Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	**Helping people to make healthy lifestyle choices**
Meeting Date:	9 May 2013
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Muriel Scott, Director of Public Health

Action Required:	To update the board on the position and progress against priority 7 of the Health and Wellbeing Strategy; helping people make healthy lifestyle choices. However further action is required and next steps have been identified in addition to suggested actions for the Board. However further action is required and next steps have been identified .

Executive Summary	
1.	Helping people make healthy lifestyle choices is one of the priorities of the Health and Wellbeing Board. This report highlights the progress that has been made to enable people in Central Bedfordshire to adopt healthy lifestyle behaviours and further action required by the Board.

Background	
2.	Promoting health and wellbeing of the people of Central Bedfordshire is a key priority within 'Delivering Your Plan- our plan for Central Bedfordshire 2012-2016'. Bedfordshire Clinical Commissioning Groups' (BCCG) Commissioning Plan is also underpinned by a focus on prevention, delivered in part through helping people to make healthy lifestyle choices.
3.	Adopting healthy lifestyles can prevent or delay ill health. On average a person who adopts a healthy lifestyle and therefore doesn't smoke, eats 5 portions of fruit and vegetables a day, drinks moderate amounts of alcohol and is physically active, will live 14 years longer than a person who adopts none of these behaviours.
4.	Lifestyle behaviours such as smoking, lack of physical activity, poor diet, heavy alcohol consumption and substance misuse are the leading causes of cardiovascular disease, cancers, obesity and diabetes. These non-communicable diseases (non infectious) are now the biggest cause of death and ill health in the developed world.

5.	Smoking is the primary cause of preventable ill health and premature death in England. Increasing access to stop smoking support to assist people to quit will reduce the health burden associated with smoking related illness and death in Central Bedfordshire.
6.	Physical activity provides important health and wellbeing benefits across the life course and a lack of sufficient physical activity is associated with premature death.
7.	Alcohol misuse is the third greatest overall contributor to ill health after smoking and raised blood pressure. Alcohol consumption is a contributing factor to hospital admissions and deaths from a range of conditions such as liver disease as well as contributing to anti-social behaviour and domestic and sexual violence.
8.	Substance misuse can significantly impact upon individuals, families and the wider community. For the individual, the physical and psychological impact can lead to impaired health and premature death. The impact upon families and the wider community can range from increased risks of transmission of blood borne viruses, reduced parenting capacity and increased offending behaviour.

Update on delivery	
	Support people to stop smoking through good access to services and tobacco control.
9.	Good progress has been made towards the target to reduce the smoking prevalence in Central Bedfordshire and this has been assessed through a number of measures. In particular; the 4 week quit target, quits among routine and manual workers and smoking at time of delivery. Targeted work to reduce health inequalities associated with smoking has been delivered to groups within the population who tend to experience higher rates of smoking. Routine and manual workers make up about 40% of all smokers and smoking prevalence is often higher among those living in the 20% most deprived areas.
10.	Smoking during pregnancy can cause serious health problems for both mother and baby. The effects of smoking during pregnancy is considerable in terms of illness and potential death and associated risks with complications during labour. There is also an increased risk of miscarriage, premature birth, still birth, low birth weight and sudden infant death syndrome.

Progress to date

11.

Measure	Progress to date	Comments
Four week quitters **(2012/13 target- 1850 quits)**	Q3 data showed that 1268 people had stopped smoking	This is 102% of the projected annual target
Quits among routine and manual workers	450 people from these groups have stopped smoking	This is an overachievement of the period (Q3) target by 120%
Smoking quits among the 20% most deprived	355 people from these areas have stopped smoking	This represents 96% of the period (Q3) target
Smoking in pregnancy- reported at provider level	Luton and Dunstable Hospital- 22.4% prevalence	The target is to reduce this to 15% by Q4
	Bedford Hospital- 11.2%	The target is to ensure prevalence remains below 13%

12. The Balding Health Related Survey was completed by year 10 pupils (aged 14-15 years) across 12 schools in Central Bedfordshire in 2012 and indicated an 8% smoking prevalence. In comparison, the smoking prevalence in England in 2011 was 11%. A school based prevention programme called KICK ASH which aims to stop young people from taking up smoking has been piloted in All Saints Academy, Dunstable and the middle schools that feed into the Academy. Year 10 pupils have been trained to support their peers to stop smoking through the programme.

Next Steps

13. Targets for smoking quitters in 2013/14 within General Practices have been weighted to ensure that greater numbers of quitters are achieved in the areas of higher deprivation, thereby helping to reduce health inequalities.

14. Establish a referral pathway from adult social care to stop smoking support and to the smoke free homes initiative. Increase referrals from hostels, residential settings and
care homes to reach vulnerable groups such as those with poor mental health or disability who may find it difficult to access health services.

15. Continue to increase access to stop smoking support and the smoke free homes initiative for more vulnerable families through Children Centres where a number of staff have been trained to deliver stop smoking interventions.

<table>
<tr><td>16.</td><td>The successful delivery of making every contact count will ensure that smokers are given brief interventions and signposted on for further support by a range of health and social care professionals with whom they may come in contact with.</td></tr>
<tr><td>17.</td><td>Continue to focus on the wider Tobacco Control agenda prioritising the prevention agenda through the following:
Expanding the delivery of KICK ASH in two more Upper Schools during the 2013/14 academic year
Reducing the use of illegal tobacco by building upon the 2012/13 campaign to raise awareness through a local marketing campaign
Additional clinics will also be offered in areas of high deprivation.</td></tr>
<tr><td>18.</td><td>Monitor the 2013/14 contracts with acute and community health providers which have included targets which will contribute towards reducing smoking prevalence. These are shown below;
<table>
<tr><th>Measure</th><th>Luton and Dunstable Hospital</th><th>Bedford Hospital Trust</th></tr>
<tr><td>Smoking status at time of delivery</td><td>Q1- 24% Q2-21% Q3- 18% Q4- 15%</td><td>13%</td></tr>
<tr><td>Smoking quitters at 4 weeks</td><td>160 first time attendees at stop smoking services</td><td>800 referrals with a 40% conversion rate form referral to first time attendee</td></tr>
</table></td></tr>
<tr><td></td><td>Support people to access free weight loss programmes in the community and ensure that the built environment and leisure services support people to be physically active</td></tr>
<tr><td>19.</td><td>Reducing obesity is a major challenge due to the wider and indirect factors that influence its development. Interventions to reduce obesity among adults currently focus on two specific programmes which are initiated within primary care and accessed in the community through leisure centres. Tackling the wider determinants will require other strategies such as the Leisure Strategy, Planning (Green spaces) and the Built Environment to support people being physically active.</td></tr>
<tr><td>20.</td><td>The Weight Management Referral Scheme is commissioned by Public Health Shared Function and is delivered by Weight Watchers and Slimming World through GP Practices. In 2011 only 19 of 31 surgeries were participating in the scheme whilst in 2013 all 31 surgeries are participating.</td></tr>
<tr><td>21.</td><td>The exercise referral scheme is delivered by the Central Bedfordshire physical activity team through GP practices. GPs will refer patients whose health will benefit from structured physical activity. Qualitative evidence is collected on all patients before and after the exercise referral programme and individual patients are tracked throughout the programme to monitor their progress.</td></tr>
</table>

	Progress to date
22.	There are 5 out of 6 leisure centres participating in the exercise referral scheme and plans are in place to bring the final leisure centre into the programme. In September 2012 an Exercise Referral Coordinator was appointed to ensure effective communication and delivery of the programme through improved monitoring and reporting of the scheme.
23.	<table><tr><th>Number of people referred to weight referral scheme between 2011 & 2013</th><th>% achieving a 5% weight loss</th></tr><tr><td>1226</td><td>41-53%</td></tr></table>
24.	Q3 2012/13 is the first quarter where data is reported due to a new coordinator in post under the new Service Level Agreement.
25.	<table><tr><th>Exercise Referral Scheme Figures 2012/13</th><th>Q3 2012/13</th></tr><tr><td>**Referred**</td><td>35</td></tr><tr><td>**Completed**</td><td>20</td></tr><tr><td>**Dropped out**</td><td>7</td></tr><tr><td>**DNA**</td><td>5</td></tr><tr><td>**Males**</td><td>15</td></tr><tr><td>**Females**</td><td>20</td></tr></table>
	Next Steps
26.	Reporting activity and outcomes from weight watchers and slimming world will be monitored at a GP practice level on a monthly basis to encourage further uptake of the scheme among patients.
27.	A training programme for leisure centre activity staff will continue to be delivered to ensure that exercise referrals can be taken by all leisure centres within Central Bedfordshire. Activity and outcomes will be monitored on a bi monthly basis by the public health obesity lead.
28.	Ensure that tackling obesity is addressed within the leisure strategy (currently in draft format) including a continued commitment to deliver exercise referral programmes in leisure centres across Central Bedfordshire.
29.	Refresh the Central Bedfordshire Obesity Strategy and establish a cross department Obesity Strategic Group to deliver further improved outcomes.

30	It is anticipated that the re-procurement of the Leisure Management Contracts (for Sandy, Saxon Pool, Flitwick and Houghton Regis Leisure Centres) from April 2014 will include incentives for providers to actively work with specific groups to improve access and reduce inequalities. In addition each year providers will produce an annual health and wellbeing plan, signed off by CBC, which will contribute to increase levels of physical activity and reduce obesity.
	Helping people who want to make changes to their lifestyle by making every contact count
31.	Equipping staff across a range of services with the skills and confidence to identify and make the most of every opportunity to Making Every Contact Count (MECC). This will enable them to promote and signpost people to a range of support including weight management, stopping smoking, alcohol and substance misuse, mental health and dementia.
32.	An action plan is in development for 2013/14 and will prioritise the expansion of the MECC train the trainer model. Supporting resources have also been developed and will continue to be distributed among staff from across a range of services in Central Bedfordshire.
	Progress to date
33.	A post has been created in public health to coordinate and develop MECC and Health Checks in Central Bedfordshire.
34.	MECC targets have been included in the 2013/14 contracts for the Acute Trusts, SEPT Mental Health services and SEPT Community Services.
35.	170 front line staff have been trained to deliver MECC including social care, children centre staff, parenting advisors and health visitors.
36.	MECC is now an element of Year Two Nurse training at the University of Bedfordshire.
	Next steps
37.	Capacity to deliver MECC has increased through the new MECC and Health Checks post in the public health team.
38.	Broaden out the staff groups that are trained to deliver MECC using the train the trainer model.
39.	Continue to promote the ethos of MECC and support the delivery of MECC in health, social care and wider setting.

	Early identification and treatments to prevent or delay the consequence of disease through NHS Health Checks to all 40-70 year olds
40.	Central Bedfordshire NHS health checks are 5 yearly health checks offered to every person between the ages of 40 and 74 years who have not been identified as at high risk of vascular disease such as heart or kidney disease. The health check assesses an individual's risk of cardiovascular disease through measuring blood pressure, weight (including body mass index) and blood cholesterol level. The majority of checks are delivered by GPs in their practices. Increasing the number of Health checks is important to identify early signs of poor health leading to opportunities for interventions.
41.	The target represents 20% of the eligible population (40 to 74 years old without a pre-existing cardiovascular condition, diabetes or chronic kidney disease) each year on a rolling 5 year programme. Since the programme began in 2010/11, 25,394 people have accessed health checks in Central Bedfordshire.
	Progress to date
42.	

	Target	**Projected outturn based on 2012/13 data up to the end of February**
Health checks offered 2012/13	23, 312	25, 394
Health checks delivered 2012/13	11, 656	9, 939

43.	During the first six months of 2012/13, as a result of health checks, 1088 Cardiovascular Disease (CVD) risk factors were identified.
44.	Nationally there is a significant challenge in reaching targets set for this year which are substantially higher than last year. Central Bedfordshire is one of the better performers nationally and significantly ahead in terms of quality assurance.
45.	A community outreach team from Horizon Health Choices, a private company formed from clinicians and managers previously working within Bedfordshire, deliver a number of Health Checks in the community at pre-arranged events such as village halls and religious centres. These events are targeted at areas of higher need such as within lower socio-demographic areas.

46.	Horizon Health Choices also deliver health checks in GP Practices that request additional support, particularly out of normal working hours and through the Active Transport Hub in Dunstable as part of a joint venture with CBC sustainable transport team.
47.	More health checks have been delivered this year than last but the percentage of people accepting an offer is declining. This is because as the programme expands, encouraging the more hard to reach and at risk groups to participate is a continuing challenge.
48.	Questions regarding dementia and alcohol, including awareness and signposting have recently been included within the health check assessment.
	Next Steps
49.	A detailed plan is in development and will incorporate information from the learning event and feedback from GPs and the Clinical Commissioning Group (CCG).
50.	Manage the new Service Level Agreement (SLA) with GPs and ensure poor performing Practices are supported, or subsequently that the task of delivering Health Checks in that locality is passed to alternative provider.
51.	Develop and deliver a concerted and sustained social marketing programme, increasing public recognition and promoting uptake of Health Checks when offered.
52.	Internal CBC communications should promote all eligible staff to take the offer of a Health Check and actively promote the programme. A health checks session specifically for CBC members and staff has been arranged for the 17th May.
	Supporting people to reduce their drinking to safe levels through community based support
53.	Whilst Central Bedfordshire is a relatively safe place to live, understanding the risks and effects of alcohol can make it an even safer place. Alcohol is strongly related to crime and disorder and in particular violent crime, including child abuse, youth violence, intimate partner violence, sexual violence and elder abuse. Violence that occurs under the influence of alcohol can also result in more serious injury. Other crimes that can be attributed to alcohol include anti-social behaviour, under-age drinking and drink driving.

54. There is a two pronged approach to reducing the impact of alcohol misuse in the local community. Firstly early intervention and prevention to reduce the number of individuals experiencing the health and social related problems associated with alcohol misuse and therefore reduce the need for specialist treatment services. Secondly, ensuring that alcohol treatment interventions are available when and where individuals require them.

55. To ensure that progress is made towards reducing alcohol related harm, implementation of the recommendations from the Central Bedfordshire Alcohol Strategy will be assured through the delivery of a comprehensive action plan. Governance of which will be through the Acting Early and Reducing Poverty Group, the Healthy Communities and Older People Partnership Board and Central Bedfordshire Community Safety Partnership Board.

Progress to date

56.

Number of alcohol related admissions in Q2 (Target)	Number of alcohol related admissions in Q2 (actual)	Comments
4,799	4,987	Central Bedfordshire is currently RAG rated amber in respect of alcohol related admission/attendances in 2012/12. This increase in numbers has been anticipated, in part due to an improvement in data collection within the Accident and Emergency department.

57. CAN (the new drug and alcohol provider) have been commissioned to deliver the community alcohol liaison service (CALS). The CALS workers are based in GP surgeries and healthcare settings across Central Bedfordshire and provide an 'in reach' service to the hospital.

58. The Audit C Screening tool is used by professionals as a means of identifying harmful levels of drinking and guide onward referral to CALS or CAN. A range of front line workers such as police, Accident and Emergency staff, social workers and children's centre staff have been trained to use the tool with their service users.

	Next Steps
59.	Commit investment to increase the capacity of the CALS workers to provide alcohol advice/treatment and support in the community of Central Bedfordshire.
60.	CALS data has shown that the majority of patients (from Central Bedfordshire) being seen at Bedford Hospital for alcohol related issues are men and women aged between 40-52 years. In order to target this group, training on the Audit C tool will be delivered within workplaces so that managers and HR staff can implement the tool where appropriate in addition to frontline professionals.
61.	Alcohol will be included in health checks from 1st April 2013 therefore training on the Audit C tool will be offered to primary care staff in order to identify and signpost individuals with alcohol issues.
62.	Public health, in partnership with Bedsafe will gather and collate evidence on the patterns and degree of alcohol misuse within Central Bedfordshire to understand what type of drinkers there are (for example home drinkers, professional drinkers) and how best to support them.
63.	Replicate the data collection process (in place at Bedford Hospital) at the Luton and Dunstable Hospital to capture information about where people have been drinking prior to their arrival at the Accident and Emergency Department. This will enable public health to map the extent of local alcohol related problems to inform decisions regarding developing or reviewing licensing policy. There is currently a national consultation to add a health related indicator for local responsible authorities to consider in regards to licensing.
	Supporting people with substance misuse difficulties through access to effective substance misuse services
64.	Substance misuse treatment services are delivered by CAN and incorporate and an approach to reduce harm, which is used with individuals still using drugs with a view to motivating them to change. Treatment for people experiencing substance misuse has to be accessible to all and tailored to the specific needs of the presenting individual.
65.	Effective treatment, including substitute prescribing and talking therapies are provided to those seeking to reduce their drug use.
66.	CAN provides wrap around support to clients to ensure that their wider needs are addressed and supported. A client who has sustainable housing and improved relationships is more likely to sustain recovery than someone who has just stopped using drugs.

67.	Peer support is a strong component and this is being prioritised and developed within the treatment system so that there is an emerging recovery community.
	Progress to date
68.	There is a comprehensive action plan to ensure that all aspects of the treatment system are aligned to facilitating the process of having an efficient treatment system that reduces harm, effectively engages clients in treatment and has recovery accessible at every stage of the treatment journey.
69.	

Successful completions of treatment- Opiate clients	**Q2 2012/13**	**Q3 2012/13**	**Comments**
	6.7%	8.5%	This is represented as a proportion of all in treatment. The treatment system has been reconfigured and following the appointment of a new provider, an increased number of clients leaving treatment drug-free.
Re- presentations for Opiate clients	25.7%	7.9%	Re-presentation is the term given to clients who leave treatment drug free and return with six months of their last treatment episode.
Successful completions of treatment- Non-Opiate clients	37.2%	38%	
Re- presentations for Non-Opiate clients	No re presentations	No re presentations	

	Next Steps
70.	There is additional work being undertaken following the appointment of the new provider, through regular meetings, to ensure that all work streams are on track. As alcohol treatment has now found a place within the treatment system, an attractive and successful treatment system will mean that there is an increased likelihood for more people to come forward for alcohol treatment. The impact of this increased demand upon service capacity will be closely monitored.

71.	Continue to explore the potential of accessing additional funding for residential support. A briefing paper for the provision of inpatient detoxification from substance misuse has been put forward to the BCCG for consideration and a number of Health Needs Assessments have been undertaken over the years, the most recent in 2012. Unless other resources are identified and made available the risk is that this specialised treatment that supports people to gain and maintain a robust recovery, will only remain available to a small proportion of the treatment population.
	Detailed recommendations
	It is recommended that the Health and Wellbeing Board:
72.	Recognise the progress to date to deliver priority 7: Helping people make healthy lifestyle choices.
73.	Promote MECC across organisations by supporting front line staff to training and creating a MECC ethos within teams. This will help embed a preventative approach across organisations and support individuals to make healthy lifestyle choices.
74.	Ensure that the delivery of a preventative approach by promoting healthy lifestyle choices is embedded within strategies and commissioning across the health, social care, community and voluntary sectors.
75.	Continue to challenge perceptions around harmful and hazardous drinking, which effects all elements of society and is not confined to vulnerable groups and young people.
76.	The Board is asked, via its BCCG representatives, to support and actively encourage all practices to meet stop smoking and Health Check targets.
77.	Ensure that CBC and Health staff are supported to make healthy lifestyle choices

Issues	
Strategy Implications	
78.	Helping people make healthy lifestyle choices is one of the priorities of the Health and Wellbeing Strategy.
79.	There is clear alignment with the BCCG Strategic Commissioning Plan and the Central Bedfordshire Delivering your priorities plan through the focus on early intervention and prevention of ill health.

Governance &Delivery	
80.	Delivery and progress are reported through the following groups; the Healthy Communities and Older People Partnership Board, the Acting Early, Reducing Poverty and Improving Health group and the Bedfordshire Drug and Alcohol Team Board (BDAT).
Management Responsibility	
81.	Responsibility for the delivery of the outcomes rests with the Director Of Public Health. This responsibility may be delegated for day to day operational delivery.
Public Sector Equality Duty (PSED)	
82.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty **No**
	No Yes *Please describe in risk analysis*

Risk Analysis
Briefly analyse the major risks associated with the proposal and explain how these risks will be managed. This information may be presented in the following table.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Source Documents	**Location (including url where possible)**