Swindon Borough Council

Health and Wellbeing Board

Wednesday, 11 September 2013

Committee Room 6, Civic Offices (Anticipated meeting room)

At 2.00 p.m.

Contact Officers:
Shaun Banks (Committee Officer), 01793 463606, sbanks@swindon.gov.uk
Cherry Jones (Deputy Director of Public Health), 01793 444681, cherry.jones@swindon.gov.uk

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AGENDA

1. **Apologies for Absence**

2. **Declarations of Interest**
   Members are reminded that at the start of the meeting they should declare any known interests in any matter to be considered, and also during the meeting if it becomes apparent that they have an interest in the matters being discussed.

3. **Public Question Time**
   See explanatory note below. Please phone the Committee Officer whose name and number appears at the top of this agenda if you need further guidance.

4. **Minutes** (Pages 1 - 4)
   To receive the minutes of the meeting held on 10th July 2013.

5. **Health and Social Care Integration Transformation Fund** (Pages 5 - 22)

6. **Hepatitis B & C Joint Strategic Needs Assessment (JSNA)** (Pages 23 - 38)

7. **Learning Disability JSNA: Progress Report** (Pages 39 - 74)

8. **Healthy Weight Strategy** (Pages 75 - 128)

9. **Local Government Declaration on Tobacco Control** (Pages 129 - 140)

10. **Board Membership (Oral)**

Date of Despatch: 06 September 2013

Public Question Time *- Swindon Borough Council is committed to increasing its accountability to the public and to promoting active citizenship. Up to 15 minutes will be allowed at the start of all Council meetings for questions to the Chair from members of the public about the work of the Committee (except for confidential matters and specific planning applications). Questions must be relevant, clear and concise. Because of time constraints Public Question Time is not an opportunity to make speeches or statements. Prior notice of a question to the Director of Law and Democratic Services is desirable - particularly if detailed background information is needed.*

Access Arrangements - *The venue is wheelchair accessible and an infrared receiver hearing system is provided. If you would wish to attend the meeting but have any special requirement to enable you to do so please contact the Committee Clerk, whose name appears at the top of this agenda, as soon as possible prior to the date of the meeting.*

If you would like to receive any of the pages contained in this agenda in a larger print size please contact the Committee Officer whose name appears on the first page of this agenda.

HEALTH AND WELLBEING BOARD

WEDNESDAY, 10 JULY 2013

PRESENT:- Councillors David Renard (Chair), Brian Mattock and Ray Ballman; Gavin Jones (Chief Executive, Swindon Borough Council), Tony Ranzetta (NHS Swindon Clinical Commissioning Group Accountable Officer) John Gilbert (Director of Adult Social Care/Children's Services, Swindon Borough Council), David Wray (Third Sector representative), Cherry Jones (Acting Director of Public Health, Swindon Borough Council), Jennifer Howells (NHS England), and Clare Davis (Healthwatch Swindon representative).

An apology for absence was received from Dr Peter Crouch (NHS Swindon Clinical Commissioning Group)

10. Declarations of Interest

The Chair reminded Members of the need to declare any known interests in any matters to be considered at the meeting. Councillor Ray Ballman made a non-prejudicial declaration of interest in her capacity as a Board Member of SEQOL. David Wray made a non-prejudicial declaration of interest in respect of Agenda Item no. 6 in his capacity as a member of the Dementia Action Alliance.

11. Public Question Time

Mr Brian Cockbill, a resident of St Margaret, asked whether the Health and Wellbeing Board covered the Borough of Swindon or whether it covered a wider area.

The Chair confirmed that the Swindon Health and Wellbeing Board covered the Borough of Swindon only.

Mr Cockbill also asked what strategies were in place to ensure that good practice was fed downwards and what strategies were in place to consult with members of the public.

Tony Ranzetta (Clinical Commissioning Group) and Jennifer Howells (NHS England) outlined how they developed strategies for sharing good practice and also how members of the public were involved in developing plans and priorities.

12. Minutes

Resolved – That the minutes of the meeting held on 8th May 2013, be confirmed and signed as a correct record.

13. Health and Wellbeing Board Terms of Reference

Cherry Jones, Acting Director of Public Health, explained that the Clinical Commissioning Group had requested a number of amendments be made to the terms of reference for the Health and Wellbeing Board that were considered at the last meeting. These amendments were highlighted in the appendix to the report

and, whilst not major changes, were about working together to promote positive changes. Jo Osorio commented that the NHS Commissioning Board was now known as NHS England and Cherry agreed to amend this.

Councillor Brian Mattock felt that it would be useful to have a Board sponsor/champion for each of the key responsibilities outlined in the terms of reference and it was agreed that this would be explored further, particularly in relation to specific topics, such as Dementia.

Mike Howard, Chair of the Local Safeguarding Adults Board (LSAB) commented on the relationship between the Health and Wellbeing Board and the Local Safeguarding Boards, as identified in the Slough protocol. Doug Bale added that it was important to include Vulnerable Adults within the terms of reference. It was agreed that Cherry Jones would make the suggested amendments to the terms of reference, in consultation with the Chair.

Resolved – (1) That the Terms of Reference for the Health and Wellbeing Board, incorporating the amendments from the Clinical Commissioning Group and the amendments raised at the meeting, be agreed.

(2) That further work be undertaken to explore the possibility of Board Members becoming sponsors or champions for specific topics.

14. Joint Strategic Needs Assessment - Dementia

Cherry Jones, Acting Director of Public Health, presented the Joint Strategic Needs Assessment (JSNA) on Dementia and asked the Health and Wellbeing Board to agree the recommendations within the JSNA Bulletin. She explained the JSNA process and gave a brief presentation on dementia within Swindon.

Tony Ranzetta, Clinical Commissioning Group, added that a workshop had been held in June 2013, attended by a range of people who were working towards developing a dementia strategy. A steering group had been established and they had identified that there were a number of examples of best practice that could be visited; that no dementia case was the same and there was therefore a need for a menu of choices; and, that it was the carers that needed most support.

A number of questions and comments were raised by members of the Board including:-

- The need to link into the work of the Localities, in particular around the work on healthy lifestyles.
- The possible link between dementia and the social/economic status, noting that deprivation had an impact on health in general. There was a definite link between social deprivation and more recently a potential link to smoking.
- Better understanding of what training was available from the different organisations and to ensure that all training and other activities were co-ordinated.
- Under the recommendations in the JSNA Bulletin, it was agreed to add 'to have fun' under recommendation 4 (h).

Tony Ranzetta confirmed that the Commissioning Leadership Group had welcomed the layout of this Bulletin and had endorsed all the recommendations.

Resolved – (1) That, subject to the inclusion of 'to have fun' under recommendation 4 (h), the recommendations from the Dementia JSNA Bulletin, be noted and approved.

(2) That it be noted that the Board supports the development of a Dementia

Strategy and Action Plan for Swindon.

(3) That the Board receive quarterly reports on the progress on dementia work in Swindon.

15. Winterbourne View Improvement Programme - Stocktake

Dale Bale (Head of Service – Adult Social Care) introduced a report setting out a stocktake of progress on meeting the Concordat agreement (a joint response of agencies including the Local Government Association, National Health Service to the Department of Health Transforming Care report.

He highlighted a number of key issues in the report and answered questions relating to service provision offered in Swindon and to Swindon residents and outlined the role of the Health and Wellbeing Board in this process.

Resolved – That the content of the stocktake submission, attached as Appendix 1 to the report, be noted.

16. Transfer of Funding from NHS to Local Authority (report to follow)

The Chair advised that this item had been withdrawn and would be submitted to the Health and Wellbeing Board in September 2013.

Councillor Brian Mattock asked whether it would be possible to see the report before the September meeting to ascertain whether there would be a prior need to actively lobby to ensure that Swindon would receive its fair share of resources. Cherry agreed to contact the Lead Officer to request that the report be circulated to Members of the Board prior to the September meeting.

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Health and Social Care Integration Transformation Fund

Health and Wellbeing Board **Date: 11th September 2013**

Author:	Acting Director of Public Health/Head of Commissioning – Children and Adults
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

1.1 To inform the Health and Wellbeing Board of the funding arrangements and amounts to be transferred from the NHS to local authorities during 2014/15 - 2015/16 as set out in the June 2013 Spending Round.

1.2 The pooled funding will formally sit with local authorities but will be subject to plans being agreed by local Health and Wellbeing Boards and signed off by Clinical Commissioning Groups (CCG's) and council leaders.

1.3 The report also covers the proposed interim arrangements for 2013/14 where it is proposed that £2.75m transfers from NHS England to Swindon Borough Council.

2. Recommendations

The Board is recommended to:

2.1 Discuss the implications of the 2013 Comprehensive Spending Review (CSR) and future funding transfers from the NHS to local authority.

2.2 Note and agree the conditions associated with the transfer.

2.3 Agree to establish a working group with SBC and CCG representation to recommend how the funding is allocated in 2014/15.

2.4 To note and agree the proposed spend of the £2.753m for 3013/14 from NHS England to Swindon Borough Council as outlined in paragraph 3.16 and outcome measures.

3. Detail

Transformation Fund 2014 - 2016

3.1 The Spending Review (SR) announcement at the end of June included setting up a £3.8bn pooled budget across health and social care (known as the Integration Transformation Fund). The purpose of the fund is to protect adult social care services, promote integrated health and social care and incentivise shared local

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, cherryjones@swindon.gov.uk.

strategies to reshape health and social care so that they are sustainable over coming years.

3.2 This funding, which is described as a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities, is seen as an opportunity to improve the lives of some of the most vulnerable people within our society.

3.3 The Local Government Association and NHS England published a joint statement 8th August 2013 about this funding known as the health and social care Integration Transformation Fund (ITF) outlining how the fund could work and next steps. (See appendix one).

3.4 The June 2013 SR set out the following:

3.4.1 2014/15 – an additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned.

3.4.2 2015/16 - £3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements. This is made up of the £1.9 billion existing funding from 2014/15 and already allocated across NHS and social acre to support integration, and an additional £1.9 billion from NHS allocations which includes £1billion that will be performance related.

3.5 Although the ITF does not come into full effect until 2015/16 it is essential that we build momentum in 2014/15 (using the additional £200million due to be transferred to local government from the NHS to support transformation) and develop two year plans for 2014/15 and 2015/16.

3.6 To access the ITF we must develop a local plan by March 2014. The plan will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance related element will be met.

3.7 Details of the scheme regarding the conditions of the performance related element of the ITF have not been finalised but it is anticipated that it will consist of a combination of national and locally chosen measures.

3.8 Plans for the use of the pooled monies must be developed jointly by the NHS Swindon CCG and SBC and signed off by each organisation and by the Health and Wellbeing Board.

3.9 The ITF is a pooled budget that is subject to a number of national conditions that must be addressed in the plans:

3.9.1 plans to be jointly agreed;

3.9.2 protection for social care services (not spending);

3.9.3 as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;

3.9.4 better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health);

3.9.5 ensure a joint approach to assessments and care planning;

3.9.6 ensure that, where funding is used for integrated packages of care, there will be an accountable professional;

3.9.7 risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and

3.9.8 agreement on the consequential impact of changes in the acute sector

3.10 The intention is that local health and Wellbeing Boards will sign off the plans ensuring that they are the best for the locality; the plans will then go through an assurance process involving NHS England to assure Ministers.

3.11 A broad outline timetable has been agreed for 2013/14 for developing the pooled budget plans;

August to October:	Local planning discussions. Nationally further work to define conditions
November/December:	NHS Planning Framework issued
December to January:	Completion of local plans
March:	Plans assured

<u>Interim arrangements for the Transfer of NHS funding to Local Authorities for 2013/14</u>

3.12 For 2013/14 NHS England will transfer £2,753,293 to Swindon Borough Council. The funding must be used to support adult social care services which also have a health benefit.

3.13 NHS England wants to provide flexibility for local areas to determine how this investment in social care is best used. They have decided that Health and Wellbeing Boards will be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.

3.14 In line with our responsibilities under the Health and Social Care Act, NHS England will make it a condition of the transfer that SBC and CCG have regard to the Joint Strategic Needs Assessment , and existing commissioning plans for both health and social care, in how the funding is used.

3.15 The funding can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The funding can also support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified. The *Caring for Our Future* White Paper also sets out that the transfer of funding can be used to cover the small revenue costs to local authorities of the White Paper commitments in 2013/14 (excluding the Guaranteed Income Payments disregard, which is being funded through a grant from the Department of Health).

3.16 By this stage in the financial year firm spending plans for this allocation have, inevitably, been discussed between the two organisations and implemented by the Council. The areas being supported are summarised in the table below, with more detail provided in the subsequent sections.

Services 2013/14	**£**
Crisis support and Intermediate Care	662,100
Community Rehabilitation Team	93,600
Reablement*	699,300
Overnight Service	75,000
Social Enterprise transformation costs	574,000
Nursing Hospital Discharge Beds	153,200
Telecare	100,500
Fessey House Step Down Beds	270,593
Community Navigators*	125,000
Total	**2,753,293**

*The funding for community navigators and reablement is subject to Swindon Clinical Commissioning Group agreeing to fund £300k for the advice and information solution.

3.17 Crisis Support and Intermediate Care, Rehabilitation and Reablement are provided in Swindon through 3 multi –disciplinary teams

- Swindon Intermediate Care Centre (SwICC) provides 30 rehabilitation beds and 26 step up beds.
- Community Intermediate Care provides programmes of rehabilitation for up to six weeks following injury or surgery.
- Reablement provides programmes of reablement for people with poor physical or mental health to help them accommodate their illnesses (or condition) by learning or relearning how to manage activities of daily living.

  Evidence from the Department of Health Care Services Efficiency Department (CSED) shows that timely bursts of social care reablement, focusing on skills for daily living can enable people to live more independently and reduce their needs for on going homecare support. Homecare reablement complements the work of intermediate care and crisis services.

3.18 Overnight Service - The overnight service is a short-term intervention running in parallel with the reablement service and crisis service to deliver check calls and toileting call in the users home to avoid either a hospital admission or residential care admission during a period of crisis or reablement. During this period, where toileting needs are the main focus, alternative methods of meeting the need will be assessed.

3.19 Social Enterprise transformation costs are essential to ensure the effective establishment and further development of the Social Enterprise to deliver our integrated Health and Social Care services.

3.20 Nursing Hospital Discharge Beds - These nursing beds are for GWH in-patients who have been assessed as requiring nursing care but are medically fit for discharge from an acute setting however the first choice of home is not available. This service allows the discharge to a temporary placement pending the permanent first choice becoming available. These services are deemed as NHS services and therefore any delay is attributed to the NHS. These beds reduce the number of in-patients in hospital awaiting permanent nursing placement. These beds are also used for crisis service users to where otherwise a hospital admission would be required. These can include service users who require IV fluids.

3.21 Telecare – greater utilisation of telecare assistive technology to maintain individuals in their own home or reduce 1:1 support costs in residential or nursing settings with a greater focus on learning disabilities. This has included greater use of epilepsy monitors, falls mats and door sensors but also incudes medication prompt technology and has enabled a number of waking night support packages to be reduced to sleeping night in both health and social care packages.

3.22 Fessey House step down beds. An additional 10 crisis and step down beds are provided at Fessey House to avoid admission to residential care from an acute hospital setting.

3.23 Community Navigators – A pilot project is being set up in up to 4 GP practices in Swindon. A Community Navigator will be based in each practice to work with the integrated care teams made up of district nurses, social workers, localities leads and community matrons to successfully reduce hospital admissions. Too many patients and carers feel that they are required to fit their needs and lives around the services on offer, rather than the other way round. This new project looks to change that. It is about being able to work better as a team and look at expertise available for the benefit of the patient.

3.24 Although it is possible for the current year spending plans to be revised in light of feedback from the Health and Wellbeing Board, this would cause disruption to services and staffing if it happened in the middle of the financial year. On this basis the Board is requested to confirm the current year's allocations and make suggestions for revised areas of focus as part of the planning process for 2014/15.

4. Alternative Options

4.1 No alternative options are recommended within this report

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 Although the ITF does not come into full effect until 2015/16 it is essential that the CCG and SBC build momentum in 2014/15 using the monies due to be transferred to local government from the NHS to support transformation and build on the commitments already made in 2013/14. There will need to be two year plans for 2014/15 and 2015/16 in place by March 2014 therefore requiring detailed planning in the autumn and winter.

Legal and Human Rights Implications

5.2 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 The ITF is seen to provide an opportunity to improve the lives of some of the most vulnerable people in our community and to enable people to live more independent lives.

The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings and builds on the work we are already doing.

Links to One Swindon, Strategic Objectives, Plans and Policies

5.4 The principles of the Integrated Transformation Fund to use a single pooled budget for health and social care services to work more closely together aligns directly with our draft Joint Health And Wellbeing Strategy to improve health and wellbeing and ensure everyone in Swindon lives a healthy, safe, fulfilling and independent life.

This also links directly to the One Swindon priority of creating a healthy, caring and supportive place.

Diversity Impact Assessment

5.5 A Diversity Impact Assessment (DIA) has not been done as this report does not make any new recommendations that would have a detrimental impact on services

Risk Management

5.6 No specific risks identified at this stage

6. Consultees

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

7.1 None

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, cherryjones@swindon.gov.uk.

8. Appendices

8.1 Appendix one. Statement on the health and social care Integration Transformation Fund 8th August 2013. NHS England Publications Gateway ref. No.00314

8.2 Appendix two. Outcome measures for 2013/14

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, cherryjones@swindon.gov.uk.

Local Government Association

NHS England

Statement on the health and social care Integration Transformation Fund

Summary

1. The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society. We must give them control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better quality of life. Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives.

2. The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". We are calling this money the health and social care Integration Transformation Fund (ITF) and this note sets out our joint thinking on how the Fund could work and on the next steps localities might usefully take.

3. NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) are working closely with the Department of Health and Department for Communities and Local Government to shape the way the ITF will work in practice. We have also established a working group of CCGs, local authorities and NHS England Area Teams to help us in this process.

4. In '*Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

5. Whilst the ITF does not come into full effect until 2015/16 we think it is essential that CCGs and local authorities build momentum in 2014/15, using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and

2015/16, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter.

Context: challenge and opportunity

6. The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The ITF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. We see the ITF as a significant catalyst for change.

7. There is also an excellent opportunity to align the ITF with the strategy process set out by NHS England, and supported by the LGA and others, in *The NHS belongs to the people: a call to action*[1]. This process will support the development of the shared vision for services, with the ITF providing part of the investment to achieve it.

8. The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CCGs and local authorities are already doing, for example, as part of the integrated care "pioneers" initiative and Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

Background

9. The June 2013 Spending Round set out the following:

2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements.

10. In 2015/16 the ITF will be created from the following:

£1.9 billion existing funding continued from 14/15 - this money will already have been allocated across the NHS and social care to support integration
£130 million Carers' Breaks funding.
£300 million CCG reablement funding.

[1] http://www.england.nhs.uk/2013/07/11/call-to-action/

c. £350 million capital grant funding (including £220m of Disabled Facilities Grant).
£1.1 billion existing transfer from health to social care.
Additional £1.9 billion from NHS allocations Includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. Includes £1 billion that will be performance-related, with half paid on 1 April 2015 (which we anticipate will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in-year performance).

11. To access the ITF each locality will be asked to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

12. Plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

Conditions of the full ITF

13. The ITF will be a pooled budget which will can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health;
- ensure a joint approach to assessments and care planning;
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

14. Ministers have agreed that they will oversee and sign off the plans. As part of achieving the right balance between national and local inputs the LGA and NHS England will work together to develop proposals for how this could be done in an efficient and proportionate way.

Conditions of the performance-related £1 billion

15. £1 billion of the ITF in 2015/16 will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014/15 as the first half of the £1 billion, paid on 1 April 2015, is likely to be based on performance in the previous year. We will be working with central Government on the details of this scheme, but we anticipate that it will consist of a combination of national and locally chosen measures.

Delivery through Partnership

16. We are clear that success will require a genuine commitment to partnership working between CCGs and local authorities. Both parties need to recognise the challenges they each face and work together to address them.

- Finding the extra NHS investment required: Given demographic pressures and efficiency requirements of around 4%, CCGs are likely to have to re-deploy funds from existing NHS services. It is critical that CCGs and local authorities engage health care providers to assess the implications for existing services and how these should be managed;
- Protecting adult social care services: Although the emphasis of the ITF is rightly on a pooled budget, as with the current transfer from the NHS to social care, flexibility must be retained to allow for some of the fund to be used to offset the impact of the funding reductions overall. This will happen alongside the on-going work that councils and health are currently engaged in to deliver efficiencies across the health and care system.
- Targeting the pooled budget to best effect: The conditions the Government has set make it clear that the pooled funds must deliver improvements across social care and the NHS. Robust planning and analysis will be required to (i) target resources on initiatives which will have the biggest benefit in terms outcomes for people and (ii) measure and monitor their impact;
- Managing the service change consequences: The scale of investment CCGs are required to make into the pooled budget cannot be delivered without service transformation. The process for agreeing the use of the pooled budget must therefore include an assessment of the impact on acute services and agreement on the scale and nature of changes required, e.g. impact of reduced emergency activity on bed capacity.

Assurance

17. Local Health and Wellbeing Boards will sign off the plans, which will have been agreed between the local authority and CCGs. The HWB is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process. The plans will then go through an assurance process involving NHS England to assure Ministers.

Timetable and Alignment with Local Government and NHS Planning Process

18. Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans;
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)
- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows.

19. The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:

• August to October:	Initial local planning discussions and further work nationally to define conditions etc
• November/December:	NHS Planning Framework issued
• December to January:	Completion of Plans
• March:	Plans assured

Next Steps

20. NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk-sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

8 August 2013

NHS England Publications Gateway Ref. No.00314

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Appendix 2

1. Measureable Benefits

How are the objectives/benefits going to be proved? (Can be taken from the Acceptance Criteria)

Benefit	Description	Measures & Monitoring mechanism
Patients and carers have increased access to a wide range of services that are flexible to their individual needs	From the 2012/13 client & carer survey our results show that 65% of respondents say it is easy to find information about services. This is lower than the national average which is 71.5. This is a drop in performance from the previous year, but this year carers are also included in During the year, 2895 people who contacted Adult Social Care that didn't go on to assessment, received information and advice following their contact. This is a 20% increase on the previous year when a total of 2322 people received information and advice following a contact with us.	Number of carers and patients who say that they have access to good advice and information – ASCOF 3D Target – 74%
People will have more control of and will be better able to manage their own care through advice and advocacy, thus	From the 2012/13 client survey we know that 73.1 of people who use services say they have control over their daily life, this is a slight drop on the previous year when we achieved 75.7. The national average for 2012/13 is 75.6. We also know that 78.1% of people who use services said that those services have made them feel safe and secure. This is just slightly below the national average which is 78.3%.	% of people who use services say they have control over their daily life. ASCOF 1B Target – 75%- % of people who use services said that those services have made them feel safe and secure – ASCOF 4B Target 78.5%-
To enable people to be independent by making the most of their skills and capabilities	In 2012/13 we continue to reduce the numbers of people admitted into permanent residential and nursing care. Our result for younger adult admissions was 10.8 per 100k pop (equates to 14 people) and for older people our result was 619 per 100k pop (equates to 178 people). Both results are better than the national average which is 15.2 per 100k pop for younger adults and 709.3 per 100k pop for older people.	Reduced admission to residential and nursing care Reduced number of hospital admissions and re-admissions ASCOF 2A (1 + 2) Admissions for 18-64.& 65+. The 2013/14 target for 2A1 (older people) reduce admissions by 9 people (equates to 5%) . The target for 2A2 (younger adults) reduce admissions by 1 person (7%)

	In 2011/12 we supported 178 clients with crisis domiciliary care to help avoid hospital admission. There were also 360 people who were placed into crisis temporary placements. In 2012/13 we changed our provision of crisis care meaning more people are being supported in their own home. 652 people received crisis domiciliary care, and 264 have been placed into crisis temporary placements.	
To support those who have lost skills to regain them and adapt to a potentially new situation	In 2012/13 delayed discharges of care from hospital for Swindon was 8.4 per 100k pop, compared to 8.7 per 100k pop nationally. Broken down to those just attributable to social care the number reduces to 4.5 per 100k pop which is just above the national average of 3.1 per 100k pop. During 2012/13, 22 existing social care clients received a period of reablement. Of those, 5 people or 23% needed no services following, 2 people or 9% had their package reduced and 6 people or 27% maintained their existing package and 9 people or 41% had their package increased.	Reduced delayed discharge due to reablement support This is a local contract indicator for reablement services provided by SEQOL: target 100% of existing packages reduced.
Community based networks have increased and are supporting people locally	Timebank launched July 2013	Number of people Timebank in 2013/14 to establish a baseline for end of March 2014
Patients are in control of managing their long term condition	During 2012/13 there were 183 social care clients who were supported with telecare equipment. This is an increase on the numbers from last year when 174 people received telecare to help them remain living independently.	Increase in number of people with long term conditions using telehealth Reduction in unplanned admissions for those with long term conditions using telehealth (CCG data) .
Service users will be supported to maintain and or regain their independence and	In 2012/13 the proportion of people aged 65+ who were still living in their own residence following discharge from hospital	Service users & their family carers will maintain a good quality of life & positive health and well-being. Significant

able to continue to live in their own home. DC	with a reablement package in the period October to December was 80%. This is slightly below the national average of 82.8%. A total of 225 people received an episode of reablement during the year. Of those 203 people were new to social care, and 22 people already had an existing package with us. Of the new clients, 163 people needed no services following reablement and the remaining 40 people received a mainstream package following their episode. .	improvement in perceived quality of life will be achieved after receiving re-ablement services. National measure Proportion of older people (65+) who were at home 91 days post discharge from hospital into reablement services (effectiveness of the service): Target 84% .

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Hepatitis B & C Joint Strategic Needs Assessment (JSNA)

Committee: Health and Wellbeing Board Date: 11th September 2013

Author:	Acting Director of Public Health
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

1.1 The aim of this report is to inform the Health and Wellbeing Board of the findings of the Hepatitis B & C Joint Strategic Needs Assessment (JSNA), seek support for its recommendations, and raise awareness of the health care related needs of those infected with Hepatitis B and C in Swindon

1.2 Hepatitis B & C are important public health problems. Both are blood borne viruses which can cause liver disease. They are known to affect vulnerable population groups who tend to have less contact with health services than the general population.

1.3 The Hepatitis B and C JSNA provides an objective analysis of the current and future needs of people with Hepatitis B and C in Swindon. It uses available local and national data to estimate current and future numbers of people affected by the infections, describe current care pathways in Swindon and identify gaps in and barriers to treatment, and points on the pathway where patients 'drop off'. It combines the views of service providers and service users with current evidence and best practice to make recommendations as to how prevention, screening, diagnosis and treatment in Swindon could be improved.

2. Recommendations

Recommend to Cabinet and the Governing Body of Swindon Clinical Commissioning Group that they:

2.1 Note and agree the recommendations from the Hepatitis B & C JSNA Bulletin (Appendix one).

2.2 Support the development of an action plan for the implementation of the recommendations.

2.3 Identify how the Board would like to be kept up to date on progress on work to prevent Hepatitis B & C in Swindon and improve access to treatment.

3. Detail

3.1 What is Hepatitis?

3.1.1 Hepatitis is a term used to describe inflammation of the liver. Whilst some hepatitis infections will pass without causing permanent damage to the

Further information on the subject of this report can be obtained from Sarah Weld, 01793 444629, sweld@swindon.gov.uk

liver others can persist for many years and cause liver disease, which can be fatal. Treatments are available for those diagnosed with Hepatitis B and C, however, the number of people treated is low both nationally and locally.

3.1.2 Whilst the Hepatitis B and C viruses are different, there are parallels between the two, and routes in to treatment are similar. Both infections are known to affect vulnerable population groups who tend to have less contact with health services than the general population. Paired with the fact that both Hepatitis B and C infections are largely symptom free this means that many individuals remain undiagnosed and only a small proportion of those infected come into contact with treatment services. People with an untreated infection are not only at high risk of developing liver disease but remain infectious and are therefore a risk to others.

Hepatitis B High Risk Groups

- People born or brought up in Africa, Asia, the Caribbean, Central and South America, Eastern and Southern Europe, the Middle East and the Pacific islands.
- Babies born to mothers infected with hepatitis B.
- People who have ever injected drugs.
- Men who have sex with men.

Hepatitis C High Risk Groups

- People who have ever injected drugs.
- People who received a blood transfusion before 1991 or blood products before 1986, when screening of blood donors for hepatitis C infection, or heat treatment for inactivation of viruses were introduced.
- People born or brought up in a Africa, Asia, the Caribbean, Central and South America, Eastern and Southern Europe, the Middle East and the Pacific islands.
- Babies born to mothers infected with Hepatitis C.
- Prisoners, including young offenders.

3.2 Policy Context

3.2.1 The incidence and burden of liver disease in the UK is increasing and has become one of the major causes of death. Liver disease is associated with substantial costs to the NHS related to hospital inpatient admissions and liver transplants and these costs are expected to increase.

3.2.2 A striking 90% of people who die from liver disease are under 70 years old. When measured as 'years of life lost', liver disease is therefore much more prominent than many other causes of death and reducing deaths is a government priority in the UK.

3.2.3 Improving prevention, screening and access to treatment for those with chronic Hepatitis C infection have been the focus of work in Swindon for a number of years. With the abolition of Primary Care Trusts on 31st March 2013 and the move of Public Health to Local Authorities and much of local NHS commissioning to GP led Clinical Commissioning Groups the need to draw together the learning from previous work in to one document, and to clarify the need for service improvements was identified. Because of the parallels between Hepatitis B and C in terms of risk groups and pathways in to treatment it was felt that the opportunity should be taken to include both infections in this needs assessment.

3.3 Key Findings

3.3.1 Understanding how many people in Swindon are affected by Hepatitis B and C is difficult. Many infections are undiagnosed and there are limitations associated with the way laboratory data are collected. It is estimated that 627 people in Swindon have an ongoing Hepatitis B infection, and between 519 and 836 people are living with Hepatitis C.

3.3.2 There is currently no formal pathway for Hepatitis B or C in Swindon that covers the whole patient journey from testing through to specialist treatment, although specific pathways for antenatal screening and vaccination of babies born to Hepatitis B positive mothers are in place.

3.3.3 There are some very good services to support people affected by Hepatitis B and C in Swindon, but testing and diagnosis needs to expand, and access to treatment improve, in order to prevent further infections and unnecessary liver disease and deaths.

3.3.4 Limited data was available about the numbers of patients being treated for their infection in Swindon. Nationally the number of patients being treated is low; it is estimated that only 26% of those with chronic Hepatitis B have had their infection diagnosed and of these 5% receive antiviral treatment each year, whilst approximately 3% of those chronically infected with Hepatitis C are currently treated each year.

3.3.5 Specialist Hepatitis C care for patients in Swindon is provided by the John Radcliffe Hospital in Oxford. Patients find travel there difficult.

3.3.6 There are strong arguments for investing in prevention and treatment for hepatitis.

- To prevent further infections

- To reduce under-75 mortality from liver disease
- To reduce costs to the NHS
- To reduce health inequalities

3.4 Recommendations

The JSNA Bulletin sets out evidence based recommendations as to how prevention, screening, diagnosis and treatment could be improved in Swindon. It should be noted that a whole system approach to implementing these recommendations is required, with collaboration between commissioners and service providers at all stages of the care pathway.

3.4.1 Local service providers and community and voluntary groups including the Blood Borne Virus Co-ordinator should work together with support from Swindon Borough Council Public Health leads to develop and deliver evidence based campaigns, materials and resources to raise awareness about Hepatitis B and C among the general population and those at increased risk of infection. This should build on existing nationally produced materials wherever possible and include up-to-date information on:

- The main routes of infection and transmission
- Local services providing testing and Hepatitis B vaccination
- The potential for infection to be asymptomatic
- The benefits of early testing and treatment
- Overcoming social and cultural barriers and improve access to testing and treatment

3.4.2 Swindon Borough Council Public Health leads should work with local commissioners and service providers to develop and deliver education programmes to improve the knowledge and skills of healthcare professionals and others providing services for people at increased risk of Hepatitis B or C infection. This should build on existing nationally produced materials wherever possible and include up-to-date information on:

- Epidemiology of Hepatitis B and C – local prevalence, at risk groups
- Testing and diagnosis
- Treatment
- National guidance on testing and delivery of care
- Skills to overcome social and cultural barriers and improve access to testing and treatment

3.4.3 Commissioners in the Local Authority, Clinical Commissioning Group and NHS Commissioning Board should ensure testing for Hepatitis B and C

(venous and/or dried blood spot as appropriate) and Hepatitis B vaccination is available in-line with NICE Guidance in:

- Primary Care
- Drug and Alcohol Services
- Sexual Health Services

3.4.4 Swindon Borough Council Drug and Alcohol Treatment Commissioners should work with the new Swindon drug service provider, CRI, to ensure that all service users entering drug treatment are routinely offered Hepatitis B and C testing and Hepatitis B vaccination at their initial assessment, and that annual testing for Hepatitis C is offered to people who test negative but remain at risk of infection. Commissioners should routinely audit data collected.

3.4.5 Services providing testing should ensure that all those who undertake testing are trained and competent to provide appropriate pre- and post-test discussions and that testing is accompanied by appropriate information resources and support while waiting for test results and following diagnosis.

3.4.6 A named commissioning lead for viral hepatitis should be identified in the Swindon Clinical Commissioning Group, NHS Commissioning Board Local Area Team and Swindon Borough Council who should agree ways to work together to ensure effective commissioning of a fully integrated care pathway for those who test positive for Hepatitis B or C infection from the point of diagnosis. This should take account of the patient's psychosocial and support needs as well as treatment for their infection and include mechanisms for following up patients who defer treatment.

3.4.7 Swindon Borough Council Public Health leads should work with Commissioners and Service Providers to develop clear data recording and sharing protocols which support those receiving positive results for Hepatitis B or C to access support and move along the treatment care pathway as appropriate, and which enable the number and source of referrals for Hepatitis B and C; appointment attendance; treatment and discharge or onward referral to specialist services to be monitored.

3.4.8 Swindon Clinical Commissioning Group Commissioners should audit services available for the management and treatment of Hepatitis B and C in Swindon and ensure compliance with NICE Guidelines when they are published.

3.4.9 Swindon Borough Council Public Health leads should work with Antenatal Screening Commissioners in the NHS England Local Area Team to

undertake regular audit of the Hepatitis B vaccination programme for babies in Swindon and pathways for mothers identified as Hepatitis B positive, and take action if standards are not being met.

3.4.10 Findings of this needs assessment should be used by the Clinical Commissioning Group to consider redesign of current treatment pathways. This should include development of an options appraisal outlining models of care which would support and improve access to specialist Hepatitis B & C treatment services for patients in Swindon. Options might include:

a. A nurse led in-reach service from the John Radcliffe Hospital in Oxford for Hepatitis C treatment.
b. A nurse led service providing co-ordinated care and support hosted by the Great Western Hospital (Gastroenterology or Sexual Health Department).
c. A community based Blood Borne Virus or Hepatitis Nurse (possible hosting organisations suggested by stakeholders in this needs assessment include Carfax Medical Centre or CRI).
d. Development of the Blood Borne Virus Co-ordinator pilot and the Hepatitis C Positive group to provide non-clinical community based support for all those diagnosed with Hepatitis B and C.
e. Development of a GP with a Special Interest role in Swindon.

3.4.11 Swindon Borough Council Public Health and Drug and Alcohol Commissioners should work together to evaluate the role of the Blood Borne Virus Co-ordinator (and Hepatitis C Positive group) and secure ongoing funding for the projects.

4. Alternative Options

4.1 Not to support the recommendations identified in the JSNA bulletin.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 There are no direct financial implications from this report.

5.2 The needs assessment makes evidence based recommendations as to how prevention, screening, diagnosis and treatment could be improved in Swindon. These recommendations are based on National Institute for Health and Care Excellence (NICE) Guidelines Improving uptake of testing in those at increased risk of Hepatitis B and C and are considered to be cost effective by NICE.

5.3 If additional resources are needed to implement these recommendations a detailed business case will be developed.

Legal and Human Rights Implications

5.4 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

5.5 In consideration of any future guidance and an understanding of best practice from elsewhere, the council will work with the NHS and other partners in order to ensure that equalities and a respect for human rights are at the heart of the development of the Swindon JSNA and that everyone in Swindon has fair access to services and are free from discrimination.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.6 The Hepatitis B & C JSNA highlights a number of key areas of focus that will improve health outcomes for people with Hepatitis B & C, and prevent others becoming infected.

Links to One Swindon, Strategic Objectives, Plans and Policies

5.7 Improving health outcomes for those with Hepatitis B and C and preventing infections links directly to the Swindon's strategic priority to find new ways to reduce vulnerability and improve health for all. The recommendations made in the JSNA Bulletin also highlight areas where changes to current resources and services could be made in order to make best use of them.

5.8 There are strong links to Swindon's Health and Wellbeing Strategy; if fully implemented the recommendations would contribute to ensuring that every child and young person in Swindon has a healthy start in life; supporting adults with Hepatitis B or C to live healthier and more independent lives, and improving health outcomes for disadvantaged and vulnerable communities (including those from some black and minority ethnic groups, offenders, people who have ever injected drugs and men who have sex with men).

5.9 Reducing the under 75 mortality rate for liver disease is also a national priority and is an indicator in the national Public Health Outcomes Framework.

Diversity Impact Assessment

5.10 A Diversity Impact Assessment has not been completed at this stage.

5.11 Hepatitis B & C are known to particularly affect vulnerable groups who tend to have less contact with health services. The Hepatitis B & C JSNA considers the needs of these different communities. Any future actions or service redesign will reflect the needs and diversity of Swindon communities.

Further information on the subject of this report can be obtained from Sarah Weld, 01793 444629, sweld@swindon.gov.uk

Risk Management

5.12 No specific risks identified at this stage for this report

6. Consultees

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

7.1 None

8. Appendices

8.1 Appendix one. Hepatitis B & C JSNA Bulletin

Further information on the subject of this report can be obtained from Sarah Weld, 01793 444629, sweld@swindon.gov.uk

Swindon's Joint Strategic Needs Assessment

Bulletin 3: Hepatitis B and C

Key Points

- **The JSNA provides evidence to help us understand the health care related needs of those with Hepatitis B and C in Swindon.**
- **Hepatitis is a term used to describe inflammation of the liver. There are a number of causes of hepatitis; this needs assessment focusses on the blood borne viruses Hepatitis B & C.**
- **Whilst some hepatitis infections will pass without causing permanent liver damage others can persist and cause liver disease which can be fatal.**
- **Treatments are available for those diagnosed with Hepatitis B and C; however the number of people treated is low both nationally and locally.**
- **Understanding how many people in Swindon are affected by Hepatitis B and C is difficult. Many infections are undiagnosed and there are limitations associated with the way laboratory data are collected. It is estimated that 627 people in Swindon have an ongoing Hepatitis B infection, and between 519 and 836 people are living with Hepatitis C.**
- **There are some very good services to support people affected by Hepatitis B and C but testing and diagnosis needs to expand, and access to treatment improve, in order to prevent further infections and unnecessary liver disease and deaths.**
- **Specialist Hepatitis C care is provided by the John Radcliffe Hospital in Oxford. Patients find travel there difficult.**
- **The JSNA makes eleven recommendations – these are set out on pages 7 & 8.**

What is Joint Strategic Needs Assessment?

Joint Strategic Needs Assessment (JSNA) helps us to understand:

- what we know about the current health and wellbeing needs of local people;
- how their needs are being met;
- what we think their future needs are likely to be; and
- how their needs can be best met.

The JSNA process involves many different partners and is overseen by Swindon's Health and Wellbeing Board.

Understanding Swindon's changing population, the factors that affect health and wellbeing, the town's assets and the implications for future services are vital in setting priorities and planning future services.

The Hepatitis B & C JSNA

This needs assessment explores the health care related needs of those infected with Hepatitis B and C in Swindon. It focusses on the main stages of the care pathway for each of the viruses.

- Testing
- Diagnosis and referral
- Initial assessment
- Specialist management and treatment

Areas of prevention relating to healthcare provision including vaccination and screening are also discussed.

Hepatitis is a term used to describe inflammation of the liver. There are a number of causes of liver disease; this needs assessment focusses on the blood borne viruses Hepatitis B & C. Whilst some hepatitis infections will pass without causing permanent damage to the liver others can persist for many years and cause liver disease, which can be fatal.

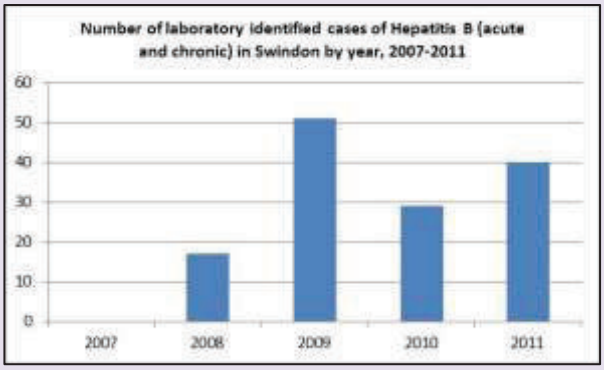
Liver disease is a government priority. It is associated with substantial morbidity and mortality and costs to the NHS related to hospital inpatient admissions and liver transplants and these costs are expected to increase. Yet liver disease is largely preventable.

Improving prevention, screening and access to treatment for those with chronic Hepatitis C infection have been the focus of work in Swindon for a number of years. With the abolition of Primary Care Trusts on 31st March 2013 and the move of Public Health to Local Authorities and much of local NHS commissioning to GP led Clinical Commissioning Groups the need to draw together the learning from previous work in to one document, and to clarify the need for service improvements was identified. Because of the parallels between Hepatitis B and C in terms of risk groups and pathways in to treatment it was felt that the opportunity should be taken to include both infections in this needs assessment.

The findings show that whilst only a small proportion of the Swindon population are affected by Hepatitis B and Hepatitis C numbers are expected to grow. Whilst there is strong commitment amongst professionals to support those affected by the viruses, and some excellent services available, testing and diagnosis needs to expand and access to treatment improve in order to prevent further infections and unnecessary liver disease and deaths.

There are strong arguments for investing in prevention and treatment for hepatitis.

- To prevent further infections
- To reduce under-75 mortality from liver disease
- To reduce costs to the NHS
- To reduce health inequalities



Source: Health Protection Agency - extracted from CoSurv on 23/11/2012

How many people in Swindon have Hepatitis B and C?

Understanding how many people in Swindon are affected by Hepatitis B and C is difficult. Both infections are largely symptom free which means that many individuals remain undiagnosed and only a small proportion of come into contact with treatment services. There are also limitations associated with the way in which laboratory data are collected.

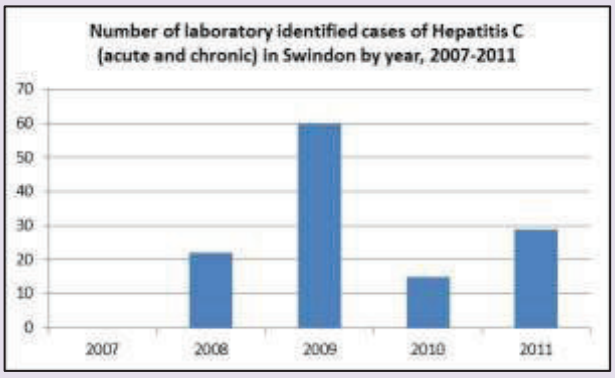
This needs assessment has collected data from a range of sources to build a picture of the likely numbers of people affected in the area. The following estimates based on national prevalence data can be made:

National Prevalence Estimate	Expected cases in Swindon
Chronic Hepatitis B infection - 0.3%	627
Chronic Hepatitis C infection - 0.4%	836

The Health Protection Agency has produced a template to help local areas estimate the prevalence of Hepatitis C in their population more accurately. It takes account of the estimated number of injecting drug users (IDU) in the population and also ethnic mix.

Population Group	Estimated cases in Swindon
Infected current IDU (15-64y)	208
Infected ex-IDU (15-64y)	232
Infected non-IDUs (16-59y)	47
Infected Asian/Asian-British (16-59+y)	28
Infected Asian/Asian-British (60+y)	5
TOTAL	**519**

This estimate is lower than the crude estimate of 836 shown above; the true value is likely to lie somewhere between the two.



Source: Health Protection Agency - extracted from CoSurv on 23/11/2012

Risk factors and high risk groups

Hepatitis B and C are blood borne viruses, which mean that they can be transmitted through contact with infected blood or other body fluids.

Whilst there are differences between the infections, both are known to affect vulnerable population groups who tend to have less contact with health services than the general population.

Hepatitis C transmission is mainly through contaminated blood. Injecting drug use is the most important risk factor for infection in the UK.

Hepatitis B can also be transmitted as a result of blood-to-blood contact. Transmission also occurs through sexual intercourse and from mother to child during pregnancy or at birth. In the UK, the majority (95%) of chronic Hepatitis B infections are diagnosed in migrant populations, and were acquired at birth, most often outside the UK.

Hepatitis B High Risk Groups

- People born or brought up in Africa, Asia, the Caribbean, Central and South America, Eastern and Southern Europe, the Middle East and the Pacific islands.
- Babies born to mothers infected with Hepatitis B.
- People who have ever injected drugs.
- Men who have sex with men.

Hepatitis C High Risk Groups

- People who have ever injected drugs.
- People who received a blood transfusion before 1991 or blood products before 1986, when screening of blood donors for hepatitis C infection, or heat treatment for inactivation of viruses were introduced.
- People born or brought up in a Africa, Asia, the Caribbean, Central and South America, Eastern and Southern Europe, the Middle East and the Pacific islands.
- Babies born to mothers infected with Hepatitis C.
- Prisoners, including young offenders.

Prevention of Hepatitis B and C

Actions required to prevent Hepatitis B and C infection include:

- increasing awareness of infection
- promoting safer sex and condom use,
- reducing injecting drug use,
- safer injecting services
- universal precautions in health care settings
- Hepatitis B vaccination
- increasing testing and diagnosis
- getting diagnosed individuals into treatment and care.

What do local people and organisations think?

As well as collecting data, part of this needs assessment included discussions with representatives from key services in the care pathway, and a focus group with Hepatitis C service users to find out about their views of local services. Quotes from these meetings are presented with the findings below to give a flavour of what local people and organisations think.

What services do people use?

In Swindon services for people at risk of or infected with Hepatitis B and C are delivered via a range of services including local GP practices, Great Western Hospitals Trust, the John Radcliffe Hospital in Oxford, drug and alcohol services and other voluntary organisations.

There is currently no formal pathway for Hepatitis B or C in Swindon that covers the whole patient journey from testing through to specialist management and treatment, although specific pathways for antenatal screening and vaccination of babies born to Hepatitis B positive mothers are in place.

A key aim of this needs assessment was to map the patient pathways for Hepatitis B & C in Swindon. The figure below shows the services offering testing and referral routes in to specialist treatment identified.

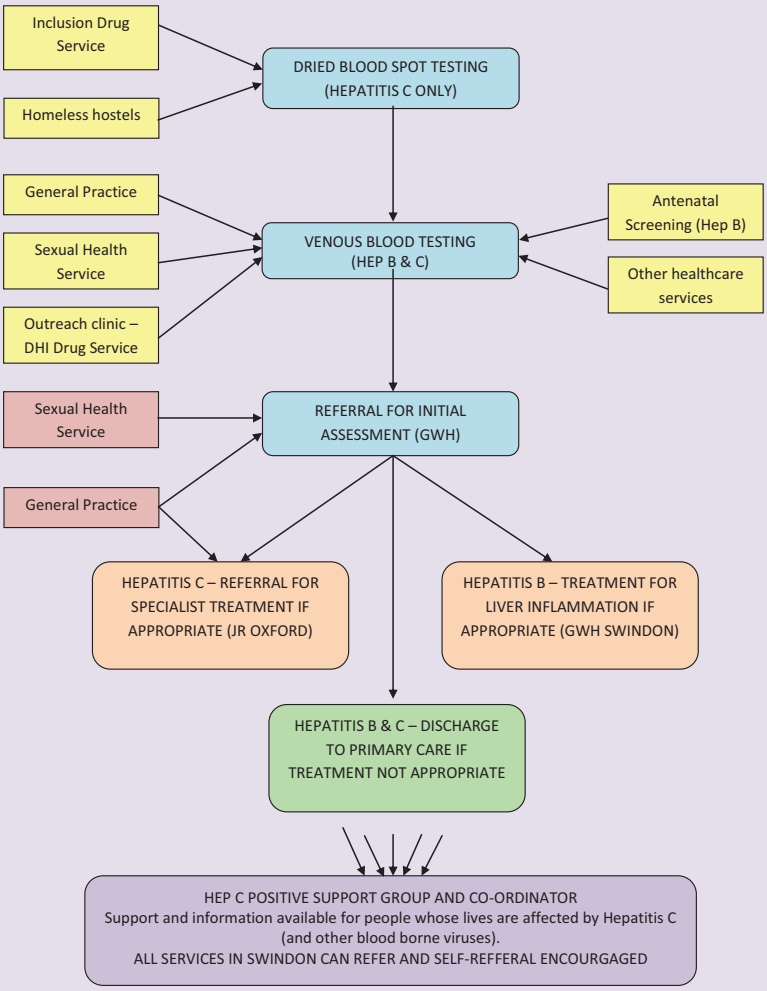


Diagram showing routes in to testing and treatment for Hepatitis B & C in Swindon
(From 1st April 2013 services provided by the drug services Inclusion and DHI have moved to the new service provider CRI).

- ## Vaccination

Hepatitis B is a vaccine preventable disease. There is no universal Hepatitis B vaccination programme in the UK; immunisation is recommended for 'at risk' groups

There is no central data collection point for Hepatitis B vaccination and it is therefore difficult to get an overall picture of the number of vaccines given annually in Swindon, or the proportion of those in 'at risk groups' who have been vaccinated.

Injecting Drug Users have been a particular target group for Hepatitis B vaccination. A review of vaccination data available through the National Drug Treatment Monitoring System suggests that coverage could be improved. The introduction of the new service provider, CRI provides an opportunity to review current vaccination provision and ensure that it is easily accessible to all those accessing drug services in Swindon.

- ## Testing

One of the main challenges with Hepatitis B and C is the substantial number of people who are unaware of their infection. In order to identify those who are infected and would benefit from treatment a diagnosis is required so that a referral to specialist care can be made.

Testing is recommended for those at increased risk of Hepatitis B or C infection in primary care, in prisons and youth offender institutions, in immigration removal centres, in drugs services in genitourinary medicine and sexual health clinics.

Testing for Hepatitis B and C is available in Swindon in a range of settings, including:

- Primary Care including Shared Care Services for drug users
- Genitourinary Medicine (GUM)/Sexual Health Services
- Drug and Alcohol Services
- Antenatal screening

No systematic review of the level of testing in Primary Care in Swindon was undertaken as part of this needs assessment, however discussions with stakeholders suggested that there is little targeted screening of high risk groups carried out and low awareness amongst GPs of Hepatitis B and C.

Testing for Hepatitis C in drug services in Swindon is done through both venous and dried blood spot testing. Discussions with stakeholders and service users highlighted a number of challenges to the current system of testing, and improvements which could be made. These were related to the lack of consistency in the way in which testing is offered and data sharing between services.

Overall, no issues were identified in this health needs assessment about access to testing through Sexual Health Services. However, concerns were raised about the lack of information sharing, particularly between Sexual Health and Drug Services.

> *"We could do a lot more – more testing and vaccination. We have the staff, we just need the resources."*
> (Service Provider)
>
> *"We need better information sharing; we don't want to waste resources repeat testing, but we don't want to miss people."*
> (Service Provider)

There are opportunities to extend testing for Hepatitis B and C in Primary Care and drug services in Swindon and to ensure that all those in 'high risk' groups are routinely offered testing according to NICE Guidelines.

- **Diagnosis and initial assessment**

Diagnosis of Hepatitis B and C, and assessment of appropriateness for onward referral requires a number of tests and investigations. For most patients in Swindon these tests will be done in Primary Care, although investigations for those identified in Sexual Health Services remain within that service. Those identified as Hepatitis C positive through dried blood spot testing must be referred to their GP to arrange confirmatory blood testing.

Following diagnosis patients are referred to the Gastroenterology Department at the Great Western Hospital for an initial assessment. All GP Practices in Swindon are able to refer their patients to this service. The Sexual Health Service refers patients directly.

Waiting times for a first appointment were 2-3 months at the time stakeholder interviews were held (January 2013). Service users consulted as part of this needs assessment reported a lack of support following diagnosis, and the need for better co-ordination of care between services, particularly when waiting for their first assessment.

> *"There needs to be some sort of level of counselling for when people are told they've got Hep C. There's is sort of stigmatism that Hep C is lethal, there's no treatment"*
> (Service User, Hepatitis C)
>
> *"You're in that half-way stage. You've got this disease. You don't know much about it. You can go on the internet and that frightens you to death reading about liver damage and all those kind of things."*
> (Service User, Hepatitis C)

- **Treatment**

Treatments are available for those diagnosed with Hepatitis B or C. Management consists of infection control and lifestyle advice and support, assessment and monitoring of liver function and consideration for antiviral treatment.

The average cost of treating someone identified with Hepatitis B is £3,474 in the first year and £9,085 for someone with Hepatitis C. There are also likely to be some ongoing costs for treatment, particularly for Hepatitis B as treatment can be required for several years. These costs compare well to the cost of care for liver disease; annual cost for a person with decompensated cirrhosis is £12,432 and of someone with hepatocellular carcinoma £11,0784 whilst a liver transplant costs more than £50,000.

Limited data was available about the numbers of patients being treated for their infection in Swindon. Nationally the number of patients being treated is low; it is estimated that only 26% of those with chronic Hepatitis B have had their infection diagnosed and of these 5% receive antiviral treatment each year, whilst approximately 3% of those chronically infected with Hepatitis C are currently treated each year.

Year	Number of Hepatitis C Patients Treated in John Radcliffe Hospital, Oxford (2007-2011)
2007/2008	7
2008/2009	10
2009/2010	10
2010/2011	13

In Swindon management of Hepatitis B is overseen by the Gastroenterology Department at the Great Western Hospital. Specialist Hepatitis C care is provided by the John Radcliffe Hospital in Oxford. Patients with Hepatitis C report receiving excellent care in Oxford, and the number treated has increased over recent years. However travel is difficult.

> *"Having to travel to Oxford when you're feeling really rubbish – it's a real grind."*
> (Service User, Hepatitis C)

- **Social Support**

Not all those diagnosed will seek treatment for their infection immediately. The Hepatitis C Positive support provides peer support to those directly or indirectly affected by the Hepatitis C and other blood borne viruses. It meets weekly and is facilitated by former service users.

> *"It was only when the Hep C Positive group…it was the first time I'd ever met anyone with Hep C. I wish I'd had that when I first found out. I had 3 years counting my life down. I just kept thinking "what's the point?" – I'm going to be dead in 10 years.*
> (Service User, Hepatitis C)
>
> *"One of the reasons why the support is so successful is because we tell everybody that the treatment is hard…but at the end of it it's beneficial."*
> (Service User, Hepatitis C)

In February 2012 the Swindon treatment system employed a Blood Borne Virus Co-ordinator to run a project with the principal aim of 'following up' service users who had agreed to a dried blood spot test for Hepatitis C. The role of the co-ordinator is to work with those people who have not acted upon their test results through counselling and/or involvement in the Hepatitis C Positive support group, and to improve links with health care and drug service providers to ensure that drug service users are provided every opportunity to gain supportive advice and interventions commensurate with blood borne virus status.

The role of the Co-ordinator, working in partnership with Hepatitis C Positive group has provided a highly valued source of support to many people living with Hepatitis C in Swindon and has been successful at identifying people in Swindon needing support and helping them to come to terms with their diagnosis and move in to treatment It also supports some people affected by Hepatitis B and HIV.

What Does the Future Look Like?

There is little published data on future population projections for Hepatitis B in England. The number of new acute cases appears to be reducing; this is likely to be due to interventions to prevent transmission in drug users such as needle exchanges; antenatal screening; and improved vaccine uptake amongst high risk groups. However, since most cases of chronic Hepatitis B are diagnosed in immigrant populations prevalence is dependent on global immunisation policy as well as national efforts and there is evidence that the prevalence of chronic Hepatitis B in the UK is increasing as a result of migration

Researchers predict that, under current treatment patterns, the overall prevalence of Hepatitis C infection will increase from 0.4% in 2010 to 0.61% in 2035. This equates to an increase in the number of persons in the UK living with Hepatitis C infection from around 265,000 in 2010 to 370,000 in 2035. A crude calculation based on the estimated Swindon population size in 2021 suggests that there would be 1198 people in Swindon living with Hepatitis C infection in 2021. This does not take account of the number of intravenous drug users and ethnic mix that the HPA template does.

Alternative Scenarios

When considering what the future might look like and alternative scenarios evidence suggests that the most important intervention would be to improve uptake of testing in those at increased risk of Hepatitis B and C. This is considered to be cost effective by the National Institute of Health and Clinical Excellence (NICE) and would have wide ranging benefits.

Detecting people with either disease will allow them to be treated if appropriate. This will subsequently lead to a reduction in the severity of adverse events associated with untreated disease. It should also increase the number of people who are vaccinated against Hepatitis B. Successful completion of treatment and

subsequent clearance of the virus will also reduce the risk of onward transmission.

Whilst increasing the number of people being tested is important it is also essential that there is adequate capacity within accessible secondary care and specialist treatment services to manage the increased demand this creates.

In Swindon this creates both opportunities and challenges. A key priority for the Swindon's Clinical Commissioning Group is to commission local services in order to ensure people have a positive experience of their care. Although patients report receiving excellent care in the John Radcliffe Hospital, in this context there is clearly a need for change to the current requirement for those with Hepatitis C to travel to Oxford for their treatment.

There are models of innovative care both regionally and nationally which could be explored in Swindon to improve access to care for both Hepatitis B and C. These include nurse led in-reach from a hospital based service; a community based Blood Borne Virus or Hepatitis Nurse; care provided by a GP with a Special Interest; or non-clinical community based support to complement hospital based treatment.

Recommendations

This needs assessment provides a chance to reflect on the needs of people with Hepatitis B and C in Swindon and the potential future demand for services, identify good practice and make further progress in improving services. A set of recommendations based on the evidence collected for this needs assessment, national best practice and NICE Public Health and Clinical Guidelines and are set out below.

It should be noted that a whole system approach to implementing these recommendations is required, with collaboration between commissioners and service providers at all stages of the care pathway.

1. Local service providers and community and voluntary groups including the Blood Borne Virus Co-ordinator should work together with support from Swindon Borough Council Public Health leads to develop and deliver evidence based campaigns, materials and resources to raise awareness about Hepatitis B and C among the general population and those at increased risk of infection. This should build on existing nationally produced materials wherever possible and include up-to-date information on:
   - The main routes of infection and transmission
   - Local services providing testing and Hepatitis B vaccination
   - The potential for infection to be asymptomatic
   - The benefits of early testing and treatment
   - Overcoming social and cultural barriers and improve access to testing and treatment

2. Swindon Borough Council Public Health leads should work with local commissioners and service providers to develop and deliver education programmes to improve the knowledge and skills of healthcare professionals and others providing services for people at increased risk of Hepatitis B or C infection. This should build on existing nationally produced materials wherever possible and include up-to-date information on:
   - Epidemiology of Hepatitis B and C – local prevalence, at risk groups
   - Testing and diagnosis
   - Treatment
   - National guidance on testing and delivery of care
   - Skills to overcome social and cultural barriers and improve access to testing and treatment

3. Commissioners in the Local Authority, Clinical Commissioning Group and NHS Commissioning Board should ensure testing for Hepatitis B and C (venous and/or dried blood spot as appropriate) and Hepatitis B vaccination is available in-line with NICE Guidance in:
   - Primary Care
   - Drug and Alcohol Services
   - Sexual Health Services

4. Swindon Borough Council Drug and Alcohol Treatment Commissioners should work with the new Swindon drug service provider, CRI, to ensure that all service users entering drug treatment are routinely offered Hepatitis B and C testing and Hepatitis B vaccination at their initial assessment, and that annual testing for Hepatitis C is offered to people who test negative but remain at risk of infection. Commissioners should routinely audit data collected.

5. Services providing testing should ensure that all those who undertake testing are trained and competent to provide appropriate pre- and post-test discussions and that testing is accompanied by appropriate information resources and support while waiting for test results and following diagnosis.

6. A named commissioning lead for viral hepatitis should be identified in the Swindon Clinical Commissioning Group, NHS Commissioning Board Local Area Team and Swindon Borough Council who should agree ways to work together to ensure effective commissioning of a fully integrated care pathway for those who test positive for Hepatitis B or C infection from the point of diagnosis. This should take account of the patient's psychosocial and support needs as well as treatment for their infection and include mechanisms for following up patients who defer treatment.

7. Swindon Borough Council Public Health leads should work with Commissioners and Service Providers to develop clear data recording and sharing protocols which support those receiving positive results for Hepatitis B or C to access support and move along the treatment care pathway as appropriate, and which enable the number and source of referrals for Hepatitis B and C; appointment attendance; treatment and discharge or onward referral to specialist services to be monitored.

8. Swindon Clinical Commissioning Group Commissioners should audit services available for the management and treatment of Hepatitis B and C in Swindon and ensure compliance with NICE Guidelines when they are published.

9. Swindon Borough Council Public Health leads should work with Antenatal Screening Commissioners in the NHS England Local Area Team to undertake regular audit of the Hepatitis B vaccination programme for babies in Swindon and pathways for mothers identified as Hepatitis B positive, and take action if standards are not being met.

10. Findings of this needs assessment should be used by the Clinical Commissioning Group to consider redesign of current treatment pathways. This should include development of an options appraisal outlining models of care which would support and improve access to specialist Hepatitis B & C treatment services for patients in Swindon. Options might include:

    a. A nurse led in-reach service from the John Radcliffe Hospital in Oxford for Hepatitis C treatment.
    b. A nurse led service providing co-ordinated care and support hosted by the Great Western Hospital (Gastroenterology or Sexual Health Department).
    c. A community based Blood Borne Virus or Hepatitis Nurse (possible hosting organisations suggested by stakeholders in this needs assessment include Carfax Medical Centre or CRI).
    d. Development of the Blood Borne Virus Co-ordinator pilot and the Hepatitis C Positive group to provide non-clinical community based support for all those diagnosed with Hepatitis B and C.
    e. Development of a GP with a Special Interest role in Swindon.

11. Swindon Borough Council Public Health and Drug and Alcohol Commissioners should work together to evaluate the role of the Blood Borne Virus Co-ordinator (and Hepatitis C Positive group) and secure ongoing funding for the projects.

Where to find more information

The full Hepatitis B & C JSNA provides much more information on the issues covered by this bulletin (including full references). It can be found on Swindon's JSNA website: www.swindon.gov.uk/healthandwellbeing

The website includes a range of other documents about health and wellbeing in Swindon. If you have any queries (or would like to contribute to needs assessment activities in Swindon) please contact: CBartlett@swindon.gov.uk

This bulletin will be reviewed in June 2015.

Learning Disability JSNA: Progress Report

Health & Wellbeing Board **Date: 11th September, 2013**

Author:	Board Director Commissioning
Wards:	All Wards
Locality Affected:	All Locality Areas
Parishes Affected:	All Parish Areas

1. Purpose and Reasons

1.1 This report explains the approach being taken by the Learning Disability Partnership Board (LDPB) to monitor progress against the recommendations in the Learning Disability Joint Strategic Needs Assessment (JSNA). It also outlines the work being undertaken to complete Swindon's submission to the the new Joint Health and Social Care Self-Assessment for learning disabilities.

1.2 The LDPB has been identifying work already underway to address the JSNA recommendations and suggesting further actions. It is also planning how the Swindon Self- Assessment submission will be completed. This is a progress report to inform the Health & Wellbeing Board.

2. Recommendations

The Board is recommended to:

2.1 Take note of the progress made in monitoring the JSNA recommendations and consider how the organisations represented at the Health & Wellbeing Board can contribute, especially in the area of employment for people with learning disabilities.

2.2 Take note of the approach to completing the Joint Health and Social Care Self-Assessment for learning disabilities and consider whether the Health & Wellbeing Board wishes to validate the report before it is submitted in November 2013.

3. Detail

3.1 **Joint Strategic Needs Assessment** – The Learning Disability JSNA states that 716 people are known to health and social care services in Swindon. National prevalence rates would suggest that the actual number of people with learning disabilities living in Swindon is more likely to be over 3500. A large proportion of these people will have mild learning disabilities and where they receive support this could be from other sources such as mainstream services (e.g. Job Centre Plus), mental health services, the criminal justice system or services for vulnerable children and families.

3.2 Some of the key issues highlighted in the JSNA report include:

Further information on the subject of this report can be obtained from Karen Hobbs, Direct Dial (01793) 463293, Employee@swindon.gov.uk.

3.2.1 The mix of services in Swindon is still fairly traditional (e.g. day centres, residential short breaks, residential homes) compared to areas where transformation has moved at a faster pace.

3.2.2 The take up of Direct Payments and Personal Budgets (self-directed support) amongst people with learning disabilities in Swindon is much lower than other authorities.

3.2.3 The employment rate for people with learning disabilities in Swindon is recorded at 3.5% one of the lowest in the country.

3.2.4 Swindon has a higher than average number of people placed in residential care both in and outside the local authority area, although there have been developments in supported living in recent years.

3.3 The Learning Disability Partnership Board (LDPB) was involved in gathering information to produce the Learning Disability JSNA report and bulletin. Since publication in November 2012 the Board has been using their meetings to find out about work that is already underway which will contribute to achieving the recommendations. It has also been identifying gaps and further actions. A table summarising this work is attached at Appendix 1.

3.4 The LDPB has commissioned an Easy Read version of the Learning Disability JSNA Bulletin. This means that members of the Board who have a learning disability and the wider service user group are enabled to understand the recommendations, discuss the issues and take part in action planning. See Appendix 2.

3.5 The Bulletin has also been distributed to the network of providers and voluntary sector organisations who support adults with learning disabilities in Swindon and those who support people placed outside the area. The Learning Disability Provider Forum has been discussing the contributions they can make to achieve the recommendations. Representatives from this forum now attend the LDPB meetings.

3.6 The Learning Disability JSNA contains 11 recommendations for improving the health and wellbeing of people with learning disabilities in Swindon. The LDPB has been grouping them in to overarching topics and inviting relevant individuals and organisations to meetings to discuss how their work is contributing to achieving the recommendations.

3.7 So far the LDPB has found that many of the recommendations are being covered in the workstreams from the Adult Demand Programme. Links with other work programmes have also been identified and will continue to be monitored.

3.8 The main areas of progress and suggested actions to date are outlined below:

3.8.1 Personalisation – Swindon has a low number of people with learning disabilities receiving personal budgets compared to other areas. SBC commissioners are working closely with SEQOL and the Community Team for People with Learning Disabilities to ensure people are receiving person-centred annual reviews. Commissioners are now meeting with Care Managers on a weekly basis to assist them in thinking more creatively when designing solutions with individuals. The aim is to maximise the use of community resources and natural supports and reduce reliance on statutory services. It will also help people to make the best use of a personal budget where one is allocated. Targets have been agreed between commissioners and SEQOL to monitor progress. A new contract for Advocacy and Person Centred Support is being developed and will be put out to open tender in September. This will provide further support for people with learning disabilities identify outcomes and plan to achieve them. It will focus on preventative work and reducing reliance on funded services.

3.8.2 Housing – There is a Reablement and Supported Housing workstream in the Adult Demand Programme which is actively addressing the housing needs of people with a learning disability. A new Housing Strategy is being developed and is liaising with this workstream. The LDPB has been informed that SBC Cabinet have made a commitment to improving housing options for people with learning disabilities which supports this work. The LDPB will continue to monitor progress.

3.8.3 Employment – Swindon continues to have one of the lowest rates of employment for people with learning disabilities in the country. The LDPB meeting on 17th September will be addressing this issue and has invited a local employer along with supported employment providers to discuss actions required. Supported Employment is included in one of the Adult Demand workstreams but Suggested actions: local statutory services such as SBC and the NHS to become model employers in line with the Valued in Public (Valuing People, 2005) guidance; key agencies to work together to form an employment strategy; more planning around employment when disabled children are preparing for adulthood through the transitions process.

3.8.4 Health – Due to some targeted work and commitment via the LDPB Health Sub Group improvements have been made to address health inequalities for people with learning disabilities in Swindon over the past few years. The current focus is on increasing the rate of annual health checks from the current 50% of people on the learning disability GP register and building on other reasonable adjustments already developed in Swindon. The Health Sub Group has an action plan to address the areas covered by the JSNA recommendations relating to health.

3.8.5 Parents with learning disabilities – This was identified as an area that had not previous had a lot of attention. The LDPB found that the Healthy Child Programme includes parents who have a learning disability and is aiming to improve early intervention in pregnancy where a mother is found to be vulnerable or in need of additional support. SBC already commissions a small advocacy service for parents with learning disabilities whose children are subject to child protections procedures. The Local Safeguarding Children's Board has recently suggested this should be increased to include more early intervention support and the 'child in need' stage. Suggested further actions: find out how well Children's Centres are supporting parents with learning disabilities; parents with learning disabilities have said they would benefit from accessible parenting and support groups.

3.8.6 Preparing for Adulthood (transition) – There is a workstream of the Adult Demand Programme looking at the transitions from childhood to adult life for disabled young people. It will be reviewing the current Transitions Protocol in Swindon and is closely linked with a project to implement the pending changes to support for children with special educational needs as a result of the Children & Families Bill. A big focus is on improving person-centred/outcome focused planning on an individual level with better joint commissioning between education, health and social care across children and adult services.

3.8.7 Winterbourne View recommendations – work is already underway to implement the changes required following the Winterbourne View report. This is being monitored by the Local Safeguarding Adults Board who have an action plan for this work. There has been a national 'stock take' and Swindon submitted a return. The number of people from Swindon placed in assessment and treatment units is very low compared to other areas and community health and social care teams are working with commissioners to ensure this remains the case. There is a programme in place to regularly review people who are placed in such provision.

3.9 **Joint Health & Social Care Self-Assessment** - The LDPB and the Health Sub Group have been completing annual self-assessments on the progress in health and social care for people with learning for the 3 years. These self-assessments have been reported to the Department of Health, the Strategic Health Authority and latterly Public Health England as part of the national programme to monitor progress against the Valuing People agenda and recommendations from subsequent reports.

3.10 This year these separate self-assessments have been combined and new paperwork produced. The LDPB will be co-ordinating an exercise to gather and report information. There are 59 data questions and 27 statements to be RAG rated with a text explanation, links to supporting evidence and a 'real story' from

a local service user. The LDPB will seek views from a wide range of service users, family carers, support staff and professionals. There will be a Big Health & Wellbeing Day in October to review findings and agree priorities.

3.11 The guidance suggests that Health & Wellbeing Boards may wish to validate submissions for their areas before they are submitted.

3.12 The deadline for submissions is 30th November, 2013 after which a report will produced to show regional and national comparisons.

3.13 The guidance also suggests that local findings and regional/national comparisons should be reported to Health & Wellbeing Boards by March 2014.

4. Alternative Options

4.1 The Health & Wellbeing Board may choose not to support or engage with the work of the LDPB in monitoring progress with the JSNA and Self-Assessment. However, strategic oversight and direction will be required to provide accountability and ensure that work is undertaken to achieve the JSNA recommendations.

4.2 An alternative Steering Group could be set up to monitor progress but this is likely to consist of many of the same members at the LDPB. However, as an existing forum with a focus on learning disability and good representation from service users and family carers the LDPB is in a good position to undertake this work.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 The LDPB has identified that many of the recommendations are already being addressed via the Adult Demand Programme. The LDPB will be monitoring and informing this work where necessary. There are no financial implications resulting from this report.

Legal and Human Rights Implications

5.2 There is a focus in the JSNA recommendations and the Self-Assessment on safeguarding. Many of the reports highlighting health inequalities for people with learning disabilities point to clear violations of people's human rights in some health and social care settings.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 Continuing to work towards the recommendations in the JSNA will contribute to improving the health and wellbeing outcomes for people with learning disabilities and reducing health inequalities.

Links to One Swindon, Strategic Objectives, Plans and Policies

5.4 There are direct links with the Adult Demand Programme as many of the recommendations can be addressed via the workstreams.

5.5 People with learning disabilities should be benefiting from the outcomes of One Swindon alongside all members of the communities in Swindon. A number of the JSNA recommendations link to these outcomes.

5.6 The draft Health & Wellbeing Strategy recognises the needs of vulnerable groups, including those with learning disabilities. A number of the outcomes contained in the document link to the JSNA recommendations.

Diversity Impact Assessment

5.7 Involving the LDPB, people with learning disabilities and their family carers in monitoring progress against these recommendations means that their views and perspective will directly influence the actions to be taken.

5.8 There are a wide range of people within the learning disability population covering different types of disability, cultural and social backgrounds, religions, sexuality etc. The LDPB is working with service user and family carer groups to gather views from different perspectives to ensure all needs and preferences are taken in to consideration both in responding to the JSNA recommendations and in the Self-Assessment.

Risk Management

5.9 The risks of not working towards achieving the recommendations of the Learning Disability JSNA are that Swindon may fail to improve against national performance indicators particularly around employment and supported living. It will also mean that people with learning disabilities and their families will find it harder to achieve the outcomes they need to live as fully and independently as possible.

5.10 By monitoring the actions being taken and the progress being made the LDPB can help to ensure the recommendations are responded to appropriately to achieve the changes required. Completing the Self-Assessment this year and in future years will enable Swindon to measure progress.

6. Consultees

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

7.1 There are no previous papers relating to this report.

8. Appendices

8.1 Learning Disability Board JSNA Action Plan

8.2 Easy Read Version Learning Disability JSNA Bulletin

Further information on the subject of this report can be obtained from Karen Hobbs, Direct Dial (01793) 463293, Employee@swindon.gov.uk.

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Learning Disability Partnership Board (LDPB) - Joint Strategic Needs Assessment (JSNA) Action Plan

	Recommendation	What are we are already doing about this?	What else do we need to do?	Who will report to the LDPB about this work?
1	Develop a joint strategic vision for learning disability in Swindon to include action on these recommendations	• Work already done by the LDPB around Valuing People • Health Sub-group work plan • Self-Assessment Framework (joint for health & social care this year) • Joint Strategic Needs Assessment (JSNA)	• Write down the priorities so everyone can see what they are • Ask younger people and their families what they want in the future • Self-advocates/peer mentoring to get people's views • Big Health & Wellbeing Day (Oct 13)	Karen Hobbs
2	Ensure implementation of the adult social care change programme including:			
2a	Full implementation of personalisation and increase of self-directed support	• SEQOL is starting to work in a more person-centred way when they do assessments and reviews • There is a government target of 70% of people with Personal Budgets (we are at 20%) in Swindon • Commissioning Team now supporting Care Managers to plan more effectively with people	• People need clearer information about changes to social care and benefits because it is getting confusing • We need to make sure there is the right support to safeguard people who want to manage their own budget for support	SEQOL CTPLD - targets to be set and reported on SBC Commissioners
2b	Reduced reliance on residential and nursing care while ensuring person-centred planning	See notes for 2a & 2c		
2c	Provision of a suitable range of housing and supported living models	• There is a Reablement and Supported Living workstream as part of the SBC Adult Demand Programme • Cabinet is looking at making more supported housing available for people with LD • SBC will always look at supported living first, SBC now does not place anyone out of the area unless	• Make sure people with LD benefit from the supporting living workstream of the SBC Adult Demand Programme • Alan Wylde from SBC is writing a strategy about housing which needs to include the needs of people with learning disabilities	SBC Commissioners

Learning Disability Partnership Board (LDPB) - Joint Strategic Needs Assessment (JSNA) Action Plan

Recommendation		What are we are already doing about this?	What else do we need to do?	Who will report to the LDPB about this work?
		absolutely necessary • SBC are working with CTPLD to offer people the opportunity to move back to Swindon if they live out of area • SBC and CTPLD are working with young people to plan better so they do not need to move out of Swindon (this is a priority shared with the CCG)		
2d	Development of the market locally to enable people to use personal budgets effectively	• SBC is developing the voluntary sector services as part of the Adult Demand Programme • SBC is seeking to develop more volunteers to work with people • SBC is working with CTPLD to be more creative when planning with people so we get better information about the services that are needed	• Make sure people with LD benefit from improvements in information that are part of the SBC Adult Demand Programme • Changes to Leisure & Culture including changes to the Swindon Card – make sure people with LD do not miss out	SBC Commissioners
2e	Engage more proactively via targeted support in order to help support people to stay in their own homes/communities	• *Need more information from specialist services*		SBC/CCG Commissioners
2f	Improved support for carers and better understanding of their needs	• Carer's Assessments (but more people need to know they are entitled to one and why they are important) • Emergency Card Scheme	• Better information for carers about services & support as part of the SBC Adult Demand Programme • Better planning for the future especially for older carers and parents of young people moving into adulthood	*Lead required*

Learning Disability Partnership Board (LDPB) - Joint Strategic Needs Assessment (JSNA) Action Plan

Recommendation		What are we are already doing about this?	What else do we need to do?	Who will report to the LDPB about this work?
2g	Increase in the proportion of timely person-centred reviews	• The number of reviews is improving, current target is that 75% or people getting a service will have an annual review, this is starting to happen	• CTPLD to continue working on achieving their targets	Gary Latham (SEQOL)
2h	Cultural and language sensitivity	• Health - lots of work done with GPs & hospital around 'reasonable adjustments' to make it easier for people with LD to use services • Parent Carer's Group is starting to visit different community groups	• We need to ensure that when we make plans we think about how people from other cultures and communities will benefit • Look at information around LD & BME on GP register • Get an update from Parent Carer's Group about their work in this area	*Lead required*
3	Increase employment aspirations, options and support, with clear strategic links to education providers, Job Centre Plus and local employers (including the Local Authority and NHS).	• There are some supported employment services like SEQOL (Energy2) & Pluss • We have low numbers of people with LD in employment compared to other areas • Employment is discussed at reviews	• Research to understand how benefits are affecting people's plans to get paid employment • Employment strategy required	*Lead required*
4	Improve the transition process for young people into adult services, taking account of the expected Children and Families Bill, and including development of shared aspirations, expectations and outcomes as well as shared information systems across agencies.	• The cross party advisory group now includes children & adults • Transitions Workstream of SBC Adult Demand Programme	• To be addressed via the Transitions Workstream – LDPB will need to be involved and receive updates on progress	Karen Hobbs

Learning Disability Partnership Board (LDPB) - Joint Strategic Needs Assessment (JSNA) Action Plan

Recommendation		What are we are already doing about this?	What else do we need to do?	Who will report to the LDPB about this work?
5	Develop Health Checks to improve the local offer and uptake through the Learning Disability Partnership Board health sub-group.	• Health sub-group already working on this through their work plan	• See Health Sub-group work plan • LDPB to receive updates	Health-sub group
6	Ensure 'reasonable adjustments' are made by health providers to ensure people with learning disabilities have full access to mainstream health services through the Learning Disability Partnership Board health sub-group.	• Training programme for Health Facilitators • Blue Book & Health Action Plans • Health Sub-group has this in their work plan	• See Health Sub-group work plan • LDPB to receive updates	Health-sub group
7	Develop, agree and implement a Joint working protocol between Avon and Wiltshire Mental Health Partnership NHS Trust and Community teams.	• Work started on addressing recommendation in the Green Light Toolkit (NB – currently stalled due to staff changes in commissioning)	• Talk to someone from AWP – via Mental Health Commissioner • Talk to Parent & Carer's group about their work in this area • LDPB to get update on Green Light Toolkit work	Mental Health Commissioner
8	Improve life-chances of parents with learning disabilities and their children by improving early identification and support, and developing a joint working protocol between Children and Adult Social Services.	• SAM provides advocacy for parents but more needs to be done to support parents and stop children having to go in to care	• Work being done by Children's Health Commissioners – Healthy Child Programme – LDPB to get update • Need to find out how well Children's Centres support parents with learning disabilities • Parents with learning disabilities would like more accessible parenting courses and support groups	Karen Hobbs

Learning Disability Partnership Board (LDPB) - Joint Strategic Needs Assessment (JSNA) Action Plan

	Recommendation	What are we are already doing about this?	What else do we need to do?	Who will report to the LDPB about this work?
9	Improve information and intelligence systems to better inform providers and commissioners. Specific recommended projects include:			
9a	Investigating the recent increase in care packages			SBC Commissioning
9b	Developing better transition information to inform current service planning		• To be addressed as part of the Transitions Workstream in the Adult Demand Programme	SBC Commissioning
9c	Improving transition information systems which work across agencies		• To be addressed as part of the Transitions Workstream in the Adult Demand Programme	SBC Commissioning
9d	Developing use of the Swindon Learning Disability register to fully include children and young people with learning disabilities			SBC Commissioning
9e	Analysing data on children and young people with learning disabilities, using information from education and other sources to improve understanding of need and inform service planning		• To be addressed as part of the Transitions Workstream in the Adult Demand Programme	SBC Commissioning
10	To engage with One Swindon and influence in order to gain partner and business wide support for supporting and encouraging future LD employment opportunities.		• The LDPB could put a question to the One Swindon Board and/or invite someone from the Board to a Partnership Board meeting where the topic is employment	Karen Hobbs/Cllr Ray Ballman
11	Full implementation of the Winterbourne View recommendations.	• The Adult Safeguarding Board has an action plan based on the recommendations from the Winterbourne	• See the Adult Safeguarding Board action plan • Ask Doug Bale to report on progress with the action plan	Doug Bale

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Swindon Joint Strategic Needs Assessment 2012

Easy Read Version
Produced by Swindon Advocacy Movement

sam
Swindon Advocacy Movement

What will the JSNA do?	
It will help Swindon Borough Council to plan for the future.	
It helps to plan health and social care services.	
It helps decide how to provide good services to meet everyone's needs.	
It shows how Swindon is changing – new people are moving in some people are leaving.	
It shows what people think are good about Swindon.	

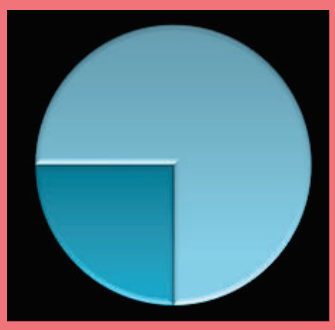
It shows what people in Swindon need to keep healthy and have a happy life.

This report is about adults with a learning disability in Swindon or live in other places but are paid for by Swindon Borough Council.

Describing a learning disability.

A person has a learning disability if they have a condition that has an effect on them that sometimes makes it harder to learn new skills and to do things in everyday life.

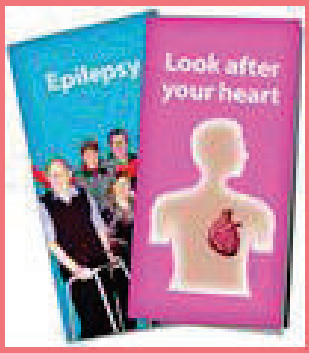
A person with a Learning Disability may need support to manage their lives

In a group of 50 people, there is likely to be 1 person with a learning disability.	
A quarter of these are likely to be known to local health and social care services.	
We have worked out there are between 3,600 and 3,800 people with a learning disability living in Swindon.	
Not all of these people get help from health and social care services. So there are lots of people we don't know about.	

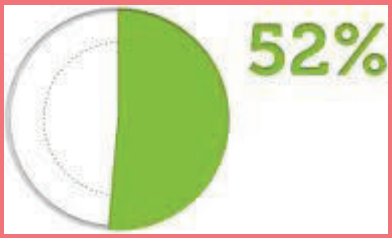
These are the people we do know about:	
716 adults with a learning disability are registered with a GP	NHS
582 people use SEQOL's learning Disability service.	SEQOL care · health · support
And this is what we know about them:	
Most people that we know about are in residential care, but this is slowly changing to have more living in the community. Most people in residential care are living outside Swindon but Swindon Borough Council still looks after them.	
Most people use support when they do things in the community.	
Not many are in paid employment.	

It is really important to think about the person when planning services. We need to find out what the person is good at, what they like to do and what they would like to do. This is called “Personalisation”.	
The things that happened at Winterbourne View have shown how important it is to make people’s lives better.	
We have found that people who provide services want to make them better.	
When we plan how to help people with a learning disability we think about four things that were suggested by Valuing People Now (2009).	

The ideas from Valuing people now that help us plan:	
Human rights	
Encouraging people to be independent	
Letting people make choices about their own life.	
People being included in the community	

Health and inequalities for people with learning disabilities	
People with a learning disability have the right to be treated with dignity and respect. This does not always happen.	
People with a learning disability	
Can be left out of their communities	
Have a shorter life expectancy	
Are more likely to have health conditions that are less likely to be treated.	

Are more likely to have mental health problems	
Will find it difficult to access services if they are from black and minority ethnic (BME) communities.	
Are less likely to be employed: of the people we know about, for every 25 people, only 1 is employed. This is low compared to other towns.	
Have a higher chance of losing custody of their child through care proceedings: we can improve the way we work together to give parents and children better chances.	
Are more likely to be victims of hate crime and they are less likely to report crime to the police.	

Health care: what is happening in Swindon?	
Learning Disability Health checks are a good way to find out what health needs people have.	
If health problems are found then they can be treated.	
In 2011/12 the number of people who had a learning disability health check increased to just over half. This is not as high as other areas.	
Where possible, hospitals need to change their services to make sure people with learning disabilities can use them.	
The first step is to know that a patient has a learning disability. They need to keep a record of this on their file. There are problems with this system which needs to be sorted out.	

Social Care: what is happening in Swindon?	
Most people that we know about are in residential care, but this is slowly changing to have more living in the community. Most people in residential care are living outside Swindon but Swindon Borough Council still looks after them.	
There are fewer people going into residential care for the first time. But people who are already in residential care normally stay there because they are used to it. More work is needed to help people decide if this is the right option for them.	
About half of Swindon's money for adult learning disability social care was spent on residential care. Swindon spends more than similar towns in the UK on residential care.	
We know reviews are important but fewer people are getting them on time. Other parts of the UK are doing better at this.	
In Swindon there needs to be a range of good quality schemes available. This needs housing and adult social services to work together.	

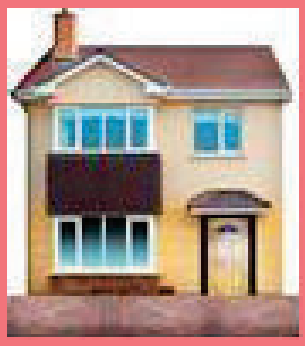
Computer software that makes things easier for people with learning disabilities is not being used much in Swindon. It needs to be used more to support independent living.	
Carer's assessments are being carried out. This will help us plan support for them.	
Transition from Children's to Adult services Is being looked at. Not all children go on to use adult services. This means we don't know how many people need help and this makes it difficult to plan services.	

What will the future be like?			
Now		**The future**	
The number of people in Swindon is growing.		The number of people in Swindon will continue to grow. This means there will be more people with a Learning Disability	
At the moment we have a lot of young people – more than most towns.		The number of older people will grow.	
Swindon has a lot of people in residential care but the number is falling.		More people living in the community	

What do local people think?	
Before we wrote this report we talked to a group of people with a learning disability. The following organisations have also been asking people what they think:	
Learning Disability Partnership Board	
Swindon Advocacy Movement	sam Swindon Advocacy Movement
Swindon Carer's Centre	SWINDON Carers Centre
Open Door	THE OPEN DOOR CENTRE (Swindon & District) LTD PASSIONATE ABOUT PEOPLE

Some of the things that came up were:	
People want to live independently. They want to do this with the support that is right for them. But first they need to learn skills so that they can manage well.	
There are examples of housing which works well However there needs to be more choice that suit people.	
More help is needed to get into and stay in employment.	
Quick access to services can help prevent problems getting worse.	

People have found health checks are useful.	
Users of Open Door said that the service was really important to them.	THE OPEN DOOR CENTRE (Swindon & District) LTD PASSIONATE ABOUT PEOPLE.
Carers need better support – this is really important for older carers.	

Swindon's 'to do' list:	
There are lots of things we could focus on. The people involved have decided these are the most important:	
1. First we need a plan. This will help us do the other things on this list. The plan will involve different organisations that want to make things better for adults with a learning disability.	
2. We have to make sure that we update the way social care is provided. We have to make sure our services are about the person and give them control over the support they get. Cut the number of people in residential and nursing care. Make sure people have control over where they live. Provide housing options that suit people.	 

Enable people to use personal budgets in the way that they want to. To do this there might have to be new services in Swindon.

Use support to help support people to stay in their own homes.

Better understanding of carers needs - leading to better support.

More person-centred reviews that are on time.

Be aware of people's needs if they come from other places.

3. Get people excited about employment.

Give more options and support.

Give good access to organisations that help people get jobs

Swindon College

Improve services for young people going into adult services (transition).

Use computers to share information:

- Young people's goals.
- What they expect to happen.
- What actually happens.

5. Get even more people to have Health Checks	
6. Make sure people with a learning disability can access health care services.	
7. Help these organisations to work together: Avon and Wiltshire Mental Health Partnership NHS Trust and Community Teams.	Avon and Wiltshire NHS Mental Health Partnership NHS Trust

8. Enable parents with learning disabilities and their children to have better lives: find ways that Children and Adult Social Services can work together	
9. Use computer software to help people with learning disabilities plan their services.	
10. To work with One Swindon to improve employment opportunities for people with learning disabilities.	One Swindon Partnership
11. Winterbourne View recommendations – make sure we put them into place in Swindon.	

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Healthy Weight Strategy

Health and Wellbeing Board **Date: 11th September 2013**

Author: Acting Director of Public Health
Wards: All
Locality Affected: All
Parishes Affected: All

1. Purpose and Reasons

1.1 To inform the Health and Wellbeing Board (HWB) about the Healthy Weight Strategy which has been refreshed and extended to cover the period 2013-2015.

1.2 Swindon Borough Council, local NHS partners and other key stakeholders across Swindon have an ambition to reduce child and adult obesity in order to improve health and wellbeing, reduce costs to social services and the NHS, and support a growth in the local economy. This updated strategy is part of the process of working towards this ambition.

1.3 Targets on the proportion of children aged 4-5 and 10-11 years who are overweight or obese are part of the national Public Health Outcomes Framework.

2. Recommendations

The Board is recommended to:

2.1 Recommend to Cabinet and the Governing Body of Swindon Clinical Commissioning Group that they approve the Healthy Weight Strategy for 2013-2015

2.2 Raise awareness of the importance of achieving and maintaining a healthy weight within their individual organisations

2.3 Acknowledge the current action plan and activity underway to achieve the aims of the strategy.

3. Detail

What is obesity?

3.1 Being overweight or obese is caused by an energy imbalance between what we eat and what we do. Healthy eating and physical activity go hand in hand to achieve a healthy weight.

3.2 Weight is often classified using the Body Mass Index (BMI), which calculates the amount of excess body fat in relation to a person's height. For adults, underweight is defined as a BMI of less than 18.5; overweight is defined as a BMI of over 25; and obesity is defined by a BMI over 30. Presently there is debate about the definition of childhood obesity and the best way to measure it in

Further information on the subject of this report can be obtained from Fiona Dickens, 01793 444680, fdickens@swindon.gov.uk. or Penny Marno pmarno@swindon.gov.uk

England. For public health programmes, such as the National Child measurement programme NCMP and the Health Survey for England, the British 1990 growth reference (UK90) charts are used.

Background

3.3 An obesity strategy was first published in Swindon in 2004 in response to guidance from the NHS (National Service Frameworks for Coronary Heart Disease (2001) and Diabetes (2002), and the NHS Cancer Plan (2000) and a Chief Medical Officers Annual report in 2002. These highlighted obesity as an important risk factor for a number of chronic medical conditions and premature death in adults. The Chief Medical Officers report recommended a co-ordinated and comprehensive response from health and local authority services and across government, together with the co-operation of the food, sports and leisure industries to tackle the problem.

3.4 Since the development of an obesity strategy in Swindon and in other areas across England, obesity prevalence has plateaued for children and adults. Obesity rates are still considered to be too high in adults and children and we are aiming to reduce the prevalence in Swindon.

Healthy Weight Strategy

3.5 The Healthy Weight Strategy outlines:

3.5.1 the causes of obesity, which is due to an energy imbalance between what we eat and how active we are

3.5.2 the evidence as to whether certain groups are more at risk of becoming overweight

3.5.3 the consequences of obesity: it can increase both the likelihood of some chronic diseases such as type 2 diabetes and premature death. It can also increase risk during pregnancy.

3.5.4 the national and local context both in terms of the prevalence of overweight and obesity and initiatives that are underway to address this.

3.6 Data from the National Child Measurement Programme for the 2011/12 school year for Swindon shows:

3.6.1 24.0% of 4-5 year olds were overweight or obese, with 9.9% obese

3.6.2 35.9% of 10-11 year olds were overweight or obese, with 19.2% obese

3.7 The strategy sets out a vision and rationale for co-ordinated multi- agency action to achieve a healthy weight in Swindon, identifying where integration of other strategies is necessary. An integral part of achieving the vision is delivery of the

Active Swindon Strategy. Moving forward the focus will be on encouraging people in Swindon to achieve a healthy lifestyle recognising the interaction between what we eat, how active we are, whether we smoke and drink. Services will be co-ordinated to promote and signpost other initiatives to support people more holistically.

3.8 The aim of the strategy is to encourage people in Swindon to reduce obesity and maintain a healthy weight creating:

- an environment that encourages people to live active and healthy lives
- an ethos of taking responsibility for the health of yourself and your family with support when needed
- communities where a healthy lifestyle is seen as desirable and the norm
- an understanding of what works most effectively at an individual, community and population level by including effective evaluation and learning from others.

3.9 There are 4 key objectives:

3.9.1 To deliver a range of evidence based policies and programmes across different settings that reflect the needs of people at different points in the life course to:

- develop a less obesogenic environment
- prevent obesity
- manage obesity

3.9.2 To link to other strategies such as Active Swindon, Children and Young People's Plan, and One Swindon

3.9.3 To tackle the inequalities in health outcomes in relation to obesity by targeting services appropriately

3.9.4 To monitor progress related to targets as part of an on-going action plan to ensure activity and investment is effective and meeting local need.

3.10 The Healthy Weight strategy for Swindon will complement and add to those population interventions developed by the Department of Health such as Change4Life, as well as implementing national initiatives locally where appropriate. As well as targeting different stages of life, activity for Swindon will also:

- be targeted via a range of different settings
- ensure that all levels of need are met via pathways to care
- focus on prevention as well as diagnosis and treatment

- reflect the whole community including those with physical or learning disabilities
- link to other strategies to ensure working stronger together applies to achieving healthy weight in Swindon

3.11 The strategy will be delivered via partnership working and engaging with local communities. Local initiatives will also be monitored and evaluated for effectiveness.

Consultation Process

3.12 The consultation process on the draft strategy ran from March to July 2013. Consultation events were held with both stakeholders and members of the public. A draft version was widely circulated for comment, and the Swindon Children's Trust Board, Swindon Youth Forum and Great Western Hospital all considered it at appropriate meetings. The consultation questions were:

- What is important for people to achieve and maintain a healthy weight?
- What should the vision be for Swindon?
- What is currently going on that's not included in the strategy?
- What should we stop doing?
- How can we best link to other strategies and initiatives?
- What activity will have the greatest impact on obesity to achieve a step change?

3.13 Feedback from the consultation process is summarised in the Healthy Weight Strategy - Appendix three.

4. Alternative Options

4.1 Not to support the Healthy Weight Strategy for Swindon

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 There are no direct financial or procurement implications arising from development of the strategy. Planned work as outlined in the action plan is covered by existing budgets or will go through appropriate Swindon Borough Council approval processes. The current public health grant allocation funding which covers both child and adults weight management programmes, NCMP, physical activity programmes, healthy schools and other initiatives as outlined in the strategy is £330,500.

5.2 Any service reviews or service requirements as a result of this strategy will be reviewed and a business case developed accordingly.

Legal and Human Rights Implications

5.3 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.4 There are implications for improving health and wellbeing, as a result of implementing the strategy through reduced levels of obesity, increased levels of physical activity, healthy eating and nutritional quality of people's diet.

5.5 There are positive implications for sustainability through increased uptake of active modes of travel (linking with the Local Transport Plans).

5.6 There should be no significant staffing or other implications arising from this report

Links to One Swindon, Strategic Objectives, Plans and Policies

5.7 This links directly to the One Swindon priorities of 'Everyone is enjoying sports, leisure and cultural opportunities and, 'living independently, protected from harm, leading healthy lives and making a positive contribution.

5.8 It also will help deliver the corporate priorities of 'Together, find new ways to reduce vulnerability and improve health for all' and 'Work with people and families to help them fulfil their potential'. The latter is particularly pertinent as obesity can lead to bullying, social isolation and further health problems and supporting people to achieve and maintain a healthy weight can significantly improve quality of life.

Diversity Impact Assessment

5.9 The strategy includes a diversity impact assessment. No adverse or significant issues were found.

Risk Management

5.10 No specific risks have been identified at this stage for this report, however not addressing issues around the potential increase in levels of obesity is likely to have a negative impact on health outcome.

6. Consultees

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

Further information on the subject of this report can be obtained from Fiona Dickens, 01793 444680, fdickens@swindon.gov.uk. or Penny Marno pmarno@swindon.gov.uk

7. Background Papers

7.1 None

8. Appendices

1. Healthy Weight Strategy 2013-2015 (as pdf attachment)
2. Summary of Action Plan

Further information on the subject of this report can be obtained from Fiona Dickens, 01793 444680, fdickens@swindon.gov.uk. or Penny Marno pmarno@swindon.gov.uk

ONE SWINDON HEALTHY WEIGHT STRATEGY 2013 - 2015

August 2013

Stronger Together
DRAFT

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Foreword

Obesity is a national health problem which costs the NHS in Swindon £31million a year, increases costs to social services and has a negative impact on the local economy. It is caused by an energy imbalance between what we eat and what we do. Overweight and obesity affects children and adults; in Swindon one in ten 4-5 year olds and one in five 10-11 year olds are obese. Being overweight or obese can affect people's ability to make the most of their lives. It also increases the risk of illnesses such as stroke, heart disease, type 2 diabetes and dementia.

Learning about healthy eating is important from a young age to enable children to make the healthy choice the first choice when growing up. This strategy includes actions to both prevent people becoming overweight and to support people who need extra help in making healthy food choices and managing their weight. Working with partners who can contribute skills, knowledge and influence is key to achieving our strategy, together with talking to local people about what encourages them or makes it difficult to be a healthy weight. It is a healthy weight rather than an obesity strategy to capture what we are aiming to achieve in Swindon and recognises that weight can be an issue for anyone.

Achieving a healthy weight depends on factors in every part of life: the environment we live in, our workplace, school, social life and the people around us. In Swindon we want to build on the good work to date and the legacy of the Olympics to create an environment where people have the opportunity and are supported to be a healthy weight. We also know that these influences are not the same for everyone – the strategy is also about reducing inequalities and ensuring people living in particular parts of Swindon are not more likely to become ill than in other areas. Eating well and being physically active go hand in hand so this strategy should be read together with the Active Swindon Strategy which is about getting Swindon moving.

We are committed to making Swindon a great place to live, work and play. Obesity levels in Swindon are not increasing but nor are they going down. We need to work together to make eating healthily and being active a reality for everyone.

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Cherry Jones
Acting Director of Public Health
& Wellbeing

Swindon Borough Council

Brian Mattock
Deputy Leader of the Council
Cabinet Member for Health and Adult Social Care
Swindon Borough Council

1. Executive Summary

The vision

A Swindon where everyone achieves and maintains a healthy weight

The Aim

To encourage people in Swindon to reduce obesity and maintain a healthy weight creating:

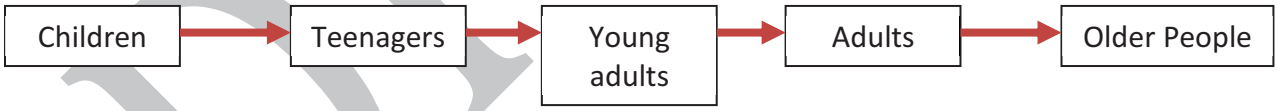
- an environment that encourages people to live active and healthy lives
- an ethos of taking responsibility for the health of yourself and your family with support when needed
- communities where a healthy lifestyle is seen as desirable and the norm
- an understanding of what works most effectively at an individual, community and population level by including effective evaluation and learning from others.

Being overweight is caused by an energy imbalance between what we eat and what we do. Healthy eating and physical activity go hand in hand to achieve a healthy weight. An integral part of achieving the vision is delivery of the Active Swindon Strategy.

Objectives

There are 4 key objectives:

1. To deliver a range of evidence based policies and programmes across different settings that reflect the needs of people at different points in the life course to:
   - develop a less obesogenic environment
   - prevent obesity
   - manage obesity



2. To link to other strategies such as Active Swindon, Children and Young People's Plan, and One Swindon

3. To tackle the inequalities in health outcomes in relation to obesity by targeting services appropriately

4. To monitor progress related to targets as part of an on-going action plan to ensure activity and investment is effective and meeting local need

Key targets

- Reducing obesity at age 11 years to the same level or less than the average for England (Source: National Child Measurement Programme (NCMP) data)

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- Increasing the number of people physically active to 25% by 2015 (Source: Active Peoples' Survey.)

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2. Introduction

Ensuring local people are encouraged to develop and maintain a healthy weight is a key part of the role of public health. Obesity is a significant problem in today's society and predicted to become worse if nothing is done. It is linked to a range of health problems particularly in later life which reduce life expectancy and reduce quality of life.

This strategy sets out a vision and rationale for co-ordinated multi- agency action to achieve a healthy weight in Swindon, identifying where integration of other strategies is necessary. Moving forward the focus will be on encouraging people in Swindon to achieve a healthy lifestyle recognising the interaction between what we eat, how active we are, whether we smoke and drink. Services will be co-ordinated to promote and signpost other initiatives to support people more holistically.

This healthy weight strategy sets a clear picture of the consequences of obesity and the current known prevalence, establishing it as a major public health issue.

The guiding principles of the strategy are to ensure that:

- Recommended actions are based on reliable up-to-date evidence, national guidelines and targets, and address health inequalities.
- Monitoring and evaluation is an integral part of all work.
- A multi-sectorial approach is used (involving the Local Authority, NHS, other public sector, voluntary sector and private business in partnership) in developing and implementing the action plans.
- The wider community are involved in development and implementation of the strategy, to ensure ownership.
- Local communities are empowered to make positive choices regarding physical activity and healthy eating, and address the barriers to weight loss and maintaining a healthy weight.
- It reflects the One Swindon vision and Corporate Strategy.
- Links to other local strategies, policies and targets which underpin the healthy weight strategy, are recognised e.g. Health and Wellbeing Strategy, Swindon Borough Council's transport strategy, Core Strategy and Development Management Policies.
- Awareness of the risks associated with obesity and the benefits of weight loss are raised, in order to create a culture of change e.g. increased risk of heart disease, stroke and type 2 diabetes.
- Needs are addressed, identifying and acknowledging cultural, religious and gender issues and those individuals at increased risk of obesity e.g. those who have stopped smoking; people in lower socio-economic groups, particularly women.
- Training and education is developed for all staff working in healthy lifestyle services so they provide consistent advice reflecting local and national best practice and are able to signpost across health services.

Much of the focus in terms of developing and maintaining a healthy weight tends to be on tackling obesity. However for around 2% of adults gaining weight is important as they are underweight according to the Health Survey for England. The strategy recognises the importance of underweight as a public health issue but does not address it explicitly. There

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are other strategies and care pathways which specifically focus on issues around being underweight.

Defining healthy weight and overweight

Weight is often classified using the Body Mass Index (BMI), which calculates the amount of excess body fat in relation to a person's height[1, 2]. For adults, underweight is defined as a BMI of less than 18.5; overweight is defined as a BMI of over 25; and obesity is defined by a BMI over 30 (see table 1).

Table 1: Classification of underweight, overweight and obesity in adults

BMI (kg/m^2)	CLASSIFICATION
Less than 18.5	Underweight
18.5 to 24.9	Healthy weight
25 to 29.9	Overweight
30 to 34.9	Obesity I
35 to 39.9	Obesity II
40 or more	Obesity III

BMI does not take into account factors such as size of body frame, proportion of lean body mass, gender and age and is not a direct measure of underweight, overweight or obesity. However it is a fairly reliable indicator of body fatness for most people and is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems. Although it does not measure body fat directly it has been shown to correlate well to direct measures of body fat. If there is doubt about a person's health risk, additional assessments such as waist circumference, skinfold thickness, diet and physical activity can be carried out.

Presently there is debate about the definition of childhood obesity and the best way to measure it in England. For clinical practice the Royal College of Paediatrics and Child Health growth charts are recommended, which include BMI, for children aged 2-18 years (2012). For public health programmes, such as the NCMP and the Health Survey for England, the British 1990 growth reference (UK90) charts are used. Assessing the BMI of children is more complicated than for adults because a child's BMI changes as they mature. Growth patterns differ between boys and girls, so both the age and sex of a child needs to be taken into account when estimating BMI. Because the relationship between a child's BMI and the level of fatness changes over time, fixed thresholds such as those used for adults should not be applied to children as they would provide misleading findings. For these reasons a growth reference must be used.

Causes of Obesity

The fundamental cause of obesity is an imbalance between energy intake and expenditure, which is brought about by consuming more calories than are expended in daily life. It has been argued that obesity is a predictable response to an increasing sedentary environment with, in general, a wide availability of food[3].

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The relationship between energy intake and expenditure may be influenced by genetic, social, cultural, psychological, environmental and economic factors. It is likely that obesity is the result of a combination of factors including[3:]

- Lifestyles becoming increasingly sedentary. The number of hours spent watching television has increased and a more automated lifestyle (increased use of domestic appliances and the motor car, and more sedentary occupations) has reduced the amount of physical activity incorporated into daily life [4,5] .
- Alcohol is associated with increased risk of obesity as many people are not aware of the calories in alcoholic drinks and alcohol consumption can be linked to an increase in food intake[i].
- Children in particular are becoming less active with only 32% of boys and 24% of girls aged 2-15 years in England in 2008 meeting the Chief Medical Officer's recommendation of a minimum of 60 minutes of at least moderate intensity physical activity each day[6]. For girls this varied by age from 35% at aged 2 to 12% at aged 14.
- The UK diet has been changing significantly since the 1950s in terms of both the types and amount of food consumed. There is an increased availability of energy dense convenience foods and an increase in food eaten outside the home.
- The high energy density of many convenience foods (a typical fast food meal contains more than one and a half times as many calories as an average traditional British meal) means that people often unconsciously consume more calories than the body needs. Studies show that there is a tendency to overeat on high fat diets, a phenomenon called 'high-fat hyperphagia' or passive over-consumption of fat[3]. Consuming high sugar foods and drinks has been shown to have a similar effect. Another factor is that portion size is increasing. Evidence from several research studies shows that when faced with larger portions, people eat more[3].

There are a number of factors that seem to predispose an individual to obesity and certain groups are known to be more at risk of obesity than others.

- Obesity is more common in some minority ethnic groups and less common in others[7]. Women of black African, black Caribbean and Pakistani origin have marked higher obesity prevalence rates that those in the general population. Chinese women have significantly lower obesity prevalence rates. Men from minority ethnic groups have markedly lower obesity prevalence rates than those in the general population, with the exception of black Caribbean and Irish men where there was a higher incidence. These differences may be the consequence of genetic, cultural or socio-economic factors or more likely, some combination of all three[8].

- Obesity prevalence is greatest among those of low socio-economic status. The Health Survey for England shows that in 2011, the prevalence of obesity increased with increasing levels of deprivation for both men and women. 22% of men and 19% of women in the least deprived quintile were obese, rising to 25% and 30% respectively in the most deprived quintile. However, the pattern was reversed for the prevalence of overweight, which was highest among both men and women living in the least deprived areas[9].

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- There is little detailed evidence on whether people who are lesbian, gay, bisexual or transgender are more likely to be overweight or obese. However some studies show a higher prevalence of obesity amongst lesbians than heterosexual women[10]. Theories as to why this is include the impact of stress, different exercise patterns and childhood sexual abuse although this has not been widely researched.
- There is conflicting evidence connected to diet related to intake in low income groups. Studies in the USA have shown that those who live in low income neighbourhoods have less access to reasonably priced healthy food than in more affluent areas[3]. This poor diet may lead to obesity. However a low income diet and nutrition survey published in England by the Food Standards Agency in 2007 did not find any direct link between dietary patterns and incomes, food access or cooking skills[11].
- There is some national evidence[12] that the prevalence of obesity is increased amongst people who have a disability or limiting long term illness (LLTI), particularly with the four most prevalent disabling conditions in the UK: arthritis, back pain, mental health disorders and learning disabilities. This is thought to be due to reduced mobility, the effects of medication, and difficulties in accessing exercise opportunities. People with a learning disability are more likely to be underweight or obese than the general population[13], with an increased risk at a younger age and with some types of learning disability such as Downs Syndrome. People who suffer from both obesity and common mental health disorders may also face particular risks to health and well-being, as it is likely that the conditions may perpetuate each other[41]
- Analysis of NCMP data for Swindon showed that the prevalence of obesity was higher in schools located in the most deprived areas compared to those located in the least deprived areas. This is also reflected nationally[14].

Consequences of Obesity

Obesity is an important risk factor for known chronic medical conditions and premature death in adults. In addition to the physical consequences of obesity the psychological and social consequences of obesity are immense.[4] There is good evidence of an association between childhood obesity, chronic medical conditions and psychological consequences[15] (Table 2).

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Table 2: Physical, Psychological and Social Consequences of Obesity[4,15]

CONSEQUENCES	ADULTS	CHILDREN
PHYSICAL	Non-insulin dependent diabetes mellitus Raised blood cholesterol Coronary heart disease Stroke High blood pressure Osteoarthritis Gall bladder diseases Ovarian cancer, breast cancer and cancer of the colon Infertility Increased anaesthetic risk Respiratory disease and sleep apnoea Pregnancy complications Surgical complications Increase premature mortality Avoidance of physical activity	Type II diabetes mellitus Raised blood cholesterol Adverse changes in left ventricular mass Increased blood pressure Development of asthma and worsening of pre-existing asthma Abnormalities of foot structure Persistence into adulthood and predisposition to the medical problems of adulthood Early puberty onset Avoidance of physical activity
PSYCHOLOGICAL	Depression Guilt, anger, frustration and low self esteem Eating disorders	Low self esteem, and depression Disordered eating, bulimia, negative self image
SOCIAL	Stigma Breakdown in relationships Potential for altered health behaviours Discrimination Isolation Employment difficulties Days lost from work Lack of participation in sport	Poor school performance Bullying Can lead to poor school attendance Lack of participation in sport

Obesity significantly increases the risk of death at any age[16] however the risk of death is influenced by the individual level of physical activity with physically fit obese individuals having lower mortality risks than otherwise unfit obese individuals[17]. For young adults the risk of mortality for someone with a BMI of 30 is 50% higher than that of someone with a BMI in the normal range (20-25). For those with a BMI greater than 35 this risk is doubled[5].

Based on international literature it is estimated that women who are obese are 12.7 times more likely to develop type 2 diabetes and 1.3 times more likely to experience a stroke than

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non-obese women. Obese men whilst having the same increased risk for stroke as women, are 5.2 times more likely to develop type 2 diabetes[4] (Table 3).

Table 3: Estimated increased risk for the obese of developing associated diseases[4] compared to people of a 'healthy weight'

DISEASE	RELATIVE RISK* FOR WOMEN	RELATIVE RISK FOR MEN
Type 2 diabetes mellitus	12.7	5.2
Hypertension	4.2	2.6
Myocardial infarction	3.2	1.5
Cancer of the colon	2.7	3.0
Angina	1.8	1.8
Gall bladder diseases	1.8	1.8
Ovarian cancer	1.7	-
Osteoarthritis	1.4	1.9
Stroke	1.3	1.3

*relative risk is used to compare risk in 2 different groups of people

In Swindon according to Quality Outcome Frame work data 2011/12 recorded by GPs, there are 10302 people with diabetes (4.7% of patients registered) and 29866 people with hypertension (13.5% of patients registered).

In addition to the above risks, obesity increases clinical risks e.g.

- Obesity in pregnancy is associated with an increased risk of a number of serious adverse outcomes, including miscarriage, pre-eclampsia, postpartum haemorrhage, wound infections, stillbirth, maternal and neonatal death[41].
- Obesity increases risks of complications following surgery[42].

Economic Cost of Obesity

A 2010 report 'the Economic Burden of obesity' by the National Obesity Observatory drew together literature highlighting:

- in 2007 direct costs of obesity to the NHS were £4.2 billion
- obesity accounted for between 0.7% and 2.8% of a country's total healthcare expenditure, raising to 9.1% for overweight and obese
- in 2008 in England the average spending by a Hospital Trust on specialist equipment (e.g. larger beds, chairs, hoists) was £60,000
- obese individuals are estimated to have medical costs 30% higher than normal weight peers.

Further work is required to calculate the costs of obesity to Local Authorities e.g. to social services, the impact on the local economy and educational achievement.

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3. Where are we now?

National context

Policy Framework

In 2008 the Department of Health published the national strategy 'Healthy Weight, Healthy Lives' followed by:

- Guidance for local areas[7]
- A toolkit for developing local strategies[8]
- Commissioning weight management services for children and young people[9]

In 2011 the Department of Health published 'Healthy Lives, Healthy People: a call to action on obesity in England which:

- Focused on a whole population approach to reducing obesity which covers all life stages
- Included plans to measure adults as well as child obesity to encourage a more outcomes based approach

This included two national ambitions:

- A sustained downward trend in the level of excess weight in children by 2020
- A downward trend in the level of excess weight averaged across all adults by 2020

It also outlines a role for local government including:

- Promoting active travel
- Ensuring widest possible access to opportunities to be physically active
- Making the most of the potential for the planning system to create a healthier built environment
- Working with local businesses and partners to increase access to healthy and affordable food choices
- Linking activities on healthy weight to initiatives relating to the environment and sustainability
- Making the most of key opportunities to engage with communities and promote behaviour change

This is underpinned by the role of the Health and Wellbeing boards which have a statutory responsibility to develop and implement a health and wellbeing strategy by bringing together key partners and understanding the needs of the local area. NICE Guidance published in November 2012 included an expectation that Directors of Public Health would secure high level commitment as part of the Health and Wellbeing Strategy to long-term integrated action on obesity.

Prevalence of Obesity

Adult obesity in the UK has more than doubled over the last 25 years; 24% of men and 26% of women were obese in 2011[21] (most recent figures) whereas 8% of men and 12% of women were obese in 1986/87[22]. Chart 1 shows the trend since 1993 (however it does not

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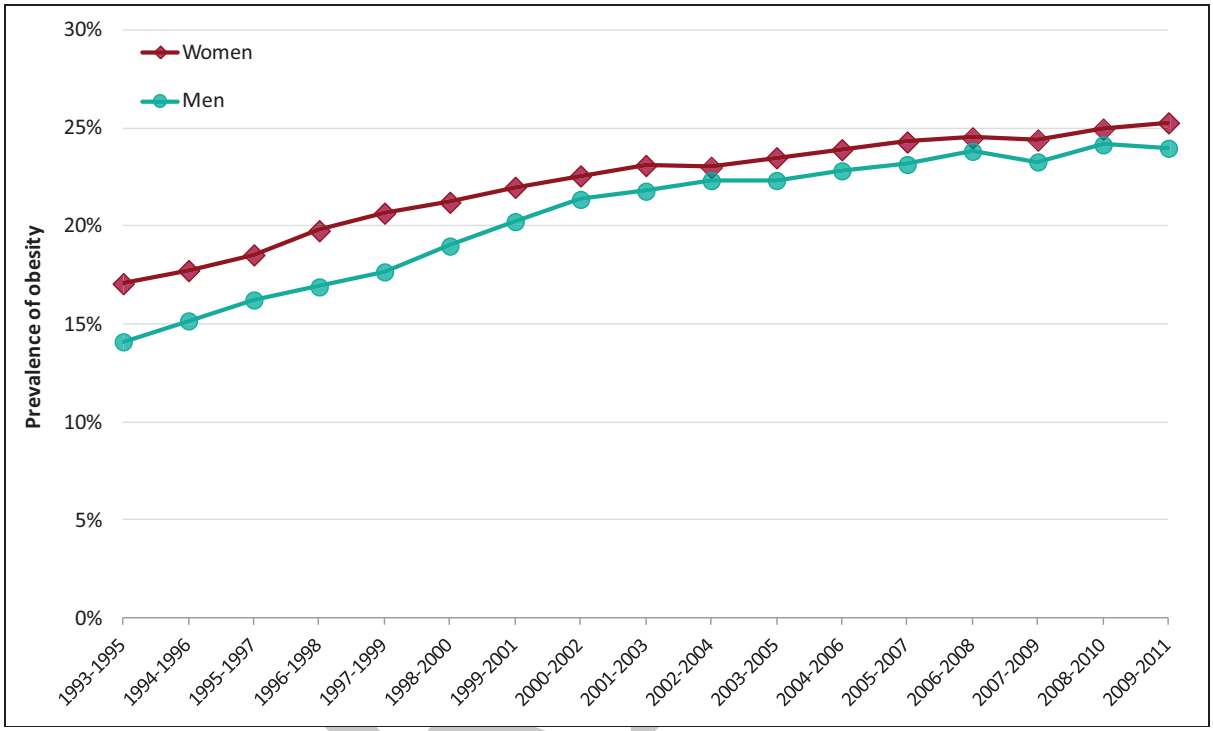
include the 1986/87 figure as it was a separate survey although done using the same methods). Obesity is also an increasing problem in children. Between 1995 and 2010 the proportion of obese children (aged 2-15 years) increased from 10.9% to 16.6% in boys and from 12.0% to 15.9% % in girls. Whilst the proportion of children who are obese has increased notably over the last 15 years, the prevalence of overweight children aged 2 to 15 has remained fairly constant[23].

Chart 1: Prevalence of obesity amongst adults[24]: (Health Survey for England 1993-2011 BMI >=30kg/m2 (3 year average))



National Interventions

There are a number of Government strategies and programmes that will impact achievement and maintenance of a healthy weight.

- **Change4life[25]** was launched in 2009 in England and is a Government backed, phased campaign aiming to prevent obesity. The initial phase was a social marketing campaign targeting young families to 'Eat Well, Move More and Live Longer'. It is now extended to include all adults and children and provides a range of resources to encourage healthy living. Evaluation[26] of the first year found that families were making changes to their children's diet or activity levels but further work was required to assess whether this led to reductions in obesity. Campaigns in 2012 included promoting quick and healthy meals on a budget and Games4Life building on the interest from the Olympics. Campaigns for 2013 included 'Get Going this Summer' promoting physical activity for adults and children and 'Back to School' to encourage and support parents to make a positive change to their family's routine

- **Every Child Matters** (2003) was an approach to the wellbeing of children and young people from birth to age 19 years[27] set out by the Labour Government. The aim was for every child, whatever their background or their circumstances, to have the support they

need to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing. Whilst this was broadly supported by the coalition, there has not been explicit development of the strategy.

- **Healthy Lives, Healthy People: A call to action on obesity** (2011) is the national strategy for improving English public health, in response to future challenges including obesity. It includes:
    - Local government taking new responsibilities for public health (including obesity and nutrition initiatives), supported by Public Health England
    - A stronger focus on outcomes
    - A commitment to reduce health inequalities

- **The Healthy Start Scheme,** which replaced the Welfare Food Scheme[28]. It allows eligible pregnant women, mothers and young children to get free vitamins and free weekly vouchers to exchange for milk, fresh fruit, vegetables and infant formula. From April 2013, it will be the responsibility of the new commissioning bodies (NHS Commissioning Board, Clinical Commissioning Groups, and where Local Authorities provide child health clinics) to arrange the provision of Healthy Start vitamins.

- **Sure Start** is a government programme to deliver the best start in life for every child focussing on disadvantaged areas[29]. Information and guidance on breastfeeding and nutrition are offered on the programme which is delivered via the Sure Start Children's Centres.

- The **Healthy Schools Programme** is delivered at local level and supported by a Healthy Schools Toolkit developed by the Department of Health. It was originally a national programme focusing on food and physical activity. Implementation and monitoring is on a 'schools led' basis.

- In 2011 the 4 Chief Medical Officers in the UK launched **new physical activity guidelines[30]**:
    - *Under-fives*
      180 minutes – (three hours) – each day, once a child is able to walk.
      Children and young people (5-18 year olds)
      60 minutes and up to several hours every day of moderate to vigorous intensity physical activity.
    - *Adults (19-64 years old) and older people (65+)*
      150 minutes – (two and half hours) – each week of moderate to vigorous intensity physical activity (and adults should aim to do some physical activity every day).

- **School meals**- New compulsory nutrient based standards and new food based standards were introduced in September 2008 in primary schools and in September 2009 in secondary schools. Food based standards for 'food other than lunch' (e.g. tuck shops and vending machines) were introduced in September 2007. Together these new standards cover all food and drink sold or served in schools[31] to ensure that children have a healthy balanced diet. This means there must be high-quality meat, poultry or oily fish, at least 2 portions of fruit and vegetables with every meal and bread, other cereals and potatoes[32]. Academy schools are exempt from the standards although some do choose to follow them.

- **5ADAY Programme**[33]-Current recommendations are that everyone should eat at least 5 portions of a variety fruit and vegetables each day, to reduce the risk of deaths from chronic diseases such as heart disease, stroke, and cancer by up to 20%[34]. The National School Fruit and Vegetable Scheme is part of the 5ADAY programme to increase fruit and vegetable consumption, offering every child at a fully state funded infant, primary or special school a free piece of fruit or vegetable on every school day.

- The Government has developed a set of **Eight Guidelines for a Healthy Diet**[35]. It aims to help people to understand and enjoy healthy eating. The guidelines are supported by the Eatwell plate, a pictorial food guide showing the proportion and types of food that are needed to make up a healthy balanced diet.

- **Choosing Better Oral Health**: an oral health plan for England (2005) highlighted that the majority of the English population consumes more sugar than the recommended 60g per day[36]. There are particular concerns over the high level of the consumption of soft drinks, confectionery and biscuits among pre-school children, adolescents and older people as well as people living in areas of material and social deprivation. Some of the foods we associate with a modern diet such as fruit, fruit teas, wine and soft drinks contain acids that can lead to acid erosion of the teeth. This is defined as loss of tooth substance caused by the direct action of chemicals on the tooth surface. It is particularly vulnerable to erosion by soft drinks including carbonated and fruit based ones, and may affect up to 25% of children with deciduous teeth. General advice is to keep food and drink that contains sugar to no more than four times in a day.

- In 2009 **Delivering Better Oral Health: a toolkit for prevention** set out the evidence base and clear guidance on healthy eating advice, toothbrushing, fluoride and the importance of regularly attending the dentist. A new version is expected in September 2013.

- **The Local Transport Plan**[37] is a statutory requirement for every local authority with a responsibility for transport. It must set out the transport objectives that the Council wants to achieve over the next five years, and the types of schemes, which the Council would like to implement. These schemes will include measures to assist walking, cycling and public transport use.

Local context

Overview of Swindon

Swindon is a new and growing town with a higher proportion of the population of working age than in England as a whole. Swindon's population is forecast to rise by about 5% by 2015 and about 15% by 2022 from around 201,000 in 2010 to 232,000 in 2022[38].

Broadly speaking, the main shift will be to a more 'middle-aged' and older population. It is estimated that the number of people aged 65+ years will increase by 34.0%, and the number of people aged 85+ by 59% by 2022.

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2011 Census data for Swindon shows 84.6% were white British, 6.4% Asian / Asian British and 1.4% Black/African/Caribbean/Black British. In addition, 0.9% consider themselves to be Irish, 0.1% are from traveller communities and 4.2% other white which includes Eastern European.

Implication of population changes for supporting increasing physical activity and eating a healthy diet are important as people's expectations and requirements change as they age. The take up of different activities can also reflect cultural strengths and barriers to participation e.g. swimming has very low uptake by Asian women.

There are extremes of poverty and wealth in the borough, and deprivation can have an impact on reducing participation rates for physical activity or affecting type of diet eaten. Of the 119 Super Output Areas' in the Swindon Unitary Authority area in 2010:

- 18 are among the most deprived 20% nationally overall,
- 1 is within the most deprived 5% nationally
- 28 are among the most deprived 20% nationally for education, skills and training,

Within life expectancy figures there are major variations with those in the lowest quintile for social deprivation in Swindon having a life expectancy of more than 5 years less than those from the highest quintile (75.7 years in Parks compared with 82.6 years in Covingham-Nythe). The Slope Index of Inequality data for 2006-08 shows that life expectancy is 8.8 years lower for men and 5.8 years lower for women in the most deprived areas of Swindon than in the least deprived areas.

Health inequalities in Swindon are focused in a small number of localities. These localities are also poor performers in relation to economic indicators and have poor educational attainment.

The impact of local demographic characteristics and changes will mean that there will be:

- increased demand for services to prevent and treat obesity due to a growing population and an increase in obesity over time in both adults and children
- a need for targeting services to tackle obesity in the most deprived communities, where obesity prevalence is highest in the population and people have less choices to improve their health.
- development of services to meet the needs of communities and groups where obesity prevalence is particularly high such as learning disability groups, certain BME communities and deprived communities.

Prevalence of Obesity

Measuring adult obesity on a population basis is very costly for local areas, therefore it is not carried out at present. Adult obesity prevalence data from synthetic estimates by the Department of Health and Association of Public Health Observatories (with interpretation by the South West Public Health Observatory[20]) predict that Swindon's prevalence of adult obesity is higher than the England average (27% compared to 24.2%).

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One of the Quality Outcome Framework (QOF) indicators for GPs is that each practice can produce a register of patients aged 16 and over with a BMI of greater than or equal to 30 in the previous 15 months: across Swindon in 2011/12 20,389 people were on the register, 9.2% of the total practice population. This underestimates adult obesity as obesity is not systematically measured in GP practices in all patients when they visit as it is not necessarily relevant to their care.

The 2011/12 NCMP results show that in Swindon the prevalence of obesity in 4 to 5 year olds is 9.9% and in 10 to 11 year olds is 19.2%.

Table 4: % of children identified as obese by NCMP[39]

	Reception Year (aged 4-5)		Year 6 (aged 10-11)	
Year	Swindon	England	Swindon	England
2005/06	11.0%	10.0%	19.1%	17.3%
2006/07	9.8%	9.9%	17.4%	17.5%
2007/08	9.1%	9.6%	19.1%	18.3%
2008/09	9.5%	9.6%	16.5%	18.3%
2009/10	9.4%	9.8%	16.7%	18.7%
2010/11	8.6%	9.4%	17.3%	19.0%
2011/12	9.9%	9.5%	19.2%	19.2%

Chart 2 shows the trend in obesity over time for Reception Year children. The confidence intervals on the columns take account of the fact that the data is from a sample of children each year and because they overlap year on year for Swindon this indicates there is no significant change year to year.

Chart 2: NCMP recorded levels of Child Obesity by year

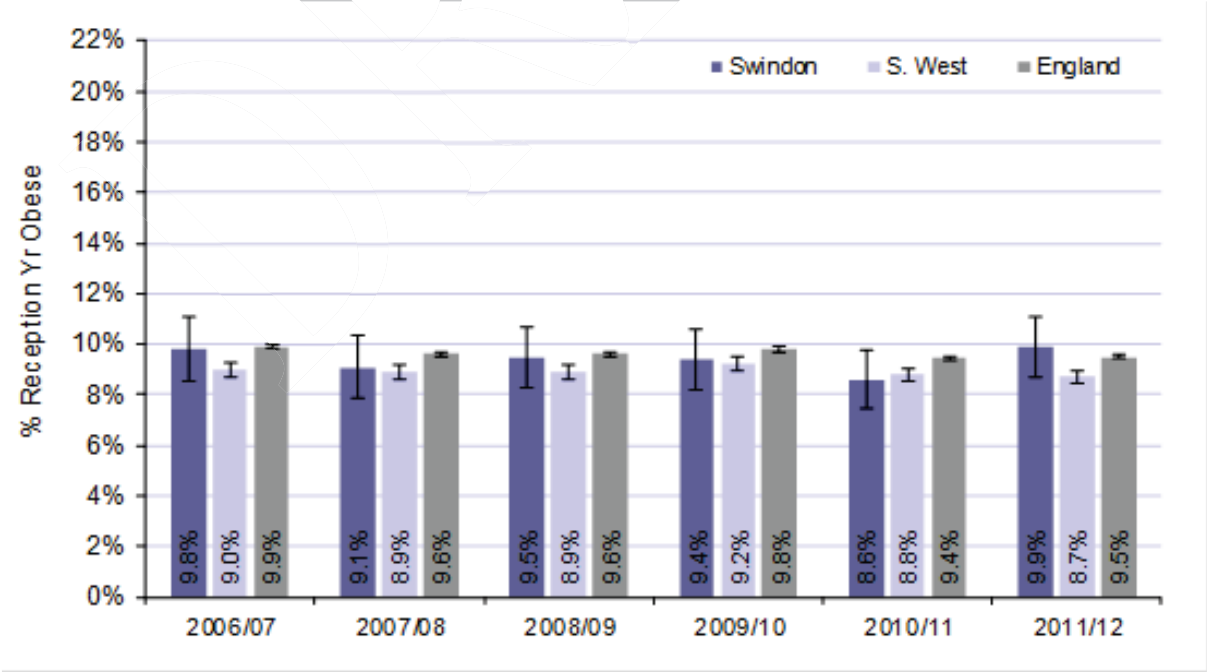
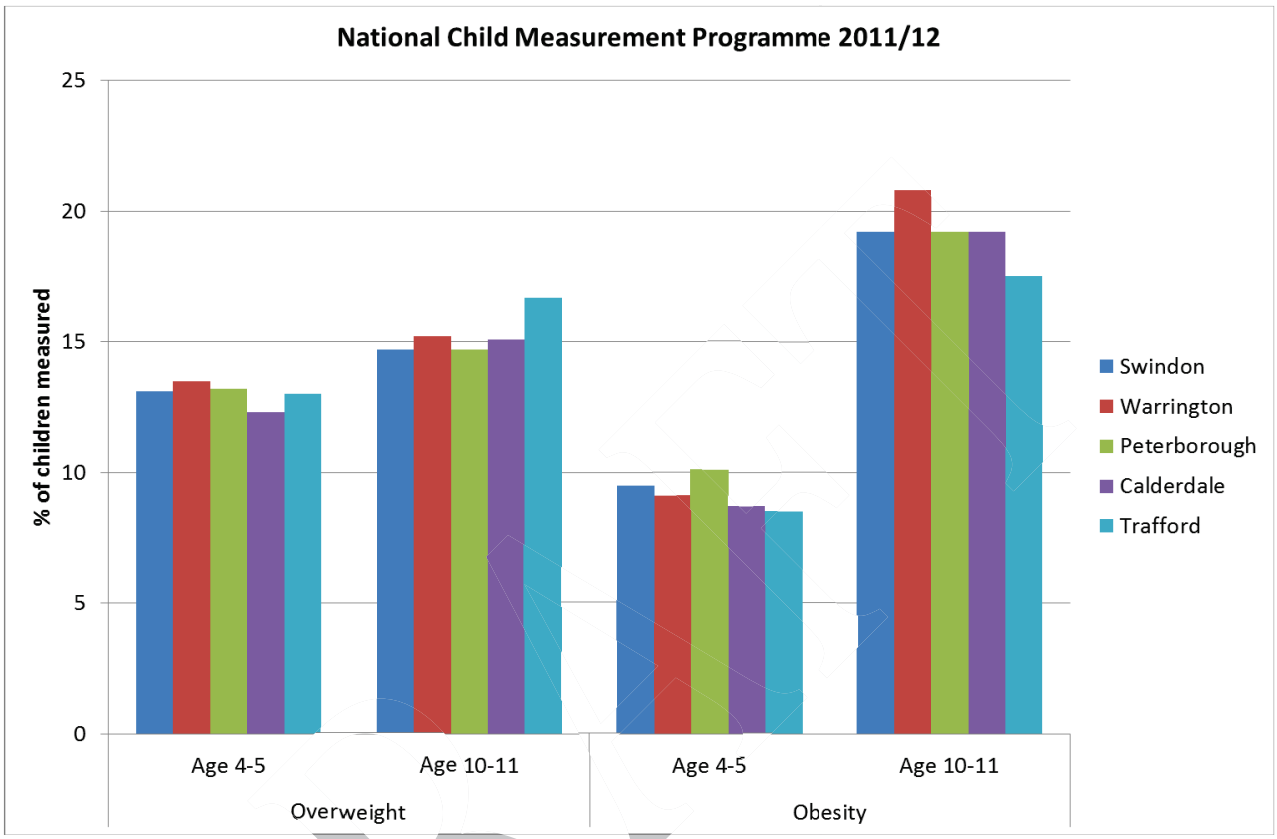


Chart 3 compares Swindon to its nearest neighbours based on a range of social and environmental factors. These are a more accurate comparison than say other areas in the south west which may be socially or demographically very different to Swindon.

Chart 3: NCMP recorded levels of childhood overweight and obesity for Swindon and comparator areas



The national dental survey[40] measures the proportion of children with teeth which are missing, decayed or filled. For Swindon in 2008/9, 28.1% of 12 year old children had some sort of decay experience (with one or more obviously decayed, missing (due to decay) and/or filled teeth). For 5 year olds (latest survey is 2007/08) this was 30.6%. Both are based on a sample of children.

Local Interventions

In Swindon interventions include both local implementation of national interventions and local activity specific to the needs of the borough. Table 5 highlights the national interventions we are implementing and Table 6 the breadth of local interventions by age groups and setting.

Table 5: Local activity on National Initiatives

	Local activity
Change4Life	Implemented locally
Every Child Matters	Informs both health and local authority strategies
Healthy Lives Healthy People: a call to action on obesity	Informs overall development of Healthy Weight Strategy
Healthy Start / Sure Start	As well as services provided by health visitors, Swindon also has a Healthy Steps programme which focus on early years. The Breastfeeding Initiative is also implemented locally.
Healthy Schools Programme	Implemented locally. Schools can also bid for funding from Public Health to support 'Healthy Weight' projects. 12 schools received funding in 2012/13 and there were 20 applications in 2013/14.
School Meals	Schools are encouraged to follow national criteria i.e. food and nutrient based standards for school meals and 'food other than lunch' standards, through the Swindon Healthy School programme. The national Food for Life Partnership programme is also promoted through the Swindon Healthy Schools programme- (www.foodforlife.org.uk/)
5ADAY Programme	All children aged 4-6 are given a piece of fruit every day.
Choosing Better Oral Health	Work has included the Happy Little Teeth Award scheme for children and nurseries and working with dentists to ensure consistent messages Classroom based lessons are also offered to all key stage 2 and 3 children in every school in Swindon and Wiltshire.
Local Transport Plan	Public health worked with the local planning department to influence and inform the development of the Local Transport Plan

Table 6: Local Interventions by setting

SETTING	**Children and Teenagers**	**Adults and Older People**
Early Years	Breastfeeding Initiative Healthy Steps Happy Little Teeth Award scheme for playgroups and nurseries Children's centres programmes Health Visitors work on weaning and healthy lifestyle	
Schools	School Fruit and Vegetable Scheme Healthy Schools Programme School meals and school food - national food and nutrition standards NCMP Food for Life Partnership in schools Sportivate – Sport England Project Active travel to school initiatives	
Community	Child & Family Weight Management Programme Working together with dental health colleagues to ensure consistent messages on public health promotion Dental staff also work with children	Change 4 Life Physical Activity Programmes Dietbusters- adult weight management Ability sports Community Dietitian Clinics Exercise on referral schemes (Steps to Health)

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	centres, health visitors and nursery nurses in baby clinics and post natal groups. Swindon Youth Forum – creation of healthy eating DVD	Walking for Health Healthy Eating Basic Cookery Courses Exercise group for COPD Patients Development of an Obesity Pathway for Adults with a Learning Disability
Workplace		Swindon Mindful Employers scheme Great Western Hospital Travel Policy to encourage walking to work
Environment		Active Travel Promotion walking and cycling as part of built environment development in the Swindon Core Strategy Implementation of the Local Sustainable Transport Fund bid
Hospital	Underweight care pathway	Obesity Care Pathway Maternal Obesity Pathway Underweight Care Pathway Intense specialist weight management programme Pre and post bariatric surgery support service Access to bariatric surgery at Bristol, Cornwall, Plymouth, Gloucestershire , Bournemouth & Christchurch or Taunton

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4. Where do we want to be?

A Life course approach

Healthy Lives, Healthy People: A Call to Action on obesity in England (2011) advocates a lifecourse approach to tackling obesity. As table 9 illustrates there are different challenges to achieving a healthy weight depending on age and the stage of life people are at. There is also increasing understanding that poor nutrition at an early age can have long term consequences for health including increasing the risk of obesity and chronic disease.

Table 7: Challenges for achieving a healthy weight by lifecourse stage

Children	Teenagers	Young adults	Adults	Older People
Early years support - breastfeeding - maternal care - postnatal depression School support - preventing obesity - identifying underweight - working with parents	Concern over image: - opportunities for healthy eating - barrier to physical activity - power of peers - power of media	Maintaining a healthy and active lifestyle: - when leaving home - at university - financial constraints	Role as parents / carers Healthy eating Risk of chronic diseases Work-life balance	Maintaining good nutrition Issues around weight loss Encouraging active lifestyle Co-morbidities and long term conditions

The Healthy Weight strategy for Swindon will complement and add to those population interventions developed by the Department of Health such as Change4Life, as well as implementing national initiatives locally where appropriate. As well as targeting different stages of life, activity for Swindon will also:

- be targeted via a range of different settings
- ensure that all levels of need are met via pathways to care
- focus on prevention as well as diagnosis and treatment
- reflect the whole community including those with physical or learning disabilities
- link to other strategies to ensure working stronger together applies to achieving healthy weight in Swindon

Priorities for Action

The Health and Wellbeing strategy for Swindon has 5 outcomes:

- Every child and young person in Swindon has a healthy start in life
- Adults and older people in Swindon are living healthier and more independent lives
- Improved health outcomes for disadvantaged and vulnerable communities
- Improved mental health, wellbeing and resilience for all
- Creation of sustainable environments in which communities can flourish

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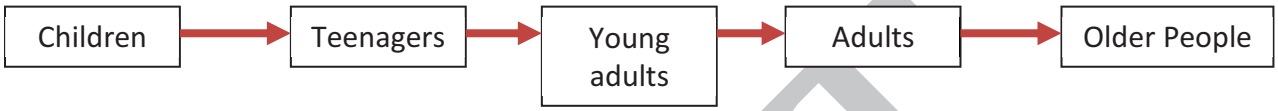
These address some of the key points across the life course and also prioritise addressing health inequalities. The objectives to address healthy weight in Swindon link and contribute to these outcomes.

Healthy Weight Objectives for 2013-2015 are:

- To deliver a range of evidence based policies and programmes across different settings that reflect the needs of people at different points in the life course to
  - Develop a less obesogenic environment
  - prevent obesity
  - manage obesity



- To link to other strategies such as Active Swindon, Children and Young People's Plan and One Swindon

- To tackle the inequalities in health outcomes in relation to obesity by targeting services appropriately

- To monitor progress related to targets as part of an on-going action plan to ensure activity and investment is effective and meeting local need

The Healthy Weight Strategy is closely linked to the Active Swindon Strategy which has the following aims:

- increase the physical activity levels in adults and young people
- create an environment that promotes physical activity as part of everyday life
- empower people to be more physically active
- increase the capacity to deliver physical activity and sport

National Targets

Within the Public Health Outcomes Framework (2012) there are 2 indicators explicitly related to overweight and obesity:

- Excess weight in 4-5 year olds
- Excess weight in 10-11 year olds

These are based on NCMP data and show Swindon as similar to the England average for 4-5 year olds (22.8% compared to 22.6%), and significantly lower than the England average for 10-11 year olds (31.2% compared to 33.4%). These will be measured annually.

There is also a measure in improving wider determinants of health on utilisation of outdoor space for exercise / health reasons. This is measured via the Natural England: Monitor of Engagement with the Natural Environment (MENE) survey which asks people whether they have taken a visit to the natural environment for health or exercise over the previous seven days.

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Local Targets

- Reducing obesity at age 11 years to the same level or less than the average for England (Source: NCMP data)

- Increasing the number of people physically active to 25% by 2015 (Source: Active Peoples' Survey)

The healthy weight strategy will also contribute to targets resulting from the Health & Wellbeing Strategy.

The strategy will be implemented through the healthy weight action plan. This outlines a framework for action that demonstrates a range of preventive and management interventions for obesity across a range of settings (community, workplaces, early years settings, local authority, and health), based upon evidence for effective interventions presented in the above strategy.

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5. How will we get there?

Working in Partnership

Tackling obesity and promoting healthy weight depends on action to address many different areas as health depends on physical, social and environmental factors. Therefore the obesity strategy will link to the range of local strategic documents which all contribute to preventing and reducing obesity and promoting healthy lifestyles:

- Active Swindon Strategy and Implementation Plan
- Swindon breastfeeding strategy and implementation plan
- Children and Young People's Plan
- Swindon Core Strategy
- Local Transport Plan
- Green Infrastructure Strategy
- Parks and Open Spaces Strategy
- Local NHS strategies on Cancer, Coronary Heart Disease, Diabetes
- Play Strategy
- Safer and Smarter Journeys to School Strategy
- Swindon Borough Councils Initiatives on Building Community Capacity and Corporate Responsibility
- Development Management Policies

Promoting healthy weight will also be a key part of workplace health initiatives and healthy lifestyle courses.

Engaging with Communities

In order to tackle obesity effectively, we need to engage with our local communities in all areas related to Healthy Weight, including developing strategies, commissioning and service provision, particularly those at higher risk of obesity. There are a number of opportunities for engagement. These include at local events and festivals, using local volunteers and champions from health programmes (e.g. walk to health volunteers and Health Ambassador Health champions) and local networks.

Monitoring and Evaluation

Evaluation is vital for understanding what works and why, and also for ensuring that funding is spent in the most cost-effective way. Evaluating interventions to tackle obesity can be

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challenging as short term success is not always sustained long term and following up people over time is difficult. Any commissioned initiatives are required to include evaluation as part of delivery.

A separate action plan is available which outlines service development, programmes and actions that need to be developed to meet local obesity related targets. The action plan is separate as it is a working document- available from Fiona Dickens, Public Health Programme Manager at Swindon Borough Council (Contact details: fdickens@swindon.gov.uk 01793 444680)

Communication

Communication is important in a number of ways:

- To provide consistent messages to local people about what is important for achieving and maintaining a healthy weight
- To link lifestyle services so people are aware of what is available in Swindon to keep active, stop smoking, improve their mental health as well as specifically about weight management
- To celebrate success.

The action plan will include a communications strategy which incorporates these aspects.

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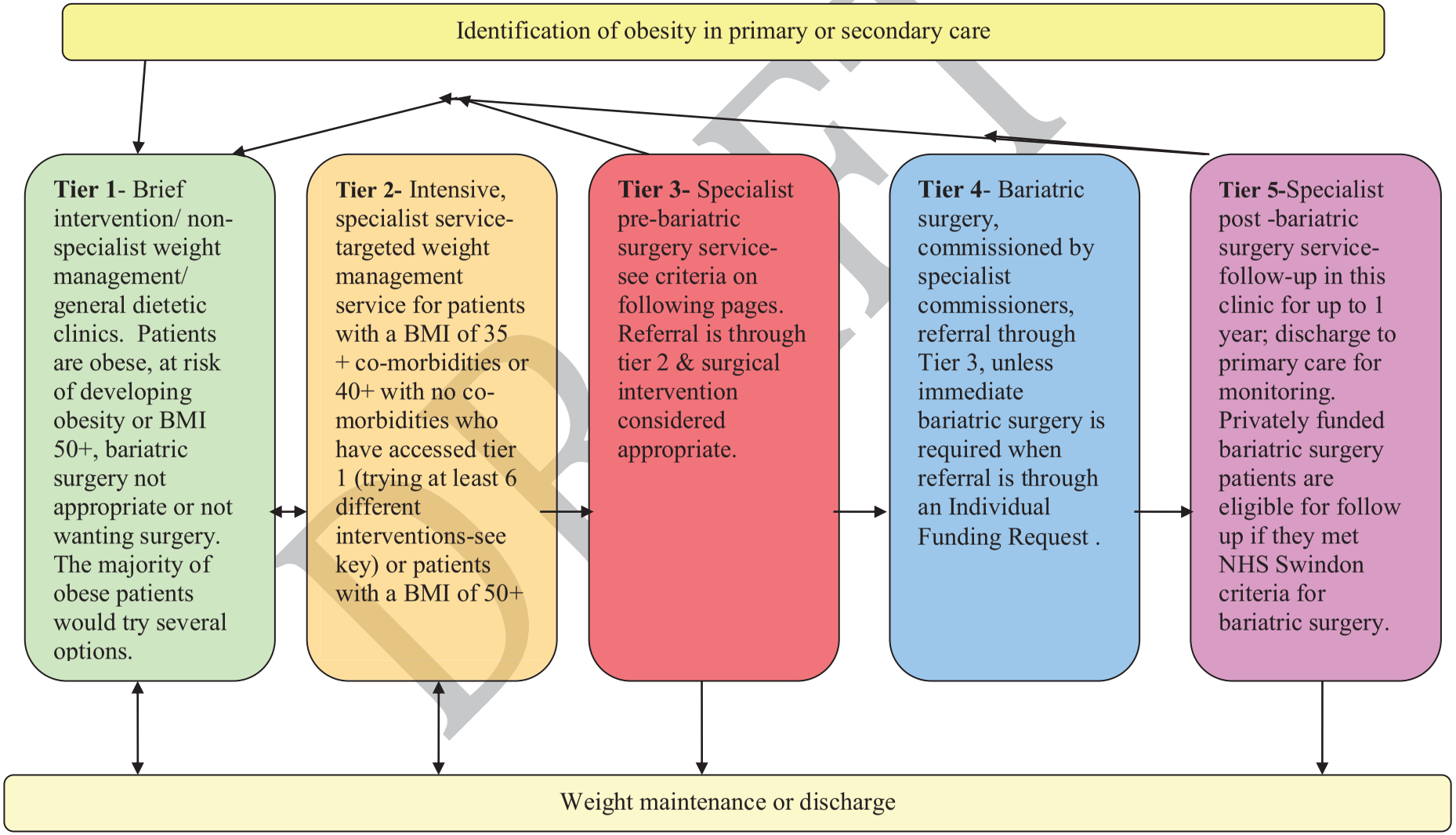
Appendix 1: Adult Healthy Weight Care pathway- Managing adult obesity in primary and secondary care in NHS Swindon (adults aged over 18 years): April 2012



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Appendix 2: Progress against Healthy Weight Strategy 2009-2011

Objective	*Milestones*	*Progress*
To establish a baseline of obesity levels in children and monitor progress related to targets	Information routinely uploaded to NCMP and quarterly performance reports produced.	*All met*

To deliver evidenced based programmes in a range of settings to prevent obesity with a focus on early years, breastfeeding support, training and embedding prevention in the work of health professionals	Milestones include raising awareness around obesity prevention for professionals and a range of projects and initiatives including delivery via Children's Centres, school based activity, active travel for schools, a breastfeeding action plan, and engagement with Swindon Youth Forum	• Breastfeeding- aiming to increase breastfeeding prevalence at 6-8 weeks through full Baby Friendly Initiative accreditation in the Great Western Hospital NHS Foundation Trust and Swindon Community. Great Western Hospital: Stage 2 Assessment, achieved May 2012. Now working towards stage 3 (final stage) - takes up to 1 year. Swindon Community: Stage 1 assessment passed March 2012. Now working towards stage 2 which takes up to one year.
		• Development and implementation of an early years healthy lifestyle programme, called Healthy Steps, which is being implemented in Children's centres
		• Implementation of school based programmes, including the:
		  • NCMP
		  • Swindon Healthy Schools programme, which has supported programmes to reduce obesity, including implementation of the Food for Life Partnership programme
		  • support with implementation of national school meals standards
		  • support to develop active travel policies and programmes
		• Swindon Youth Forum- reducing obesity is one of 5 priorities of the forum. A cookery DVD is currently being produced by the forum, to support home cooking of healthy food. The forum has supported work on improving school meals in the last 2 years.
		• Walking for Health programme- currently 13 free weekly walks in Swindon for

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		adults to support an increase in physical activity. • Ability sports- a range of activities for adults with physical and learning disabilities • Active travel (promoting and encouraging people to cycle and walk) is promoted and encouraged through the development of the Local Transport Plan (LTP3). • Built environment - promoting and encouraging walking and cycling are key considerations in the Swindon Core Strategy and Supplementary Planning Documents. • Local Sustainable Transport Fund (LSTF) -The LSTF project is focussed on partnering the economic (business) sector to target employees who currently drive to work in the town centre. The target is reducing the need to travel, providing personalised travel planning advice and identified missing infrastructure, associated with walking and cycling. • Raising awareness/ training- Specific training on effective interventions to prevent obesity, including brief intervention, at an individual and group level have been available free to primary care health professionals and other community staff annually for the last 3 years. • Promotion- use of the Change4Life brand and sub-brands to promote local health programmes, linking to national Change4life programme
To deliver evidenced based programmes in a range of settings to manage obesity with a focus on continuing expansion of services	This covers tier 1, 2 and 3 services for obesity treatment plus maternal obesity programmes and exercise referrals. Many of the measures are delivered via contracts with providers.	• Tier 1 (community based initiatives): ▪ Child and Family weight management group service ▪ Adult weight management group service- including Dietbusters, Weight Watchers and the Friday Fit club (for adults with a mild learning disability). ▪ Avon and Wiltshire Mental Health Partnership NHS Trust offer a free weight management course for people who need extra support in putting lifestyle changes into practice. ▪ Individuals who do not wish to attend a group can be referred to a Dietitian and in some GP practices, the practice nurse or nursing assistant offer weight management advice.

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		▪ Exercise on referral programme- for adults who are obese and would like support in developing an appropriate exercise programme. This programme is for patients at any stage of the obesity care pathway • Tier 2 (intensive, specialist weight management service in community and hospital settings) ▪ Adult programmes, consisting of a mixture of group and individual support, provided in community and hospital settings. ▪ Maternity obesity clinic-based at the Great Western hospital. • Tier 3 (Specialist pre-bariatric surgery service- assesses a patient's suitability for surgery and manages their expectations of surgery.) • Tier 4 (bariatric surgery) • Tier 5 (specialist post-bariatric surgery service)

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Appendix 3: Consultation Feedback

A draft strategy was developed, followed by an extensive consultation process. This included a stakeholder group, public consultation, Swindon Youth Forum, Children's Trust Board, and distribution of the draft strategy to interested organisations and individuals. Their comments which were gratefully received have informed both the final version of the strategy and the development of annual action plans.

The following provides a summary of the feedback.

27th March Stakeholder Consultation – 8 people

Overarching themes

- Better coordination between action to promote healthy eating and action to promote physical activity – one should be an opportunity for the other but currently much more siloed.
- Need to address healthy lifestyle in a much more holistic way – move towards commissioning lifestyle service
- There needs to be clear consistent messaging across all lifestyle related services – communication strategy
- Could include healthy options in vending machines as one of the criteria for reviewing healthy school status
- should include more on motivation and psychological support – what really makes people change behaviour
- systems approach – recognise role of environment and community as well as individual
- don't commission things that can't be evaluated – need to understand which interventions are making a difference and which are not

Themes from discussion

- Understanding that the primary purpose of some activities is not about losing weight and yet they are missed opportunities for giving broader healthy lifestyle messages e.g. many people do healthy walks for the social benefits and then meet for cake and coffee which could be an opportunity to promote healthy eating.
- Need a much more holistic approach to healthy lifestyle – e.g. healthy choices / eating as part of smoking cessation service and vice versa. E.g. recognition that teenagers often see smoking as a way to manage weight and need support / information to avoid replacing one unhealthy behaviour with another.
- All staff should have basic training in all lifestyle services.
- Scope for reviewing vending machines and including healthy options both in leisure centres and schools.
- Employers should also set an example with vending machine choices – mixture of options but also information about comparisons e.g. mars is more calorific than a kitkat, or a list of 100 calorie snacks. Public sector could lead the way with this. Focus on choice not ban.
- Strategy should focus more clearly on what is working well and what is most effective in terms of intervention – use intelligence to really understand what people like and which interventions make them change their behaviour – recognition evaluation can be a challenge and NCMP data doesn't allow identification of which intervention might be affecting trends.

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- Need greater clarity on structure of different levels of intervention and how to access them – how do people know what is available?
- Strategy should include more on motivation and psychological support e.g. LIFT, programmes for 50+ which includes physical activity could expand to look at healthy eating, falls prevention etc. Age well course has run previously.
- Need to look at how vulnerable groups access services (or not) – what are the barriers e.g. attitude of staff in leisure centres – if people try once and fail they don't go back again. Brief intervention training may be useful (evidence of effectiveness?)
- Need to get information outside leisure centres and into the community e.g. children's centres who can target vulnerable people but recognise some people do not access anywhere. Opportunity in terms of role of health ambassadors – extending role to work across healthy lifestyle and providing training rather than signposting.
- Need to focus on perception of normal = healthy
- Promoting ideas of taking responsibility for self and children – can't 'do' things to the community but can facilitate the creation of peer groups to support people in the community
- In tackling obesity – recognise the role of place and community – not just individual. Greater focus on systems and hence the role of planning, environmental health etc. Recognition that the environment may be working against people having a healthy weight – vision needs to capture this wider community aspect.

One thing to make a difference

- Joining up issues – lifestyle approach
- Normalising healthy behaviour e.g. positive marketing – 85% of young people don't drink 'I want to be in that group'. Could apply to messages on smoking, fizzy drinks, healthy eating – would need partners for an ongoing campaign.
- Need all organisations to sign up to vision
- Build HIA into planning decisions – scope to develop Bristol model where public health review planning applications – encourage use of S106s to promote healthy lifestyles
- Opportunities to work with retailers
- Programme of activity needs to be aspirational / normalising a healthy lifestyle by capturing people's imagination and making it exciting. Event to celebrate success / achievements.
- Need to develop a communications strategy – with clear and consistent message.
- Stop commissioning things we can't evaluate – define what the difference is for each intervention commissioned – how effective is what we pay for

<u>16th April: Community Consultation Event attended by ~25 people</u>

Overarching themes

- Complete integration of the role of healthy eating and exercise
- Physical activity is both organised and self-generated – people understand the benefits of walking
- Motivation for a healthy lifestyle is to avoid illness and look good
- Key barriers are time , lack of information and depression or lack of motivation

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- For people who are obese being supported / mentored / encouraged and being given good information to inform choices was felt to be most important
- Suggestions for improvements in Swindon covered every type of setting (e.g. home, school, GPs, work, social life) recognising the holistic approach needed
- Priorities included making the consequences of obesity clearer, limiting temptation, and supporting people to make the healthy choice the easy one.

- *What do I do that's healthy?*

Watching portions
Walking, cycling, eating fruit and veg, cutting fat off meat, grilling instead or frying, reducing oil, herbal teas, lots of water
Walking, cycling, swimming, fitness classes, gym
Run, cycle, walk, swim, pilates, eat fruit & veg
2 health walks per week
Zumba, tai chi, barn dances, U3A walk 3-5 miles, always played sport
Painting
Looking after grandchildren
Do not sit in front of television
Eat healthily – no meat (veggie) eats fish
Plain food (no butter etc) – 3 meals
Not smoking
Joined walking group
Learnt to swim
Go walking, cut down portions, eat more vegetables
Lunch clubs, exercise class x3 a week

- *What encourages me to eat well and do exercise?*

Joint problems
Maintaining weight and looking good
Getting around the house
Health risks
Social interaction
Feeling better
Cheaper / free activities
Feeling healthier
Awareness e.g. classes
Eating – stay slim
Cancer – ill health
Brought up with good lifestyle attitudes
Keep mid-age weight down – plus age related health conditions
Mental wellbeing
Seeing positive results from making healthy changes
Clothes fit
Feel fitter which encourages perseverance - difficult as there's lots of temptation

- *What makes it difficult to eat well and do exercise?*

Being on your own not bothering with cooking

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Depression
Fear of the unknown
Dark evenings
SAD
Lack of information on food products
Confusing information
Cost e.g. healthy food
Time – fast food, exercise
Finances
Time
Lack of organisation
Lot of salt / sugar in food
Lack of cooking skills, lack of budget skills
Lack of understanding about content in foods
Time, label reading – when you're out for the day it's harder
Healthy food can be cheaper than fast food (most people think healthy=expensive)

- *What would help people who are obese?*

Food diary
Encouragement from other people, friends, family
Education, mentoring
Health awareness
Awareness of portion size
Time of eating
Making it not acceptable
Encouraging people to move more
More awareness – alcohol, sugars etc
More hard hitting information – TV adverts etc. Dangers highlighted re: obesity
Keep food diary – that should open their eyes
Eat breakfast
Encourage restaurants to show / calculate calories per meal / item
How to approach obese people?
Information re: not dieting but lifestyle changes
Changing their diet, walking, exercise, leisure cheaper
More activities available – motivation of others

- *How could things be improved to encourage eating more healthily in Swindon?*

Affordable fruit and veg
Education in schools
Cookery
School cookery lessons
Attracting new mothers
Doctors surgery
Work-based policies e.g. vending machines, rules re: food
Parental guidance – role models
Restaurants – food labelling
More food offers on fruit / veg in supermarkets

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More education in schools – compulsory
Parents should teach children cooking and budgeting
More meetings to encourage people in Swindon to discuss health issues
More awareness of what's available
Spreading the word
More local advertising
Less distractions – tv, video and cinema that encourages being sedentary
Healthier ready meals – but still a long way to go
More awareness about consequences of not eating healthy
Health needs to start from a young age – more education around health in schools
More encouragement to promote a healthy balanced diet
Parents need to be more involved

- *How can professionals help? What can local people do?*

Professional chefs – more recipes that are healthy – currently use lots of salt and sugar
Role for doctors, nurses, midwives, health visitors
Domestic science classes
Issue more information, more joined up advice
Nutritionists, dietitians attached to doctors surgeries
Information / awareness – harder impact as in smoking
Professionals more accessible – advice / information
People into communities – health promotions e.g. health ambassadors, information on walks / exercise
GP's able to give advice and should do so – should be more proactive and not re-active
Health professionals should set example
Proper breaks at work – activity @ work place
More promotion around these meetings
Continuing to have consultation meetings
As locals – volunteer to speak to others – talking to others about health – raising awareness
Recognise professionals can't always be around

- *Priorities: what one thing:*
  … do people think is most important for helping people in Swindon achieve a healthy weight
  … do people think is most important for health and wellbeing in Swindon?

Happiness
Fear of disability
Prioritisation, budget management
Education, education, education – children, young mums, everybody
Doctor surgeries should refer more and include nutritionist / dietitians and advisors or health ambassadors
Being able to walk / cycle safely
Choice e.g. able to eat healthy / information
Encouraging businesses that promote healthy choices e.g. juice bar
Awareness of what's available and dangers of being obese
Everything in moderation
Alcohol consumption should be reduced
Keep open spaces – so people can go freely. Green spaces.

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Serious messages at school that kids can relay back to parents
Gardening / growing own veg
Remove sweets from near tills
Remove multi-buys
Encourage smaller businesses e.g. green grocers / fishmongers
Need to tackle alcohol issues
Real hard-hitting adverts on TV etc.
More visual aids to produce impact leading to change
Education at younger age
People to listen and change their attitudes and lifestyle
Be more active – get encouragement from a young age and at school
More opportunities to learn how to cook healthy
More opportunities to be active in a safe environment that is cost effective
More leaflets available / posters at doctor's surgeries
More social groups e.g. walks to feel safe
Needs to come from within – people need to take responsibility

- *One Point Summary Per Group*

Portion control important
Education most important – schools / young mums / pensioners
Education – hard hitting adverts / danger of obesity
More promotion at doctor's surgeries
Encouraging businesses who promote healthy choices e.g. juice bar in old town

Youth Participation Consultation April 2013

Overarching themes

- Being healthy is seen as physical activity more than food choices.
- Motivation for being healthy comes from looking good and being more confident
- Barriers are around information, skills and consistent messages and more should be done around education and a whole family focus.

What do you do that's healthy?
Football
Running
Walking
Eat healthily
Yoga
Cricket
Golf
Dancing
Cycling
Performing arts
Ice Skating
Swimming
Gym

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What encourages you to eat well and do exercise?
Want to be healthy
My family, we all eat healthily
So I don't get overweight and out of breath
Look like celebrities
Makes me feel better than eating McDonalds
Thought of my future
Makes me feel good
Local places to do sports
Makes me feel more confident
Fun to do exercise with friends, keeps me motivated
Like looking and feeling good
Easy to get to sports centres
Cheap cost of activities
Self esteem
Stuff to do in my area

What makes it difficult to eat well and do exercise?
Cost of food, and exercise
Chocolate
TV / Xbox / PlayStation
Healthy food doesn't taste as nice as junk food
How to make healthy food
Sticking to a routine
McDonalds
Advertising
Mum cooks food, don't have a choice
Friends don't bother
Laziness
Easier to be unhealthy than healthy

What can local people do to encourage their family and community to be more active and eat a healthy diet?
Start a running club
Exercise club for people who don't normally exercise
Cooking lessons for healthy food
Promote healthy activities more
Learn from early age about being healthy
Lessons in schools about dangers of getting fat and un-healthy
Educate them
Health festival where you can try nice healthy food and do different sports
Cooking competition with prizes
Get kids to show mums and dads how to cook good food
Healthy shopping booklet with recipes
Watch the Swindon Youth Forum Healthy eating DVD!!

Swindon Children's Trust Boards feedback

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There was praise for the Swindon context.

Name of strategy should be healthy weight strategy not obesity strategy as this is the outcome we are trying to achieve, and was a more positive message than calling it an obesity strategy.

Re. the definition of BMI: 'BMI does not take into account factors such as size of body frame, proportion of lean body mass, gender and age and is not a direct measure of underweight, overweight or obesity. Therefore these need to be considered when interpreting BMI'. Need to explain more about why we use BMI if we say it has limitations e.g. have several of the children who are told they are overweight by the NCMP just got a big frame?

This strategy should focus on obesity, not related areas such as eating disorders and underweight. It should define what is included and what is not, saying that associated issues are not part of this scope and are covered elsewhere in clinical care pathways and/ or strategies.

'What works' to reduce obesity and can we do more of it?

Email feedback

Discussion on the definitions of childhood obesity

Not sure whether you note the increased clinical risk associated with obesity, across all specialties e.g. a woman's choice of childbirth delivery will be impacted by a clinical assessment of the attendant risks (inc. those associated with obesity), assume we have recovery data that show longer timescales associated with weight.

Have you captured a strong enough message about the mental health dimension?

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Appendix 4: Diversity Impact Assessment

Swindon Borough Council Diversity Impact Assessment

1 What's it about? Refer to equality duties

What is the proposal? What outcomes/benefits are you hoping to achieve?

The Healthy Weight Strategy sets out the rationale, vision and objectives for people in Swindon, to improve their health, by identifying effective strategies and interventions to prevent obesity and help people in Swindon to achieve and maintain a healthy weight. It covers the period 2013-15, and incorporates national and local targets to reduce childhood obesity from the current baseline.

The aim is to encourage people in Swindon to reduce obesity and maintain a healthy weight creating:

- an environment that encourages people to live active and healthy lives
- an ethos of taking responsibility for the health of yourself and your family with support when needed
- communities where a healthy lifestyle is seen as desirable and the norm
- an understanding of what works most effectively at an individual, community and population level by including effective evaluation and learning from others

The strategy will impact on all of the equality duties.

Who's it for?

The strategy covers and is relevant for all the community as its focus is not only on people who are obese or overweight but also on encouraging everyone to maintain a healthy weight.

How will this proposal meet the equality duties?

1. Eliminate discrimination, harassment and victimisation

National surveys indicate that people who are overweight or obese are often victims of discrimination or bullying. Action to support people to achieve / maintain a healthy weight will help people feel more confident and supported. The range of projects and initiatives commissioned and proposed are targeted in different settings such as at school or in the community, and for different groups of people. There is also tiered support so those with the greatest need get the most intervention. For children some initiatives are about healthy eating and being active rather than weight management to reduce stigma, whilst others provide a safe supportive environment for children and their families to learn about ways to reduce obesity.

2. Advance equality of opportunity

Underpinning the strategy is the opportunity for everyone to maximise the likelihood of achieving a healthy life and reducing the risk of illness. By providing additional support and information for people who may be overweight, this promotes equality of opportunity to health. The strategy also explicitly recognises the increased risk of obesity and subsequent ill-health in different communities such as some BME communities and amongst people with learning disabilities.

3. Foster good relations

As a healthy weight strategy rather than an obesity strategy it is about drawing together communities to achieve their health potential. This is particularly demonstrated via initiatives

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such as healthy walks which bring together people to walk, motivate and socialise with each other.

What are the barriers to meeting this potential?

More could be done to meet the understand the cultural needs and barriers for people from different ethnic groups and to reflect religious and cultural diversity: this could be achieved by working with people from different communities to lead groups and support each other and the consultation process for the strategy looked at this.

Perceptions around obesity are also heavily influenced by the media and national initiatives and so the strategy recognises the need for a strong and consistent communications strategy in Swindon.

2 Who's using it? Refer to equality groups

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)?

The strategy is evidence based and draws on national and international research about the prevalence of obesity and interventions that are effective. It includes data on national, regional and local trends. Pages 10-11 in the strategy considers how obesity may vary within and between different groups including the BME community, socio-economic status and income, the LGBT communities and people with disabilities. There is no information that obesity varies on the basis of religion. For some disabilities obesity may be both a cause and a consequence; it can also be considered an illness itself requiring medical intervention[103].

The development of actions plans and service specification will also recognise that there are groups such as those with sensory loss or physical impairment that whilst there is no evidence of increased obesity in these groups, access to services may be more difficult.

Services that are currently commissioned collect data on who is using them and this is regularly reviewed to ensure they are accessible to the whole community. Service specifications include requirements for assessing diversity impacts and equality of access.

One challenge is measuring adult obesity as the only source is by survey and this is known to include biases. Information on obesity in different equality groups is only from cohort studies if available.

How can you involve your customers in developing the proposal?

The development of the strategy included a public consultation. This actively encouraged a broad outreach response including people from different BME communities in Swindon, health ambassadors and people who use those services, people who currently attend health walks, the Swindon Youth Forum and contacts via the link nurse at Carfax Medical Centre. The consultation event was advertised by word of mouth and via social media. Whilst there was not a formal equality analysis of consultation respondents, many groups did contribute.

People who currently use projects to support their weight management are asked to evaluate the service and this is used for future service delivery.

One of the recognised challenges is understanding how effective interventions are at having long-term impact on maintaining a healthy weight as most outcome measures are short term. This is an issue nationally as well as locally.

Who is missing? Do you need to fill any gaps in your data? (pause DIA if necessary)

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The strategy development was informed by a detailed literature review and the latest available data. For some protected characteristics there is little evidence that

3 Impact Refer to dimensions of equality and equality groups

Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation and if appropriate: financial economic status, homelessness, political view

Using the information in parts 1 & 2:

a) Does the proposal create an adverse impact which may affect some groups or individuals? Is it clear what this is? How can this be mitigated or justified?

The strategy recognises the important of a lifecourse approach to supporting people achieve and maintain a healthy weight from early years and the benefits of breastfeeding to older age. It also focusses on specific times in the life course where obesity is an increased risk factor for ill health and /or is a good opportunity for obesity prevention, such as during pregnancy. Exercise on referral and weight management services such as Dietbusters are available to all adults but may be more aimed at those of working age. The introduction of two elder health ambassadors and initiatives on healthy ageing may mitigate this.

Obesity is a sensitive topic and children and adults can feel very stigmatised: a mixture of school wide initiatives such as the Healthy Schools Initiative together with more targeted projects can help this.

There is ongoing work with specific BME communities in Swindon to identify and address barriers to services: an example of this is work around diabetes with the Goan community.

There is little evidence for LGBT communities specifically around obesity but a recognition that they may face additional barriers to services which need to be acknowledged and addressed when services are being commissioned.

Impact on dimensions of equality:

- Longevity – positive impact as proposals should result in an increased number of people having a healthier lifestyle
- Physical security – neutral impact only as a result of increased health and mobility resulting of reduced levels of obesity
- Health – positive impact as strategy makes clear case for health impact of being overweight or obese
- Education – positive impact as many initiatives resulting from strategy include educational approaches of learning about healthy eating and lifestyle choice
- Standard of living – neutral impact
- Productive and valued activities - positive impact as being obese can be a barrier to full engagement in activities and community life
- Individual, family and social life – positive impact as some initiatives resulting from strategy are targeted at families working together to learn about healthy eating and improving their lifestyle
- Participation, influence and voice – neutral impact
- Identify, expression and self-respect – positive impact as strategy promotes a tiered approach to intervention, allowing people who are a healthy weight, overweight or obese

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to access an appropriate service to manage their weight and improve confidence and wellbeing.

- Legal security – neutral impact

What can be done to change this impact?

See above

b) Does the proposal create benefit for a particular group? Is it clear what this is? Can you maximise the benefits for other groups?

The Healthy Weight Strategy is applicable for the whole community and outlines a Swindon wide approach. Services are a mixture of universal and targeted provision: Targeted provision includes walking groups for women only, weight management services in known areas of higher deprivation, adjustments in physical activity and weight management programmes to be accessible and appropriate for people with physical activities and physical activity and healthy eating groups for people with learning disabilities.

Does further consultation need to be done? How will assumptions made in this assessment be tested?

Approval of the strategy will be via the Health and Wellbeing Board which is a public meeting. The communications strategy will identify ways for people to be consulted on an on-going basis and informed of progress. There is also a healthy weight implementation team so any suggestions / comments from service users will be discussed and actioned at that group.
The assumptions in the strategy will be tested via on-going feedback and input from service users who access commissioned projects. There is an expectation that providers will demonstrate awareness of equality and diversity and that staff delivering services will feel confident to implement inclusive practice and challenge where necessary.

4 So what? Link to business planning process

What changes have you made in the course of this DIA?

Doing the DIA has widened the protected characteristics considered by the strategy, and encouraged a broader consideration of how the strategy can reflect the different barriers that arising from different needs.

What will you do now and what will be included in future planning?

We will include equality and diversity requirements within our commissioning specifications and require providers to demonstrate how services reach different groups in the community.
The women only walking group is an example of responding to an identified need in the community where some BME communities feel more comfortable in a single sex activity. Over the next year we will also look at service provision for LLTI.

When will this be reviewed?

The 3 year strategy is supported by an action plan which is reviewed annually in March. The next review will be March 2014.

How will success be measured?

Targets have been set as to the success of the strategy as outlined in chapter 4. Where available data will also be gathered on these broken down by protective characteristics.

For the record	
Name of person leading this DIA- Fiona Dickens	Date completed
Names of people involved in consideration of impact- Penny Marno, Nick Stephenson	

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Name of manager signing DIA Fiona Dickens	Date signed

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Appendix 2: Summary of Action Plan

Purpose To improve the health of the people of Swindon by identifying effective strategies and interventions to prevent obesity and help overweight and obese people to lose weight.

The action plan sets out details for local action to tackle obesity, based on national guidance and evidence base. It needs to be read in conjunction with Swindon's Healthy Weight Strategy, which sets the context and gives local targets as well as evidence of effectiveness of programmes.

Objective 1- to establish a baseline of obesity levels in children and monitor progress related to targets throughout 2013-14

1. Establish and track local obesity prevalence rates through regular recording of BMI in Swindon children through NCMP
2. Monitor and report on progress against child obesity and breastfeeding targets
3. Track progress of obesity related target

Objective 2- To deliver evidenced based programmes in a range of settings to prevent obesity, with a focus on early years, breastfeeding support, training and embedding prevention in the work of health professionals

1. Provide a range of health walks suitable for different clients groups
2. Swindon Borough Council to support behaviour change at community events, while promoting the Change4Life brand
3. Provide Healthy Steps programme in Children Centres. It is a preventive programme for families with children aged 0-5 years that incorporates healthy eating, physical activity and parenting advice as well as a practical 'cooking on a budget' workshop
4. Continue Walk4Life 5 minute walk zone scheme with schools
5. Investigate and develop scooter training scheme for primary schools
6. Continue to support Sustrans Bike It project
7. Continue to develop and review school travel plans that promote walking or cycling to school
8. Develop Y6/7 transition programme to promote active independent travel
9. Increase breastfeeding prevalence at 6-8 weeks through implementation of breastfeeding action plan

10. Continue implementation of Active Swindon Partnership (ASP) strategy and implementation plan- which addresses change to the structural environment, provision of a range of activities and campaigns to motivate and support people to be more physically active

11. Continued implementation of a local walking programme, particularly targeting areas of deprivation

12. Pilot an evaluation of MEND programme by school nurses- who weigh MEND children in schools

Objective 3- To deliver evidenced based programmes in a range of settings to manage obesity with a focus this year on continuing expansion of current services

1. Adult non-specialist/ tier 1 adult obesity treatment service achieves its outcome targets to reduce adult obesity-service provided by SBC Leisure Services

2. Child and family weight management service achieves its aim to reduce obesity in children and their families (provided by SBC leisure services)

3. Plot MEND Champions scheme- where MEND Graduates help to promote MEND at events or with their friends and family

4. Continue work on maternal obesity – developing appropriate services for pregnant women

5. Steps to Health, exercise on referral scheme achieves its aim to increase physical activity- provided by SBC leisure services

6. Tier 2 obesity service (intensive and specialist service) provided by the Great Western Hospital NHS Foundation Trust (GWHFT) dietetic service achieves the aims set out in the service specification

7. Tier 3 obesity service achieves its contracts aims to, assess patients for surgery and prepare patients for surgery (provided by a multi-disciplinary team at GWHFT)

8. Post-bariatric surgery clinic at GWHFT achieves its contract aims

Local Government Declaration on Tobacco Control

Health and Wellbeing Board **Date: 11th September 2013**

Author: Acting Director of Public Health

Wards: All

Locality Affected: All

Parishes Affected: All

1. Purpose and Reasons

1.1 Every year in England more than 80,000 people die from smoking related diseases. This is more than the combined total of the next six causes of preventable deaths, including alcohol and drugs misuse. Smoking accounts for one third of all deaths from respiratory disease, over one quarter of all deaths from cancer, and about one seventh of all deaths from heart disease. On average a smoker loses 10 years of life.

1.2 In Swindon there were on average over 260 smoking related deaths a year (2008 – 2010) which equates to approximately 20% of all deaths of people over 35 years old

1.3 Not only does smoking cut lives short it damages local communities and economies. It takes money out of the pockets of those who cannot afford it and causes half the difference in life expectancy between the richest and the poorest. Nationally smoking is the primary reason for the gap in healthy life-expectancy between rich and poor (Fair society healthy lives. The Marmot review. 2010).

1.4 The Local Government Declaration on Tobacco Control is a public health led charter endorsed by the Chief Medical Officer Department of Health, Chief Executive Public Health England and the Chief Executive of the Chartered Institute for Environmental Health, which aims to ensure tobacco control is part of mainstream public health work. (see appendix one and two)

2. Recommendations

The Board is recommended to:

2.1 Note the content of the Local Government Declaration on Tobacco

2.2 Consider how it could be implemented through their respective organisations or communities of interest.

2.3 Request Swindon Borough Council Cabinet to sign up to the declaration.

2.4 Make a clear commitment to tackle the harmful effects of tobacco

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, cherryjones@swindon.gov.uk.

3. Detail

3.1 Smoking continues to be the main cause of preventable disease and early death in the UK. In England alone, over 80,000 deaths per year are due to smoking.

3.2 Nationally smoking is the primary reason for the gap in healthy life-expectancy between rich and poor (Fair society healthy lives. The Marmot review. 2010)

3.3 Smoking kills more people each year than obesity, alcohol, road accidents and illegal drug use put together

3.4 One in every two regular smokers die prematurely as a result of consuming tobacco, and half of them will die before age 70, losing an average 10 years of life. Most die from one of three main diseases associated with smoking: lung cancer, chronic obstructive pulmonary (lung) disease (bronchitis and emphysema) and cardio vascular disease.

3.5 Two-thirds of smokers say they began smoking before age 18, and 9 out of 10 started before the age of 19.

3.6 The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco

3.7 Children exposed to tobacco smoke are at much greater risk of cot death, meningitis, lung infections and ear disease. Children whose parents or siblings smoke are more likely to smoke themselves.

3.8 Poorer smokers spend five times as much of their weekly household budget on smoking as richer smokers. An adult smoking 20 cigarettes a day would save about £2,300 a year if they did not smoke.

3.9 Although smoking is generally declining, the latest data within the Swindon Joint Strategic Needs Assessment (JSNA) suggests that:

3.9.1 Over 21% of Swindon's adult population still smoke, (slightly higher than the national average of just under 21%).

3.9.2 Smoking prevalence is higher in routine and manual groups in Swindon at nearly 30%.

3.9.3 Smoking rates in some of our less affluent communities is as high as 50%

3.9.4 Of the 2974 maternities in NHS Swindon in 2011/12 14.8% of women were smokers at the time of delivery.

3.9.5 The Child Health Related Behaviour Survey conducted across a number of schools in Swindon appears to show that smoking rates amongst our young people have declined from 28% in 2004 to 11% in 2011

3.10 Smoking poses substantial costs to individuals and to the community.

3.9.1 There were on average over 260 smoking related deaths a year in Swindon (2008 – 2010) which equates to approximately 20% of all deaths of people over 35 years old.

3.9.2 There were over 1400 smoking attributable hospital admissions (per 100,000 population aged 35+) in 2009/10

3.9.3 According to the national Action on Smoking and Health toolkit the annual estimated costs of tobacco for Swindon are £50million

3.9.4 Smokers have, on average, eight more days a year off sick than non-smokers

3.11 The Local Government Declaration on Tobacco Control is a response to the enormous and ongoing damage smoking does to our communities. It is a commitment to take action and a statement about a local authority's dedication to protecting their local community from the harm caused by smoking.

3.12 The declaration acknowledges that as local leaders in public health we welcome the:

3.12.1 Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;

3.12.2 Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and

3.12.3 Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

3.13 Signing the declaration commits a council to:

3.13.1 Reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities.

3.13.2 Develop plans with our partners and local communities to address the causes and impacts of tobacco use, according to our local priorities and secure maximum benefit for our communities

3.13.3 Participate in local and regional networks for support (such as the Smoke Free Action Coalition which Swindon Borough Council is already a member of)

3.13.4 Monitor the progress of our plans against our commitments and publish the results

3.14 A reduction in smoking prevalence year on year across the borough would have significant benefits on the local economy by:

3.14.1 Improving people's health and their quality of life particularly in deprived wards

3.14.2 Increasing household income when smokers quit

3.14.3 Improving the life chances of young children by

- reducing their exposure to second hand smoke
- denormalising smoking

3.14.4 Reducing the costs of dealing with smoking related fires

3.14.5 Reducing costs related to clearing up cigarette litter

3.14.6 Reducing organised crime linked to the sale of illicit tobacco

4. Alternative Options

4.1 Not to support the declaration

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 The work to support and deliver tobacco control is funded through existing capacity and exisiting budgets

Legal and Human Rights Implications

5.2 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 The contents of this report have positive implications for the health and wellbeing of the people of Swindon.

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, cherryjones@swindon.gov.uk.

The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings and builds on the work we are already doing.

Links to One Swindon, Strategic Objectives, Plans and Policies

5.4 Tobacco Control and reducing smoking prevalence will contribute to improving health and wellbeing and reducing health inequalities both of which contribute to One Swindon outcomes and aligns directly with our draft Joint Health And Wellbeing Strategy to improve health and wellbeing and ensure everyone in Swindon lives a healthy, safe, fulfilling and independent life.

Diversity Impact Assessment

5.5 A Diversity Impact Assessment (DIA) has not been done as this report does not make any new recommendations that would have a detrimental impact on services

Risk Management

5.6 No specific risks identified at this stage

6. Consultees

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

7.1 None

8. Appendices

Appendix One. The Local Government Declaration on Tobacco Control

Appendix Two. The Local Government Declaration on Tobacco Control - frequently asked questions

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, cherryjones@swindon.gov.uk.

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Local Government Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

We commit our Council from this date .....to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories

Leader of Council

Chief Executive

Director of Public Health

Endorsed by

Anna Soubry, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Professor Dame Sally Davies, Chief Medical Officer, Department of Health

Dr Janet Atherton, President, Association of Directors of Public Health

Dr Lindsey Davies, President, UK Faculty of Public Health

Graham Jukes, Chief Executive, Chartered Institute of Environmental Health

Leon Livermore, Chief Executive, Trading Standards Institute

Department of Health | Public Health England | Association of Directors of Public Health | Faculty of Public Health | Chartered Institute of Environmental Health | trading standards institute

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Local Government Declaration on Tobacco Control

Frequently Asked Questions

1. What is the Local Government Declaration on Tobacco Control

Based on the Nottingham Declaration on Climate Change, which has been signed up to by over 200 councils, it aims to ensure tobacco control is part of mainstream public health work.

The Declaration includes a number of specific commitments to enable local authorities to take leadership on tobacco:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smokefree Action Coalition

2. Why does it matter?

Every year 80,000 people a year die from smoking related illness making smoking the biggest cause of premature death. Not only does smoking cut lives short it damages local communities and economies. It takes money out of the pockets of those who cannot afford it and causes half the difference in life expectancy between the richest and the poorest.

The Local Government Declaration on Tobacco Control is a response to the enormous and ongoing damage smoking does to our communities. It is a commitment to take action and a statement about a local authority's dedication to protecting their local community from the harm caused by smoking.

Further, it is an opportunity for local leadership. We know the best way to tackle smoking is through a comprehensive approach working with all partners. The Local Government Declaration on Tobacco Control can be a catalyst for local action showing the way for partners both inside and outside the local council.

3. How would we implement the Declaration?

To some extent this depends on local practice. For some authorities it would be an acknowledgment of ongoing best practice activities for others there may be areas where further action is needed.

For many local authorities the most appropriate route for ensuring implementation of the Declaration will be through the Health and Wellbeing Board. The Health and Wellbeing Board can be tasked with assessing current practice and establishing a clear way forward. Areas for action might include:

- Ensuring there is a comprehensive tobacco control plan being implemented

- Developing a policy on protecting health policy from the influence of the tobacco industry
- Supporting local and regional networks of support
- Reviewing monitoring processes
- Joining the Smokefree Action Coalition

Regardless, of what actions need to be taken all the commitments in the Declaration are contained in existing policies, strategies and treaties which local authorities are subject to. The Declaration reaffirms these commitments and the adds the weight of local council leadership.

4. Is it really necessary to protect local policy from the tobacco industry?
Yes. Tobacco companies have a long record of attempting to influence council policies. In England they have

- Sponsored schools and museums
- Paid for industry branded smoking shelters on council property
- Provided staff and funding and sniffer dogs for joint work on illicit tobacco. These campaigns have focussed on counterfeit and "cheap white" brands rather than main stream branded products sold without tax.
- Worked through front campaigns such as "Love where you live". Supporting environmental campaigns is a great strategy for companies that produce a large proportion of street litter. It has also been a way of distributing industry branded giveaways such as portable ash trays.
- Used subsidiaries to arrange meetings with members and officers on local harm reduction policies

When they cannot divert local policies in their favour they will seek to delay and dilute their implementation. Previously secret industry papers released in court talk of "throwing sand in the gears" of health policy.

Under the World Health Organisation Framework Convention on Tobacco Control, to which the UK is a signatory, countries have pledge to protect health policy from the commercial interests of the tobacco industry. Local authorities are also subject to this treaty however policies on how to ensure local compliance are rare. By signing the Declaration councils are reinforcing their existing obligations and sending a message that they will protect policies from tobacco industry lobbying.

5. How can local government protect health policies from the tobacco industry?
Where local authorities want to take a best practice approach to protecting health policy from the influence of the tobacco industry they should look to develop and implement a local policy. That policy would ensure they were fulfilling their commitments under Article 5.3 of the World Health Organisation Framework Convention on Tobacco control.

As the Declaration states the policy should include: *"not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees"*

Such a policy should be developed with all relevant council departments and implemented among all staff that might have contact with the tobacco industry.

6. Would the Declaration cause problems for our pension fund investments?
No. Imagine Ayton Council's pension scheme has tobacco investments; but they have a clear stance which protects local policy from tobacco industry interests and

lobbying. On the other hand Beeborough Council has no tobacco investments but has industry branded smoking shelters on its property, its councillors and senior officers meet with industry representatives and attend industry funded events on illicit tobacco. It is Beeborough that needs to look at its policy urgently and would not comply with the commitments in the Declaration.

No. The Declaration does not conflict with other duties. It is a strong way of demonstrating that council's have a robust approach to engagement with the tobacco industry regardless of any share investments. It can also be a tool to deflect media and other criticism regarding tobacco industry share investment by focusing on the key issues of protecting health policy from interference.

The Declaration is not in conflict with existing duties. It commits the council to protect health policy from the influence of the tobacco industry and this can be achieved through a strong policy on engagement and transparency locally. It is possible for a local authority to do this while retaining pension investment in tobacco shares.

However, as part of the development of any policy it may be appropriate to review tobacco share investment in line with a local authorities' fiduciary duty. This will show that the council is acting appropriately.

7. We already have a strong approach to tackling smoking, do we need to sign?
Many of the early signatories will already be leaders in the field. Early signatories are not only sending a message of their commitment to their local community but also to other councils who need to make further progress.

As with the Nottingham Declaration on Climate change early adopters will lead the way for other councils and set the standard for local tobacco control.

8. This was created by a Labour-led council, is it party political?
This is a cross-party document built on the same principles as the Nottingham Declaration on Climate change which is now endorsed by over 300 councils across the country.

There is strong cross party consensus on tobacco control with every major party signed up to a comprehensive approach to reduce smoking. Everything contained in the Declaration has previously been committed to at a national level by all political parties. The Declaration is also strongly supported by the wider public health community including The Trading Standards Association, Chartered Institute of Environmental Health and the Association of Directors of Public Health as well as Public Health England, the Public Health Minister and the Chief Medical Officer.

9. Can we add to the Declaration or change some of the wording?
No but you can commit to go further. The Declaration contains overarching principles not policies. It is for local authorities to decide on the policies which are relevant for their tobacco control plan. For the Declaration to have meaning at a national level it needs to be signed up to as is. The goal of the Declaration is both to support local authority leadership on tobacco control but also to make a collective statement about the importance of this issue. Having multiple versions of the Declaration would weaken this collective statement.

That does not mean that councils can't choose to go further or focus their energy on a specific set of issues. Such extensions to the Declaration might best fit in a council's local tobacco control plan.

10. What does it mean to be a member of the Smokefree Action Coalition?
Membership of the Smokefree Action Coalition (SFAC) is a further demonstration of a local council's commitment to tobacco control and also offers additional benefits.

The SFAC is a coalition of over 170 local and national organisations and has wide membership among the Royal Colleges, the public health professional bodies, local councils and health charities. It campaigns for tobacco control at a national level and provides a network of support and advice to local public health professionals.

Membership of the SFAC gives local council's a national platform to make the case for Central Government action to reduce the level of smoking in support of local authorities. However, no member is required to agree with every policy position and all members would be contacted ahead of their name being put to a specific public statement (e.g. a briefing on a particular issue)