HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

Tuesday, 6 October 2009

at 3.00 pm

in Council Chamber
Civic Centre, Hartlepool

MEMBERS: HEALTH SCRUTINY FORUM:

Councillors Barker, Brash, S Cook, A Lilley, G Lilley, Plant, Sutheran, Worthy and Young

Resident Representatives:

Jean Kennedy, Linda Shields and Mike Ward

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 Minutes of the meeting held on 23 September *(to follow)*

4. **RESPONSES FROM LOCAL NHS BODIES, THE COUNCIL, EXECUTIVE OR COMMITTEES OF THE COUNCIL TO FINAL REPORTS OF THIS FORUM**

   4.1 No Items

5. **CONSIDERATION OF REQUEST FOR SCRUTINY REVIEWS REFERRED VIA SCRUTINY CO-ORDINATING COMMITTEE**

5.1 No Items

6. **CONSIDERATION OF PROGRESS REPORTS / BUDGET AND POLICY FRAMEWORK DOCUMENTS**

6.1 No Items

7. **ITEMS FOR DISCUSSION**

7.1 World Class Commissioning - Update:-

(a) Covering Report – *Scrutiny Manager;* and

(b) Presentation - *Director of Corporate Development / Assistant Chief Executive North Tees and Hartlepool PCT.*

7.2 Female Life Expectancy in Hartlepool:-

(b) Covering Report – *Acting Director for Health Improvement;* and

(b) Presentation - *Acting Director for Health Improvement.*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

9. **FEEDBACK FROM RECENT MEETING OF TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE**

9.1 No Items

10. **ANY OTHER ITEMS WHICH THE CHAIRMAN CONSIDERS ARE URGENT**

ITEMS FOR INFORMATION

Date of Next Meeting – Tuesday, 10 November 2009 at 3.00 pm in the Council Chamber, Civic Centre, Hartlepool

HEALTH SCRUTINY FORUM

MINUTES

23 September 2009

The meeting commenced at 3.00 pm at the Belle Vue Sports and Youth Centre, Hartlepool

Present:

Councillor: Jonathan Brash (In the Chair)

Councillors: Shaun Cook

In accordance with Council Procedure Rule 4.2 (ii), Councillor Stephen Akers-Belcher attended as substitute for Councillor Gladys Worthy

Resident representatives:
Jean Kennedy and Michael Ward

Officers: Joan Wilkins, Scrutiny Manager
Denise Wimpenny, Principal Democratic Services Officer

Also Present: Ali Wilson, Deputy Director of Health Systems and Estates Development (Hartlepool PCT)
Sarah Scott, Communication and Engagement Manager (Hartlepool PCT)

23. Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Alison Lilley, Geoff Lilley, Michelle Plant, Lilian Sutheran and Gladys Worthy.

24. Inquorate Meeting

It was noted that the meeting was not quorate.

25. Declarations of Interest by Members

None.

26. Minutes of the meeting held on 1 September 2009

Confirmed.

27. Responses from Local NHS Bodies, The Council, Executive or Committees of the Council to Final Reports of this Forum

None.

28. Consideration of Request for Scrutiny Reviews referred via Scrutiny Co-ordinating Committee

None.

29. Consideration of Budget Reports/Budget and Policy Framework Documents

None.

30. Transforming Community Services in Hartlepool – Covering Report *(Scrutiny Support Officer)*

The Scrutiny Support Officer introduced the representatives from the PCT who were in attendance at the meeting to provide an update presentation on the transformation of community services in Hartlepool.

The representative gave a detailed and comprehensive presentation which focused on the following:-

- Context - Externalisation
  - Agreed hosting arrangements
  - SLA's for all community services
  - March 2009 – community contract agreed with minimal change
  - Range of projects providing additional services/capacity during 2009
  -
- Context – Co-dependencies
  - JSNA public feedback
  - Momentum:
  - Teeswide reviews
  - PBC reviews
  - Ongoing work of LITs/planning groups
  - Examples of good practice/evidence based (MOM)
  - National Policies – Transforming Community Services
- Service Reviews Process
- Service Specifications

- Objectives
- Expected Outcomes
- Benefits
- Timescales

In addition, the Forum was provided with an update on the integrated urgent care/out of hours services in Hartlepool:-

- Lessons learnt from Pilot Project – local and responsive, right place right time, telling the story once, patient information, local calls, skill mix
- Procuring a new service – based on patient feedback and pilot, streamlining across pathways, increase use of local community services, integration MIU – one stop shop, local plus Teeswide
- Out of Hours Model of Care
- Timescales

Following completion of the presentation, discussion ensued which included the following issues:

(i) During discussions on how the service may be delivered, a query was raised on whether providers were interested in delivering the entire service or individual elements. In response, the Deputy Director referred to a recent meeting with potential providers and indicated that until expressions of interest had been received it was difficult to predict, however, from discussions, it appeared that providers were more interested in providing the whole service rather than individual elements.

(ii) The Forum commented on the potential advantages/disadvantages of public/private sector service provision, and some concern was expressed with regard to how the proposed delivery of services may affect the quality of service provision and individual patient's health. The Deputy Director advised that whilst cost was a significant factor in assessing potential service providers it was important to measure best value ie outcomes and quality of care. Details of the evaluation process were provided together with the safeguards in place to ensure best value.

(iii) In relation to integrated urgent care, discussion ensued on the types of services that could be transferred from a hospital environment to the community, the importance of communicating this information to patients, telling the story once, patients being in the right place at the right time, and reducing waiting times for call backs. Examples of individual experiences of the walk in centres were provided which included concerns that the large number of people in the waiting areas may discourage people from utilising the service. The Deputy

Director advised that this arrangement was as a result of people accessing other services from the one location and were in place to control accommodation costs. However, the Deputy Director agreed to take these comments on board.

(iv) The Forum emphasised the importance of an effective communications strategy and a query was raised as to how the types of services/choices available would be communicated to the public bearing in mind that all service users did not have access to the internet. It was reported that a campaign to address this issue would be launched shortly and a variety of measures would be used to communicate with the public. A Member outlined the benefits of communicating the information through residents groups and the voluntary sector.

The Chair thanked the representatives from the PCT for the informative presentation and answering Members' questions.

Recommendation

That the content of the presentation and the views of the Forum, be noted.

31. Issues Identified from Forward Plan

None.

32. Feedback from Recent Meeting of Tees Valley Health Scrutiny Joint Committee

The Chair provided feedback on the issues discussed at the last meeting of the Tees Valley Scrutiny Joint Committee held on 14 September 2009 .

Updates had been given on improving the sexual health service, out of hours care service redesign and cancer screening across the Tees Valley. The Reaching Families in Need final report was also presented and well received by the Committee.

Recommendation

That the information given, be noted.

33. Any Other Business – Visit to Park Road, Walk In Centre New Health Centre, Park Road

The Chair reported that the tour of the new health centre development in Park Road had been arranged for 30 October 2009 at 3.00 pm It was envisaged that the tour would be conducted in small groups of approximately 5 people and would take approximately 30 minutes. Further

details would be distributed to Members of the Forum once the programme for the visit had been finalised.

Recommendation

That the Forum note the date of the visit and further information, be awaited.

34. Any Other Business – Additional Meeting - Dust on the Headland

The Chair reported that an additional meeting would be scheduled at the end of October to discuss the continuing issue of dust on the headland. Further details would be provided once a date had been finalised.

Recommendation

That the information given, be noted and further information, be awaited.

35. Date and Time of Next Meeting

It was reported that the next meeting would be held on Tuesday 6 October 2009 at 3.00 pm in the Council Chamber.

The meeting concluded at 4.20 pm.

CHAIRMAN

HEALTH SCRUTINY FORUM

6 October 2009

Report of: Scrutiny Manager

Subject: WORLD CLASS COMMISSIONING - UPDATE PRESENTATION - COVERING REPORT

---

1. PURPOSE OF THE REPORT

1.1 To advise Members that an update presentation on World Class Commissioning will be delivered at today's meeting by the Director of Corporate Development / Assistant Chief Executive (North Tees and Hartlepool PCT).

2. BACKGROUND INFORMATION

2.1 Continuing the development of strong working / communication links between the PCT and the Health Scrutiny Forum, a request has been received from Celia Weldon, Director of Corporate Development / Assistant Chief Executive (North Tees and Hartlepool PCT), to attend today's meeting to give an update presentation in relation to the commissioning of world class services in Hartlepool.

3. RECOMMENDATION

3.1 That Members note the content of the presentation, seeking clarification on any relevant issues from the Director of Corporate Development / Assistant Chief Executive, where felt appropriate.

CONTACT OFFICER

Joan Wilkins – Scrutiny Manager
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.wilkins@hartlepool.gov.uk

BACKGROUND PAPERS

No background documentation was used in the preparation of this report.

World Class Commissioning Year 2

NHS Hartlepool

Health Scrutiny Forum

6 October 2009

Overview

NHS Hartlepool

World class commissioning is a nationally consistent system that:

- Supports and develops PCTs towards world class performance, achievement of better health outcomes and the reduction of health inequalities
- Holds PCTs to account for performance improvements in commissioning capabilities and outcome improvements
- Rewards success
- Provides a common basis for agreeing further development and enables reliable comparison across all PCTs

Results will be published nationally, assessments May 2010

Principles

- Transparent – clear methodology
- Standardised – one nationally consistent system managed locally by SHAs
- Relative – recognising starting point of different organisations and focusing on improvement
- Flexible – the framework can adjust over time as PCTs improve and support local innovation
- Challenging – matching or exceeding the rigour MONITOR applies to FTs
- Developmental – focus on supporting improvement
- Incentivised – clear incentives for PCTs showing improvements and consequences for those that do not
- Proportionate – focus on key indicators of commissioning performance and capabilities rather than an all-encompassing audit
- Consistent – with the developing NHS performance framework and aligned with the work of regulators

WCC will deliver

- Better health and well-being for all
- Better care for all
- Better value for all

Year 2 of World Class Commissioning

NHS Hartlepool

- Developed to reflect NHS feedback
  - No major changes from year 1
  - Covers:
    - Outcomes
    - Competencies
    - Governance
  - Stakeholder survey

- Developed to reflect changes in the economic context
  - £20bn gap 2011- 2014
  - Challenge to increase productivity and quality at the same time
  - Essence of commissioning

Some key changes

- New competency 11 – ensuring efficiency and effectiveness of spend
- Competency 6 requires PCTs to prioritise investment in different financial scenarios
- PCTs asked how they will demonstrate improvements to date and year on year aspirations for the next 5 years
- Greater focus on board ownership and responsibility for managing risk, strategic development and delivery

Key changes to WCC competencies (1/2)

1	•Monitoring and using patient satisfaction in reputation analysis •Using evidence to demonstrate actions taken by PCT to lead partner organisations •Adding development of commissioning staff to 'employer of choice' requirements
2	•Implementing broad clinical engagement in LAA setting •PCTs demonstrating health gains through LAAs •Taking ownership of the specialised commissioning agenda within the SCG
3	Demonstrating how PCTs can •Influence health opinions, aspirations and behaviours •Make commissioning decisions that demonstrably improve patient experience •Engage with seldom heard and equality target groups, and how this is used to improved quality
4	•Added emphasis on fulfilment of PCT's responsibilities regarding PBS •Explicit reference to engaging clinicians from all relevant organisations in achieving innovation in quality and productivity
5	•Working in partnership with local authority in conducting regular needs assessments •Benchmarking against priority outcomes as well as local health needs •Adding the requirement to incorporate projected future needs into patient level profiles

Key changes to WCC competencies (2/2)

NHS Hartlepool

6	•Incorporation of funding scenarios into strategic planning •Explicit reference made to disinvestment throughout •Prioritisation of investment on total spend
7	Explicit requirement to •Understand all segments of the market •Identify barriers to entry and exit in high priority markets and minimise where appropriate •Higher expectations of PCTs to offer patient choice
8	•Increased emphasis given to quality improvement •Explicit references made to locally agreed quality metrics, and NICE guidelines •better understanding of pathway redesign implications for provider quality and productivity
9	•Examine a broader range of provider data to understand quality and productivity •Explicit reference made to -locally defined negotiation variables -PROMS data -Use of contract quality incentives
10	•Collect and analyse performance data from all providers, at least monthly •Demonstrate the use of data to drive continuous improvement in quality and outcomes •PCTs should manage the risks related to clinical quality, access and workforce issues

Main changes to Strategy year 2 – Strategy Refresh

Vision and goals	•Health outcome aspirations •Alignment to national context, local context •Analysis and local responsibilities
Initiatives	•Clear prioritisation based on robust evidence •Inclusion of cost saving initiatives •Implications of 3 financial scenarios •Clear understanding of risks and implications for providers
Consistency to financial plan	•Detailed outline of initiative investments/disinvestments -clear link to health outcome -milestones, potential bottlenecks and mitigation plans
Achievement of milestones	•Review of delivery of strategy over past year
Board ownership	•Articulation of individual responsibilities and actions taken in governance and delivery

Year 2 assessment process

Strategic Plan and Finance Plan by 30/10/09

- Review outcome priorities and aspirations as part of Strategy refresh

OD Plan by 18/01/10

self assessment of competencies and governance by 18/01/10

nominate partners to feedback 18/11/90 and 18/12/09

collate documentation

- contracts - acute, primary care and other
- list of documents - JSNA, pathway descriptions etc

HEALTH SCRUTINY FORUM

6 October 2009

Report of: Louise Wallace, Acting Director of Health Improvement

Subject: FEMALE LIFE EXPECTANCY IN HARTLEPOOL

---

1. PURPOSE OF REPORT

1.1 The purpose of this report is to introduce a presentation on the issue of female life expectancy in Hartlepool for discussion.

1.2 The presentation will remind the Health Scrutiny Forum that life expectancy is a key priority for agencies and the Local Strategic Partnership. The presentation will describe the health status of women in Hartlepool and the challenges faced in improving life expectancy. The presentation will remind the Health Scrutiny Forum of the range of initiatives and services already available in Hartlepool for women.

2. BACKGROUND INFORMATION

2.1 The issue of female life expectancy has been brought to the attention of the Health Scrutiny Forum following the publication of Health Profiles, that showed that life expectancy in Hartlepool for women is one of the lowest across the country.

2.2 The publication of the Health Profiles generated media interest particularly through the BBC 2 'Women's Hour' programme and subsequently the Evening Gazette and Hartlepool Mail newspapers. In the light of this the Health Scrutiny Forum requested a discussion with representatives of the Primary Care Trust to further explore the issues relating to female life expectancy.

3. RECOMMENDATIONS

Members of the Forum note the content of the presentation and where appropriate seek clarification.

Contact Officer: - Louise Wallace – Acting Director of Health Improvement
Public Health Department
Hartlepool Borough Council / NHS Hartlepool
Tel: 01429 285781
Email: louise.wallace@northteespct.nhs.uk

BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

(i) Tees Strategy 2009-2014
(ii) Hartlepool Community Strategy
(iii) Public Health Profile – Hartlepool 2009

Life Expectancy – Women in Hartlepool

Hartlepool Health Scrutiny Forum

6th October 2009

Introductions

Louise Wallace
Acting Director of Health Improvement
NHS Hartlepool and Hartlepool Borough Council

Mark Reilly
Assistant Director of Public Health Intelligence
NHS Tees

Carole Johnson
Head of Health Improvement
NHS Hartlepool

Life Expectancy – Key Priority

Tees Strategy 2009-2014

- **Vision**

‘that the people of Hartlepool live longer, healthier lives’ p5

- **Aim**

‘Improve life expectancy to that experienced in other areas of England’ p5

- **Challenge**

‘Major improvements in overall health status and yet health inequality gap persistently remains’ p7

Hartlepool Community Strategy

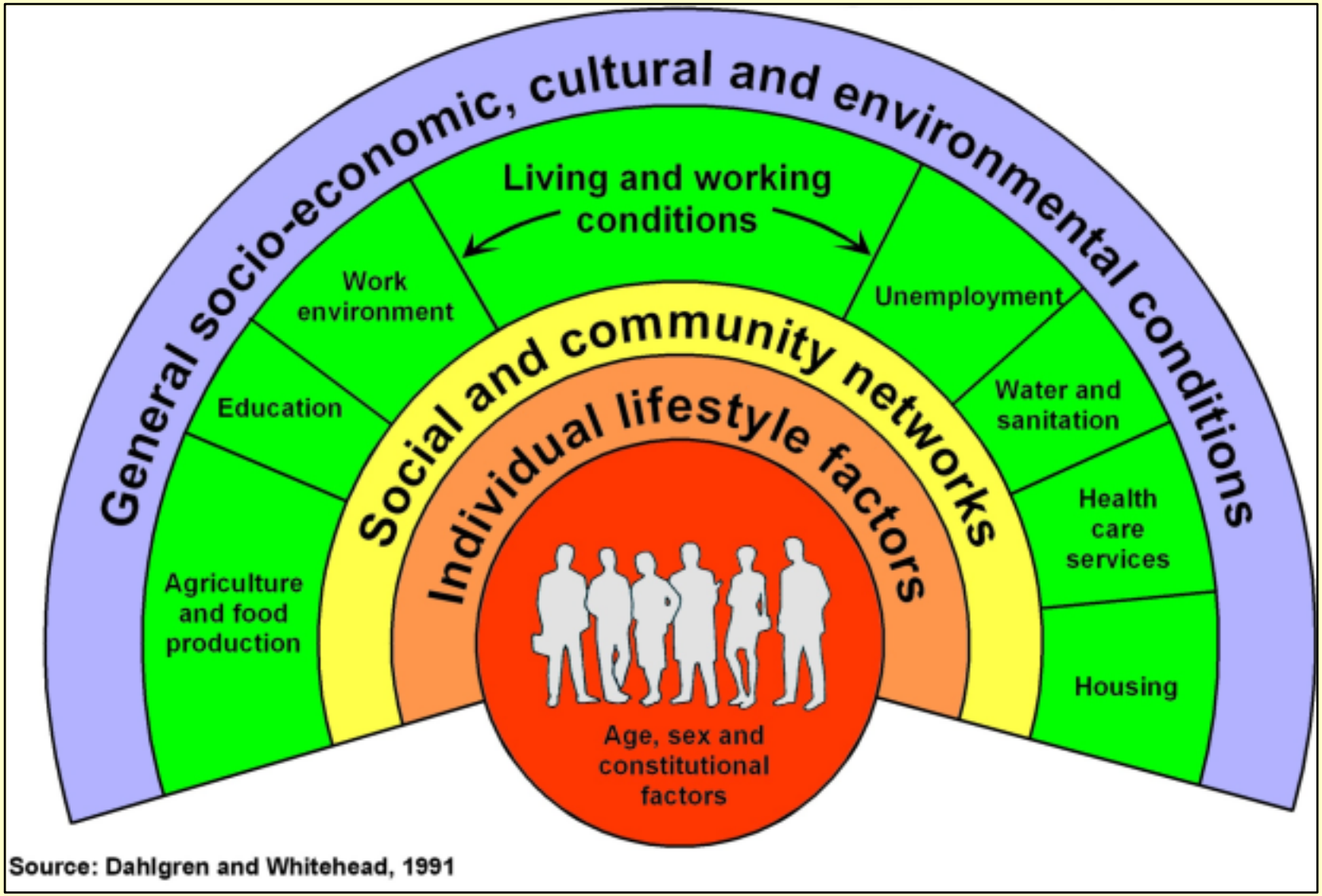
- One of the seven priority aims:

'Ensure access to the highest quality health, social care and support services, and improve the health, life expectancy and well being of the community' p9

- Delivery towards this is monitored and managed through the Local Area Agreement overseen by Hartlepool Partnership

What are the influences on health and quality of life?

The things that influence our health



This model emphasises the potential influence of local authorities on health and reminds us of the necessities of inter-agency planning and delivery

What are the practical impacts on health
and how do these change over time?

Impact of risks on health and care

for which the NHS doesn't have sole responsibility

Mesothelioma

effects of occupation

Historic threat

Alcohol (acute & chronic)

effects of behaviour choice

Current threat

Delayed achievement

effects of disengagement at school

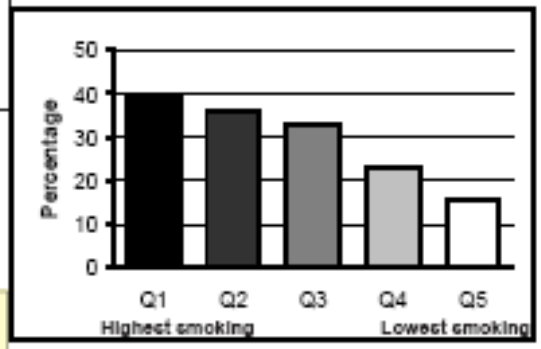
Perennial threat

What is the size of the difference in risk within populations in Hartlepool

Hartlepool

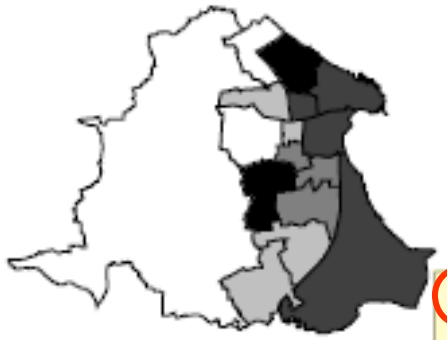
Inequality in behaviour

Estimate of proportion of adults who smoke

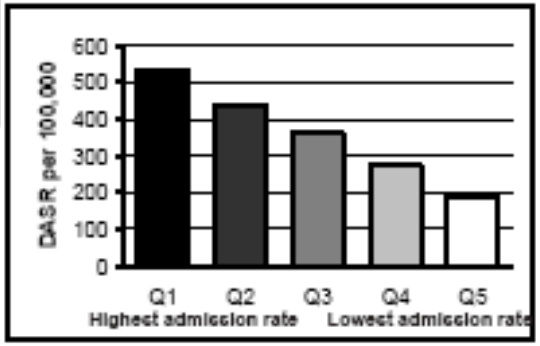


2.5-fold difference between quintiles with the highest and lowest smoking rates

Inequality in healthcare service

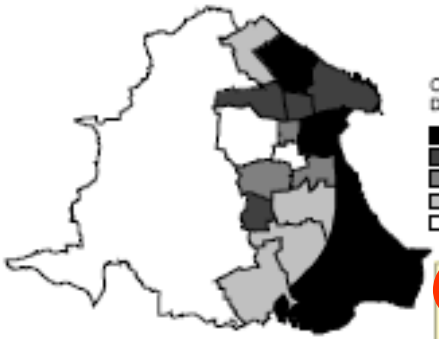


Non-elective admissions for heart disease

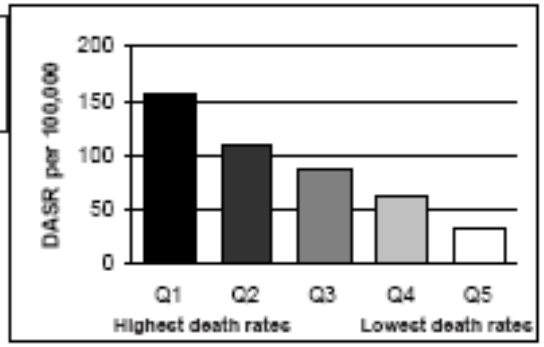


2.9-fold difference between quintiles with the highest and lowest admission rates

Inequality in death

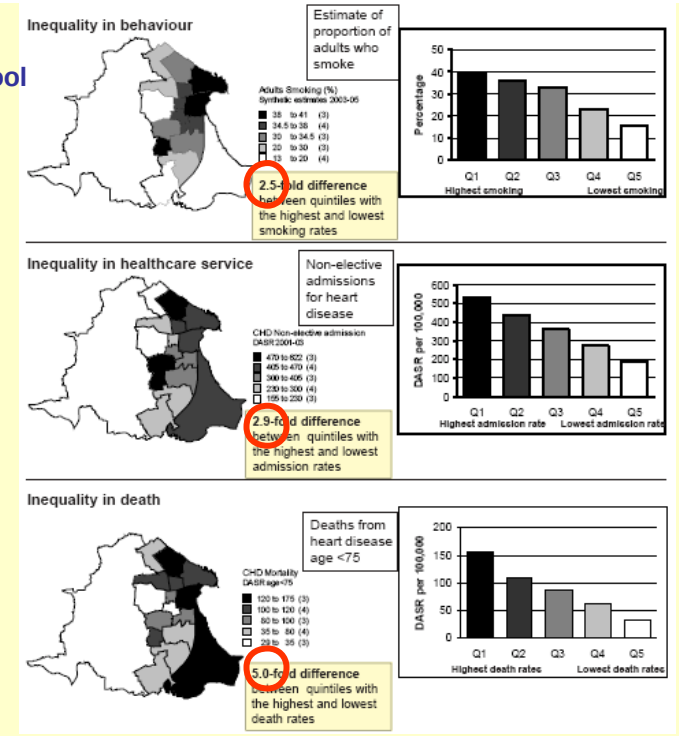


Deaths from heart disease age <75

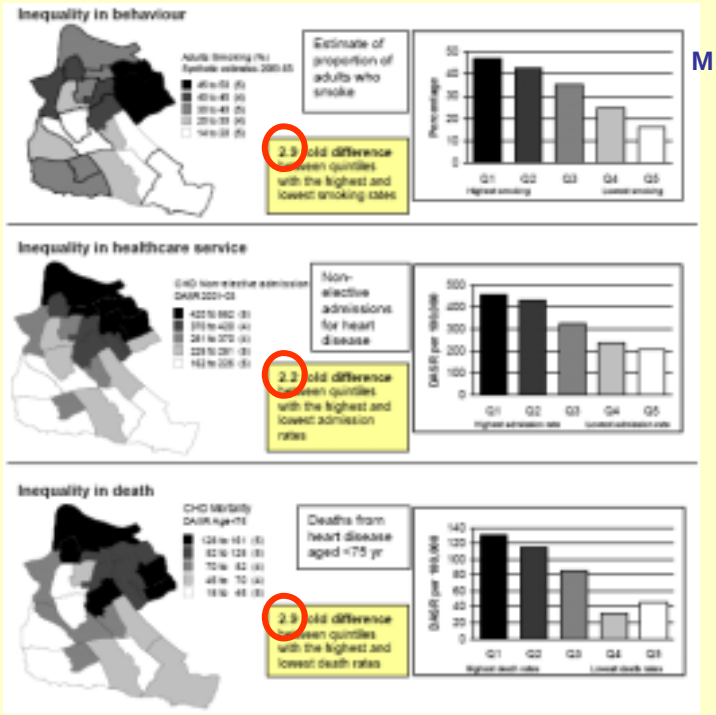


5.0-fold difference between quintiles with the highest and lowest death rates

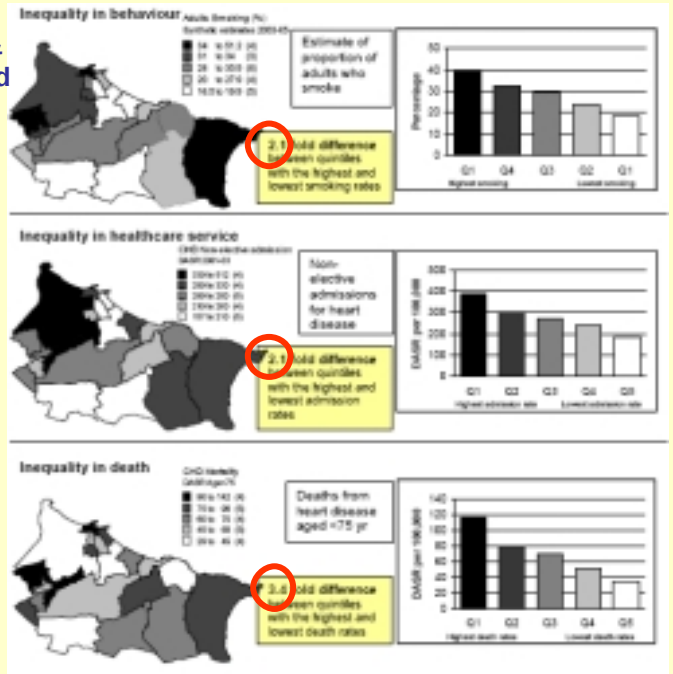
Hartlepool



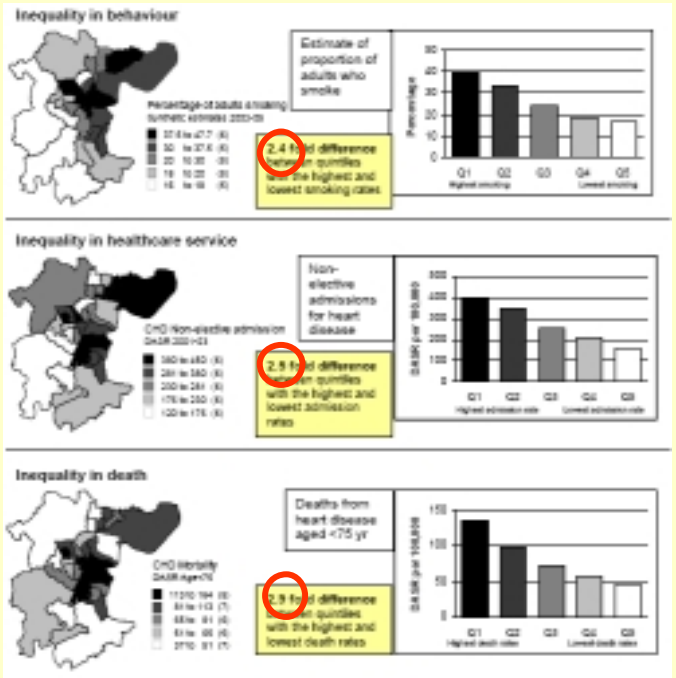
Middlesbrough



Redcar & Cleveland



Stockton -on-Tees



What does this look like when Hartlepool is compared with England average values

Hartlepool

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Income deprivation	19430	21.5	12.9	31.1		3.3
	2	Ecological footprint	n/a	5.019	5.470	6.430		4.904
	3	Homelessness	295	9.2	7.8	35.8		0.0
	4	Children in poverty	6405	33.3	21.3	58.8		5.2
	5	GCSE achievement *	688	57.5	57.5	33.6		81.9
	6	Violent crime	2919	32.4	19.8	41.1		5.0
Giving children and young people a healthy start	7	Smoking in pregnancy						
	8	Breast feeding						
	9	Obese children						
	10	Physically active children *						
	11	Teenage pregnancy (under 18) *	123	62.9	42.1	95.3		12.8
The way we live	12	Adults who smoke *	n/a	33.0	26.0	37.3		15.5
	13	Binge drinking adults	n/a	24.9	18.2	29.2		8.8
	14	Healthy eating adults	n/a	17.7	23.8	11.4		38.1
	15	Physically active adults	n/a	11.0	11.6	7.5		17.2
	16	Obese adults	n/a	23.8	21.8	31.0		14.6
How long we live and what we die of	17	Life expectancy - male *	n/a	74.1	76.9	72.5		82.2
	18	Life expectancy - female *	n/a	78.3	81.1	78.1		86.2
	19	Deaths from smoking	220	350.8	234.4	366.5		147.6
	20	Early deaths: heart disease & stroke *	129	125.8	90.5	151.3		44.9
	21	Early deaths: cancer *	155	154.2	119.0	168.0		81.6
	22	Infant deaths *	5	4.3	5.1	9.9		1.2
	23	Road injuries and deaths	48	53.3	59.9	214.1		20.2
Health and ill health in our community	24	Feeling 'in poor health'	10554	11.0	7.8	15.4		4.2
	25	Mental health	2760	50.9	27.4	72.0		8.5
	26	Hospital stays due to alcohol	281	311.7	247.7	652.4		85.6
	27	Drug misuse	846	14.7	9.9	34.9		1.3
	28	People with diabetes	3036	3.4	3.7	5.9		2.1
	29	Children's tooth decay	n/a	1.2	1.5	3.2		0.4
	30	Sexually transmitted infections						
	31	Older people: hip fracture	122	777.6	565.3	936.8		259.7

Significantly better than England average
Significantly worse than England average
Not significantly different from England average
* PSA Target Measure 2005-2006

18/26 indicators statistically significantly *worse* than England

2/26 indicators statistically significantly *better* than England

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Income deprivation	32525	23.4	12.9	31.1		3.3
	2	Ecological footprint	n/a	5.095	5.470	6.430		4.904
	3	Homelessness	454	8.7	7.8	35.8		0.0
	4	Children in poverty	11562	38.7	21.3	58.8		5.2
	5	GCSE achievement *	867	48.9	57.5	33.6		81.9
	6	Violent crime	4560	33.1	19.8	41.1		5.0
Giving children and young people a healthy start	7	Smoking in pregnancy						
	8	Breast feeding						
	9	Obese children						
	10	Physically active children *						
	11	Teenage pregnancy (under 18) *	193	59.7	42.1	95.3		12.8
The way we live	12	Adults who smoke *	n/a	34.1	26.0	37.3		15.5
	13	Binge drinking adults	n/a	26.5	18.2	29.2		8.8
	14	Healthy eating adults	n/a	15.5	23.8	11.4		38.1
	15	Physically active adults	n/a	9.5	11.6	7.5		17.2
	16	Obese adults	n/a	23.0	21.8	31.0		14.6
How long we live and what we die of	17	Life expectancy - male *	n/a	74.1	76.9	72.5		82.2
	18	Life expectancy - female *	n/a	78.7	81.1	78.1		86.2
	19	Deaths from smoking	307	336.8	234.4	366.5		147.6
	20	Early deaths: heart disease & stroke *	172	121.2	90.5	151.3		44.9
	21	Early deaths: cancer *	208	148.1	119.0	168.0		81.6
	22	Infant deaths *	11	5.9	5.1	9.9		1.2
	23	Road injuries and deaths	68	49.3	59.9	214.1		20.2
Health and ill health in our community	24	Feeling 'in poor health'	15131	10.9	7.8	15.4		4.2
	25	Mental health	4340	51.0	27.4	72.0		8.5
	26	Hospital stays due to alcohol	755	549.4	247.7	652.4		85.6
	27	Drug misuse	2019	22.3	9.9	34.9		1.3
	28	People with diabetes	4915	3.6	3.7	5.9		2.1
	29	Children's tooth decay	n/a	2.8	1.5	3.2		0.4
	30	Sexually transmitted infections						
	31	Older people: hip fracture	144	601.6	565.3	936.8		259.7

Significantly better than England average
Significantly worse than England average
Not significantly different from England average
* PSA Target Measure 2005-2006

Middlesbrough

20/26 indicators statistically significantly *worse* than England

2/26 indicators statistically significantly *better* than England

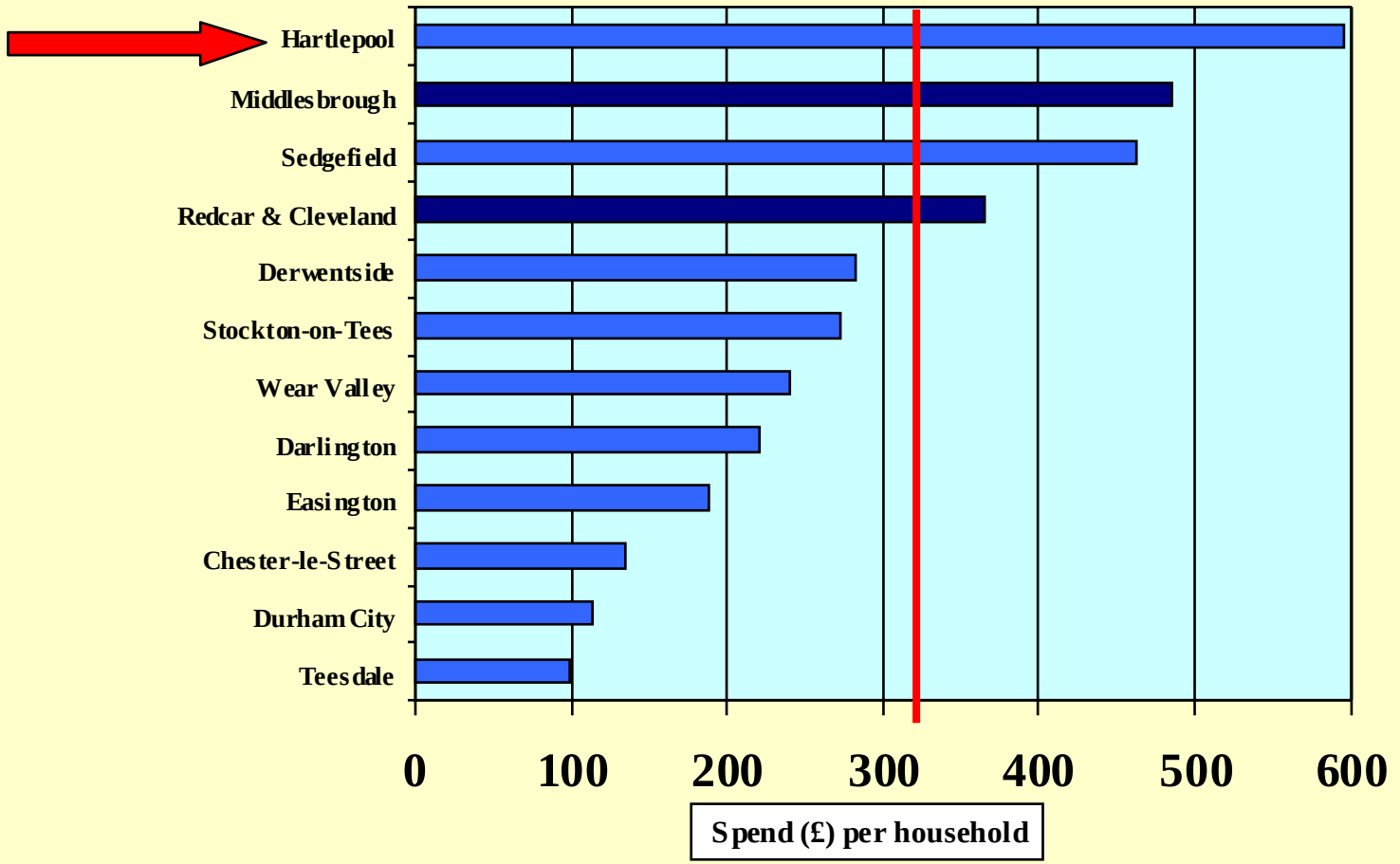
Cold kills

The impact of cold weather on health

Energy efficiency

Investment and improvement varies between areas

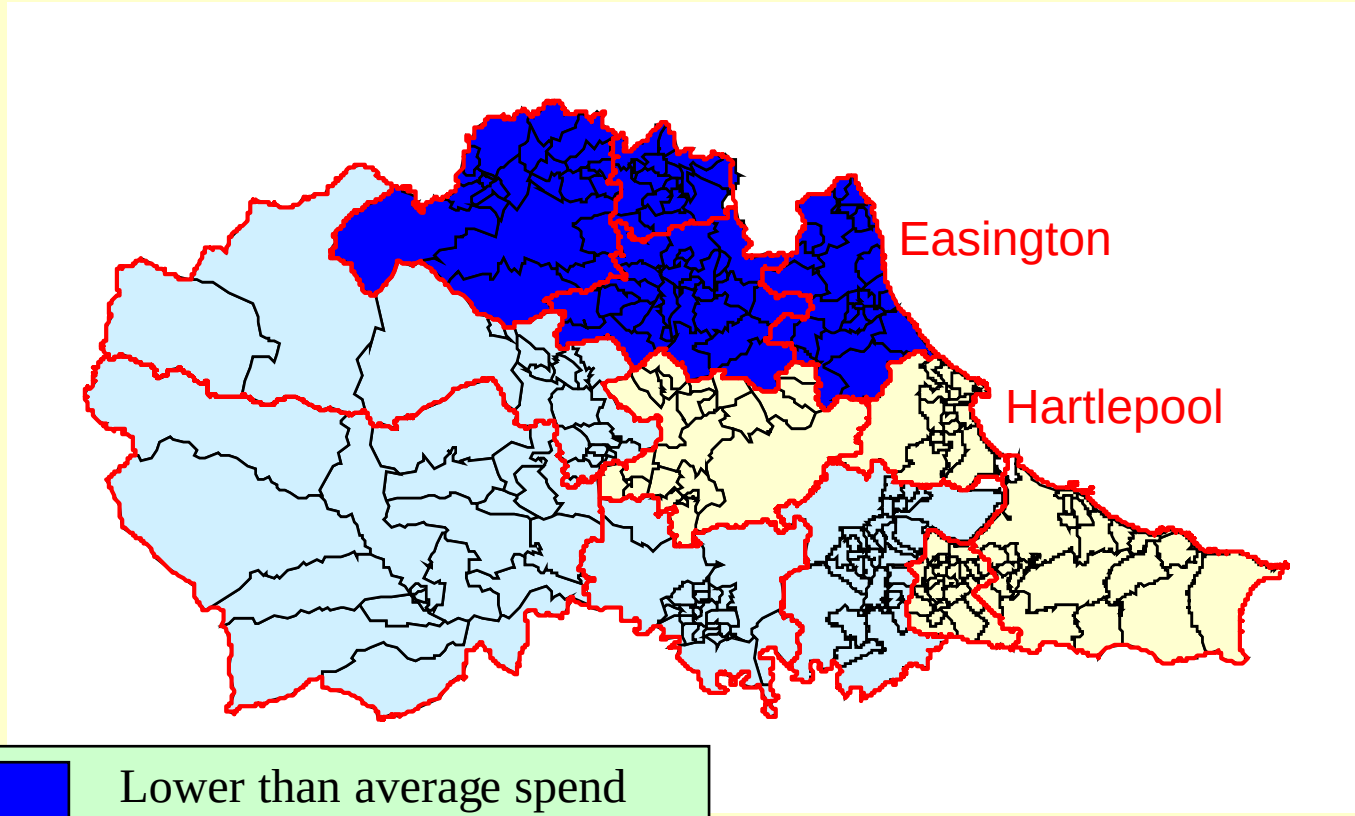
There is a 6-fold difference in spend per household on home energy efficiency improvement



Source: Home Energy Conservation Act Annual Reports

Investment & mortality

Excess deaths vary between the local authorities



Life expectancy is influenced by many processes and stages

Differences in choices – such as smoking and nutrition

Differences in opportunity – such as education, employment, wealth

Differences in aspiration – such as breaking away from ‘tradition’

Differences in awareness of risk – such as alcohol knowledge

Differences in response to symptoms – such as recognition of change

Differences in access to health and social care – such as waiting time

Differences in clinical behaviour – such as referral to hospital

Health Inequalities – Life expectancy for Women

- Focus needs to be on:
  - Helping people to stop smoking
  - Helping people to eat more healthily
  - Helping people to be more active

Health Inequalities – Life expectancy for Women

- Helping people to stop smoking
  - 13 drop in clinics spread throughout the town
  - 4 pharmacies providing full stop smoking support – Boots, Asda, Clayfields and R & J, Seaton Carew
  - Enhanced Support to Quit for those having failed a number of times
  - Initiatives in workplaces, hospitals and those specific to BME community

Health Inequalities – Life expectancy for Women

- Helping people to stop smoking (continued)
  - Screening in drop ins to detect early signs of chronic obstructive pulmonary disease (COPD)
  - Screening in GP practices for the over 40s to reduce risks from heart disease
  - Healthy heart checks provided for HBC and PCT staff (over 40s)

Health Inequalities – Life expectancy for Women

- Helping people to stop smoking (continued)
  - High rates of smoking in pregnancy. Use of social marketing approach to help reach this target group. A rewards and incentives scheme started 1st July 2009 based on the focus being the woman and not the unborn baby.
  - Plans to run a stop smoking clinic alongside current contraceptive clinic for young people

Health Inequalities – Life expectancy for Women

- Helping people to stop smoking
  - The legislation to ban smoking in public places has had a major impact
  - Much more work for Government still to do to reduce illegal sales, illicit tobacco, underage sales, get rid of point of sale advertising, plain packaging, etc.
  - HBC has been awarded £100k to use for tobacco control and stop smoking initiatives

Health Inequalities – Life expectancy for Women

- Helping people to eat more healthily
  - A very successful Health Trainer Team offering one to one advice and group work
  - Golden Apple Award established
  - Expo-chef cookery demonstrations in all primary and secondary schools – branching out into community
  - Level 2 Nutrition Training delivered to school catering staff to be followed by creative cookery training

Health Inequalities – Life expectancy for Women

- Helping people to eat more healthily
  - 17 fruit and veg bag schemes established
  - Initiatives being developed to ensure healthy eating options are in place for Tall Ships and beyond
  - Healthy eating and weight management sessions - HBC's IDeA Healthy Communities Project
  - Plans to increase number of women breastfeeding

Health Inequalities – Life expectancy for Women

- Helping people to be more active
  - Provision of a physical activity programme for children above their healthy weight range and their family (MEND - Mind, Exercise, Nutrition, Do It)
  - Women Begin to…… programme. Running, badminton, swimming
  - Community Activities Network – public health funding enabling voluntary/statutory groups to deliver physical activity

Health Inequalities – Life expectancy for Women

- Helping people to be more active
  - Free physical activity sessions offered to HBC, PCT and College of FE staff
  - A walks programme currently up to capacity
  - An effective GP referral scheme
  - A summer programme on offer available to all young people aged between 5 and 16 years
  - Free swimming for under 16s and over 60s

Life expectancy is influenced by many processes and stages

Differences in choices – such as smoking and nutrition

Differences in opportunity – such as education, employment, wealth

Differences in aspiration – such as breaking away from ‘tradition’

Differences in awareness of risk – such as alcohol knowledge

Differences in response to symptoms – such as recognition of change

Differences in access to health and social care – such as waiting time

Differences in clinical behaviour – such as referral to hospital