency and participation.

There is the potential for devolution within England to herald a new approach to health inequalities

There is the potential for devolution within England to herald a new approach to health inequalities that is based on fundamentally shifting power from central government to regions, local authorities and communities. But only if there is real devolution, rather than just rhetoric, and local powers are used to improve health and reduce inequalities – allowing them to do the right things at the right spatial scale.

None of this, however, should reduce the responsibilities of national government. The role of national government in addressing health inequalities remains of the utmost importance. Robust national policy is essential to ensure that there are sufficient public resources available and that these are distributed and used fairly to improve the life chances of the poorest fastest. National legislation remains an important mechanism for protecting people from the adverse consequences of uncontrolled commercial markets. Where services are delivered through national agencies, they need to work flexibly as part of a set of local organisations that can integrate services so that they address local needs.

4. The vital role of the health sector

We did not consider that the observed health inequalities between the North and the rest of England and within the North are caused by poorer access or quality of NHS services. Although there are still inequalities in access to healthcare by deprivation, these could not account for the size

and nature of the differences in health status that we observe. On the contrary, access to NHS care when ill has helped to reduce health inequalities. The NHS helps to ameliorate the health damage caused by wider determinants outside the health sector. To do this, NHS services in deprived areas need to be adequately resourced to enable them to reduce inequalities and the principle of the NHS as free at the point of need must be maintained.

The NHS can influence health inequalities through 3 main areas of activity. Firstly by providing equitable high quality health care, secondly by directly influencing the social determinants of health through procurement and as an employer, and thirdly as a champion and facilitator that influences other sectors to take action to reduce inequalities in health.

What could be done differently?

The most pressing concern for the NHS is to maintain its core principle of equitable access to high quality health care, free at the point of need. This will involve addressing those inequalities in health care that do exist, avoiding introducing policies that will increase health inequalities and ensuring that health care provision across the country is planned and resourced so that it reduces heath inequalities. Specifically the panel identified the following priority areas through which the health sector can play an important role in reducing health inequalities.

Firstly the NHS needs to allocate resources so that they reduce health inequalities within the North and between the North and the rest of England. There is evidence to indicate that the policy to increase the proportion of NHS resources going to deprived areas did lead to a narrowing of inequalities in mortality from some causes. This highlights the importance of having resource allocation policies with an explicit goal to reduce inequalities in outcomes.

Secondly, local health service planning needs to ensure that the resources available to the NHS within each area are used to reduce inequalities. This means targeting resources to those most in need and investing in interventions and services that are most effective in the most disadvantaged groups. The current focus of CCGs on demand management has tended to mean increased investment in services for the elderly. Whilst this is important, it should not be at the expense of investment earlier in the life course, which is a vital component of all health inequalities strategies.

Access to NHS care when ill has helped to reduce health inequalities, amelioratating the health damage caused by wider determinants outside the health sector.

Thirdly a more community-orientated model of primary care needs to be encouraged that fully integrates support across the determinants of health. This includes enabling people seeking help through the primary care system to get the support they need for the full range of problems that are driving them to seek help in the first place. These are often the wider determinants of their health, such as financial problems, unsuitable housing, hopelessness and generally feeling out of control of their lives.

Fourthly a large-scale strategy for the North of England is needed to maximize the impact of the NHS on health inequalities through its procurement and its role as an employer. There are also promising examples indicating how local NHS organisations are using their commissioning and procurement of services to improve the economic, social, and environmental well-being of their area. If the commissioning and procurement of all the NHS organisations in the North of England focused on maximizing social value for the North, this could make a significant difference.

Finally the health sector needs to be a strong advocate, facilitating and influencing all sectors to take action to reduce inequalities in health. With Directors of Public Health transferring from the NHS to local authorities there are fewer voices in the NHS speaking out on issues relating to the public's health and health inequalities. Public Health England was established to be an independent advocate for action across all sectors on health inequalities. The actions that are required to address health inequalities involve radical social change. They are therefore often controversial. Public Health England needs to be supporting and challenging all government departments to tackle health inequalities.

Recommendations

Tackling these root causes leads to a set of 4 high-level recommendations and supporting actions that build on the assets of the North to target inequalities both within the North and between the North and the rest of England. These recommendations are explained in detail in Section 4. These recommendations are formulated from a Northern perspective and address the core question: what can the North do to tackle the health equity issues revealed in this report? This perspective does not mean that we discount national actions – far from it – we give two types of recommendations for each high-level recommendation:

1) What can agencies in the North, do to help reduce the health inequalities within the North and between the North and the rest of England?

2) What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

We believe that the recommended actions would benefit the whole country, not just the North.

Recommendation 1: Tackle poverty and economic inequality within the North and between the North and the rest of England.

Agencies in the North should work together to:

- Draw up health equity strategies that include measures to ameliorate and prevent poverty among the residents in each agency's patch;
- Focus public service reform on the prevention of poverty in the future and promoting the prosperity of the region by re-orientating services to boost the prospects of people and place. This includes establishing integrated support across

the public sector to improve the employment prospects of those out of work or entering the labour market.

- Adopt a common progressive procurement approach to promote health and to support people back into work;
- Ensure that reducing economic and health inequalities are central objectives of local economic development strategy and delivery;
- Implement and regulate the Living Wage at the local authority level;
- Increase the availability of high quality affordable housing through stronger regulation of the private rented sector, where quality is poor, and through investment in new housing.
- Assess the impact in the North of changes in national economic and welfare policies;

Central government needs to:

- Invest in the delivery of locally commissioned and integrated programmes encompassing welfare reform, skills and employment programmes to support people into work;
- Extend the national measurement of the well-being programme to better monitor progress and influence policy on inequalities;
- Develop a national industrial strategy that reduces inequalities between the regions;
- Assess the impact of changes in national policies on health inequalities in general and regional inequalities in particular;
- Expand the role of Credit Unions and take measures to end the poverty premium;
- Develop policy to enable local authorities to tackle the issue of poor condition of the housing stock at the bottom end of the private rental market;
- End in-work poverty by implementing and regulating a Living Wage;
- Ensure that welfare systems provide a Minimum Income for Healthy Living (MIHL);
- Grant City and County regions greater control over the commissioning and use of the skills budget and the Work Programme to make them more equitable and responsive to differing local labour markets;
- Develop a new deal between local partners and national government that allocates the total public resources for local populations to reduce inequalities in life chances between areas.

Recommendation 2: Promote healthy development in early childhood.

Agencies in the North should work together to:

- Monitor and incrementally increase the proportion of overall expenditure allocated to giving every child the best possible start in life, and ensure that the level of expenditure on early years development reflects levels of need;
- Ensure access to good quality universal early years education and childcare with greater emphasis on those with the greatest needs, so that all children achieve an acceptable level of school readiness;
- Maintain and protect universal integrated neighbourhood support for early child development, with a central role for health visitors and children's centres that clearly articulates the proportionate universalism approach;
- Collect better data on children in the early years across organisations so that we can track changes over time;
- Develop and sign up to a charter to protect the rights of children to the best possible health.

Central government needs to:

- Embed a rights based approach to children's health across government;
- Reduce child poverty through the measures advocated by the Child Poverty Commission which includes investment in action on the social determinants of all parents' ability to properly care for children, such as paid parental leave, flexible work schedules, Living Wages, secure and promising educational futures for young women, and affordable high quality child care;
- Reverse recent falls in the living standards of less advantaged families;
- Commit to carrying out a cumulative impact assessment of any future welfare changes to ensure a better understanding of their impacts on poverty and to allow negative impacts to be more effectively mitigated;
- Invest in raising the qualifications of staff working in early years childcare and education;
- Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused according to need;
- Increase investment in universal support to families through parenting programmes, children's centres and key workers, delivered to meet social needs.
- Make provision for universal, good quality early years education and childcare proportionately according to need across the country.

Recommendation 3: Share power over resources and increase the influence that the public has on how resources are used to improve the determinants of health.

Agencies in the North should work together to:

- Establish deep collaboration between combined authorities in the North to develop a Pan-Northern approach to economic development and health inequalities;
- Take the opportunity offered by greater devolved powers and resources to develop, at scale, locally integrated programmes of economic growth and public services reform to support people into employment;
- Re-vitalise Health and Well-being Boards to become stronger advocates for health both locally and nationally.
- Develop community led systems for health equity monitoring and accountability;
- Expand the involvement of citizens in shaping how local budgets are used;
- Assess opportunities for setting up publicly owned mutual organisations for providing public services where appropriate, and invest in and support their development;
- Help develop the capacity of communities to participate in local decision-making and developing solutions which inform policies and investments at local and national levels;

Central government needs to:

- Grant local government a greater role in deciding how public resources are used to improve the health and well-being of the communities they serve;

- Revise national policy to give greater flexibility to local government to raise funds for investment and use assets to improve the health and well-being of their communities;
- Invest in and expand the role of Healthwatch as an independent community-led advocate that can hold government and public services to account for action and progress on health inequalities;
- Invite local government to co-design and co-invest in national programmes, including the Work Programme, to tailor them more effectively to the needs of the local population.

Recommendation 4: Strengthen the role of the health sector in promoting health equity.

Public Health England should:

- Conduct a cumulative assessment of the impact of welfare reform and cuts to local and national public services;
- Support local authorities to produce a Health Inequalities Risk Mitigation Strategy;
- Help to establish a cross-departmental system of health impact assessment;
- Support the involvement of Health and Well-being Boards and public health teams in the governance of Local Enterprise Partnerships and combined authorities;
- Contribute to a review of current systems for the central allocation of public resources to local areas;
- Support the development a network of Health and Well-being Boards across the North of England with a special focus on health equity;
- Collaborate on the development of a charter to protect the rights of children;
- Work with Healthwatch and Health and Well-being Boards across the North of England to develop community-led systems for health equity monitoring and accountability.

Clinical Commissioning Groups and other NHS agencies in the North should work together to:

- Lead the way in using the Social Value Act to ensure that procurement and commissioning maximises opportunities for high quality local employment, high quality care, and reductions in economic and health inequalities;
- Pool resources with other partners to ensure that universal integrated neighbourhood support for early child development is developed and maintained;
- Work with local authorities, the Department for Work and Pensions (DWP) and other agencies to develop 'Health First' type employment support programmes for people with chronic health conditions;
- Work more effectively with local authority Directors of Public Health and PHE to address the risk conditions (social and economic determinants of health) that drive health and social care system demand;
- Support Health and Well-being Boards to integrate budgets and jointly direct health and well-being spending plans for the NHS and local authorities;
- Provide leadership to support health services and clinical teams to reduce children's exposure to poverty and its consequences;
- Encourage the provision of services in primary care to reduce poverty among people with chronic illness, including, for example, debt and housing advice and support to access to disability-related benefits.

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