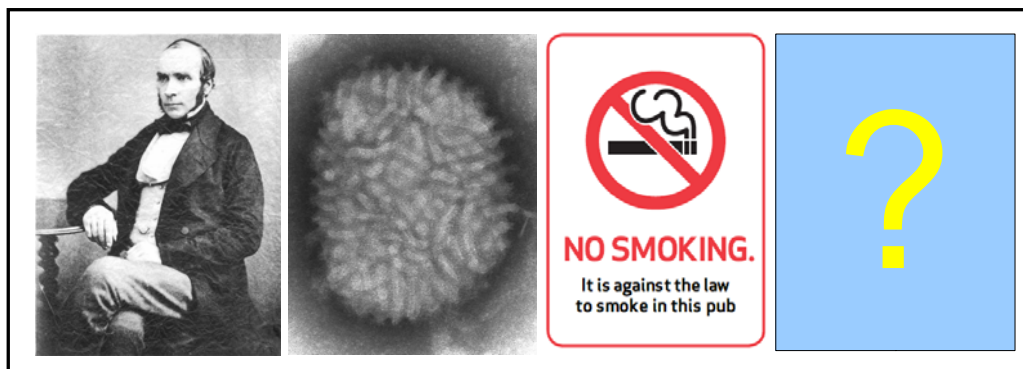


Better Health, Fairer Health

Consultation on a Strategy for 21st Century
Health and Well-Being in North East England

By the Regional Director of Public Health



October 2007

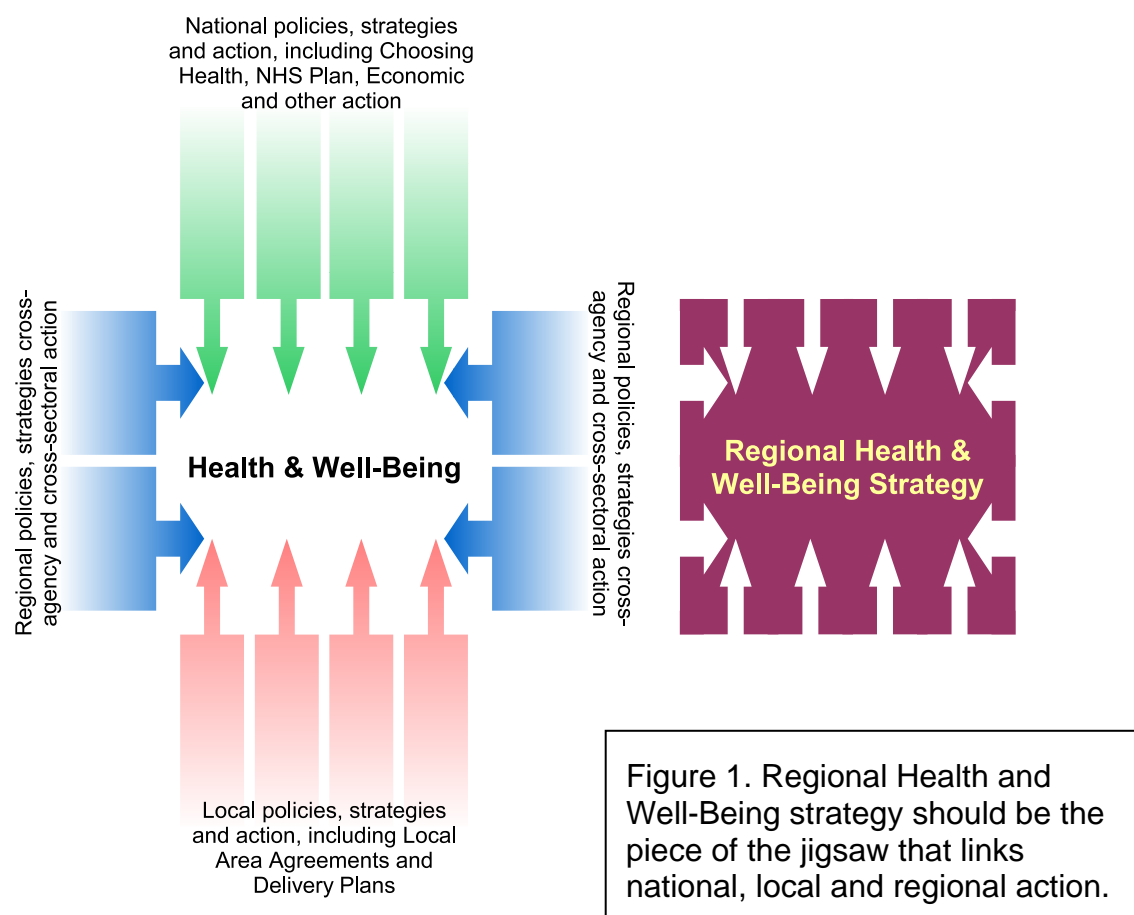
Passionate about health & well-being

Contents

I.	Foreword by the Regional Director of Public Health	4
II.	Responding to this consultation	8
1.	Introduction	9
1.1	Context	9
1.2	Why do we need a strategy?	10
1.3	Avoiding pitfalls	11
1.4	Principles underlying this strategy	13
2.	Better and fairer health	15
2.1	Reducing inequalities	15
2.2	Changing the North East 'life-course'	15
2.3	Key focus areas	17
3.	Specific areas of action	19
3.1	Smoking	19
3.2	Specific action on diet and obesity	22
3.3	Physical activity	25
3.4	Alcohol	26
3.5	Achieving better health through broader action and achieving broader aims through better health	27
3.6	Receiving help at the earliest opportunity	35
3.7	Improving mental health	38
3.8	Achieving a good death	39
4.	Making change happen	40
4.1	A matrix of action	40
4.2	Finding out what works when we don't yet know	40
4.3	Culture change in the North East	42
4.4	Social marketing	43
4.5	Legislation	44
4.6	Significant service changes and funding	44
4.7	Linking with other strategies and plans	46
4.8	Measuring progress	46
4.9	Governance and ownership	48
5.	A regional voice for health and well-being	50
6.	Key facts, milestones and timeline	52
6.1	Some key facts and indicators	52
6.2	Timeline for a regional strategy	54
7.	Summary of consultation questions	57

I. Foreword by the Regional Director of Public Health

- (i) The burden of poor health and premature death suffered by people in the North East of England is well known. Most people will also be aware of some of the underlying problems that cause this - from the high proportion of our children living in poverty to the legacy of heavy industry that is still shortening people's lives.
- (ii) What is perhaps less well known is that in some respects we are now improving that record, and quicker than anywhere else in the country. For example, premature death from heart disease and stroke is rapidly improving across the region through a combination of factors including:
 - reduction in smoking rates
 - the gradual increase in prosperity
 - excellent services in general practice (managing people with high risks)
 - excellent services in hospitals (caring for people and treating their immediate condition)
- (iii) However, we must not declare success too soon. We know there are plenty of other problems giving cause for huge concern. Too many people suffer from potentially preventable mental health problems. The rise in obesity amongst children and young people may one day reverse the trend in problems like heart disease and stroke.
- (iv) Too much alcohol is being drunk by too many people too often. Our Accident and Emergency departments are often overworked in caring for people who have been fighting or have suffered accidents as a consequence. Alcohol is the root cause of much domestic violence, the cause of many unwanted pregnancies and is ultimately the cause of a significant rise in frequently fatal liver disease amongst young adults.
- (v) There are national policies which tackle these issues and there is also a huge amount of work going on in every community. We should not understate its quality – the progress described above is, in no small part, due to that work.
- (vi) This consultation document, however, aims to fill a very significant gap: what are we doing at the regional level – what are we doing together as the people of the North East of England – that will make a significant difference to the work already going on.
- (vii) The strategy that results from this consultation should be the missing piece of the jigsaw in improving health and well-being, linking national, regional and local policies and filling the gap that currently lies between them.



- (viii) There are three important messages that I would ask you to bear in mind while reading this document:
- (a) It is a consultation paper. It is longer than I expect the final strategy to be and it may sometimes be a difficult read. Please follow it through. The problems we are trying to tackle cannot be dealt with in simple sound-bites and by collective goodwill. We need to be direct and specific based on an understanding of what might add value at the regional level. However, at this stage there is a large, clear need for consultation. Have we included the right issues? Have we missed any important actions? This is a consultation where we need your views.
 - (b) A fundamental, and perhaps the most important, issue for our region is the need to tackle inequalities in health. I want everyone in the North East to benefit from better health but I want the people and communities who have in the past been left behind to significantly catch up as a result of this strategy. This is a principle which deserves to be stated very clearly at the outset:

The actions that are proposed in response to the range of problems laid out in this consultation document have been chosen because of their potential to have significant impact on inequalities as well as delivering a health improving effect for all.

It will be necessary for us as a region to focus on fairness and to focus on implementing the strategy faster and in greater depth in some communities compared to others. As we progress through the 21st century and consider where we want to be in 25 years' time we must not tolerate unnecessary and unfair burdens of disease and poor health amongst our friends and neighbours.

- (c) This consultation lays out some ideas for specific targets in the North East during the period between now and 2032. In consulting with you I am particularly interested in what you think we should be aiming for. I am determined that we should be ambitious and direct but at the same time we can only achieve the goals of our strategy by working together. We must have confidence that if we focus our strategy and deliver the necessary changes to achieve such ambitious goals the targets are within our grasp.

How soon can we reverse the trend in obesity rising in our young people? How soon can we get smoking, one of the single greatest causes of cancer and other premature disease down to less than 10% of the population? Could we aim to be the first region of the country to be genuinely smoke-free? Should we be setting ourselves targets in relation to climate change? Please feel free to use the process of consultation to suggest your own view of where we should get to.

- (ix) The NHS in the North East has adopted a clear statement of its vision for the next 25 years. Based on a strong platform it aims to be the leader in excellence in health improvement and health service delivery. This is based on seven clear aims that move us away from success being defined as a little bit better than last year to zero tolerance of all the things we should put right:

- No barriers to health and well-being
- No avoidable deaths, injury or illness
- No avoidable suffering or pain
- No helplessness
- No unnecessary waiting or delay
- No waste
- No inequality

- (x) The challenge here is a deliberate change of thinking: what actions will we have to take to make such ambitious aims come to pass?

- (xi) The timing of this consultation coincides with a number of important changes and reviews in public policy. Among the most important of these is the Darzi review of the NHS, which, as part of its brief, will consider the NHS role in improving health and well-being. We will be working to ensure close correspondence between these processes.
- (xii) However, a key message in the scope of this paper is that achieving health and well-being is a very much greater and broader task than the activity of the NHS. Consultation is currently also underway on a review of the Integrated Regional Framework. New Local Area Agreements that will define the relationship between central government and local areas are being developed. In the near future, major regional strategies on the economy and planning are to be merged and their implementation reorganised.
- (xiii) I see no reason why we should not become the healthiest region in the country, instead of the unhealthiest. This does not stem from belief in some magic bullet to cure all ills, or that we will suddenly become the country's richest region. It stems instead from a belief that the right strategy can improve health faster in the North East than anywhere else in the country; that by maximising the potential of our young people they will make better decisions about their own health; that we can combine the best possible prevention of ill health with the best possible treatment; that well-being is the thing that we prize most and that if we genuinely will it to be so, well-being can be the new wealth of the North East.
- (xiv) You will find within the document a number of questions and clear guidance on how to respond. I look forward to hearing from you.

Dr Stephen Singleton
Regional Director of Public Health

II. Responding to this consultation

- (i) This consultation will be conducted in one stage, so that a definitive Regional Health and Well-Being Strategy can be published in early 2008. We recognise that this means certain issues arising from the consultation may, therefore, appear in the final version without additional, broader discussion.
- (ii) However, the stage beyond publication of the strategy will entail the development of work plans and establishment of a number of topic-specific work groups. The latter will be tasked to develop details of action in key areas. As part of this process, there will be further, broad, public and intersectoral engagement.
- (iii) In responding to this consultation, it is not necessary to address all of the questions, or even specifically to tie your comments to any of them. They are provided as a framework for responses but we welcome any comments that you may have.
- (iv) A summary of the consultation questions is included in section 7 of this document (page 57).
- (v) The consultation period runs from 4 October to 31 December 2007.
- (vi) The consultation document and response template is available on the Public Health North East website at:
http://www.go-ne.gov.uk/gone/public_health/improving_health/strategy
- (vii) All consultation responses should be made using the response template and sent by email to: public_health_ne@dh.gsi.gov.uk or by post to:

Health and Well-Being Strategy Consultation
c/o Public Health North East
Government Office for the North East
Citygate
Newcastle upon Tyne
NE1 4WH
- (viii) A summary of responses will be published with the final strategy at the above web address.
- (ix) Unless you specifically state that your response, or any part of it, is confidential, we shall assume that you have no objection to its being made available to the public on the Government Office for the North East website.
- (x) The final document will be published in January 2008.
- (xi) This consultation is being conducted in accordance with the Better Regulation Executive's Code of Practice on Consultation. Please address any comments about this consultation to Dr Singleton via the above contacts.

1. Introduction

1.1 Context

1.1.1 This document outlines proposals for a health and well-being strategy for the North East of England – a new initiative for the region, and for the Regional Director of Public Health.

1.1.2 In the past, directors of public health in the region have reported on the health of the population in annual reports – holding up a mirror to what is happening, commenting on shortfalls and potential improvements. These have identified how things being done could be done better, and have developed implementation plans for national initiatives.

1.1.3 What we have not done previously is to lay out an agenda for regional change to try to transform the health and well-being of our population.

1.1.4 The American psychologist Abraham Maslow defined the needs of humans in a hierarchy, from the most basic of physical needs (food, shelter, sleep) through safety (freedom from crime, possession of good health, secure income), love and belonging, esteem and respect, and finally what he termed ‘self-actualisation’ (for example creativity or morality).

1.1.5 The challenge of public health remains today, as it has always been, to help as many people as possible to move upward through that hierarchy, to achieve their full potential. More people in our society reach higher up this scale than ever before. But it is sobering that even in the 21st century there are members of our society who are struggling with even the lowest levels – of adequate food and shelter, of freedom from crime and worklessness.

1.1.6 These basic concerns continue to be central to action on health improvement as they have been since the earliest days of formal public health action in this country.

1.1.7 In Victorian England the greatest of the public health reformers were those who brought about major changes that impacted upon the lives of countless individuals and allowed them to move up Maslow’s scale; John Snow identifying water supplies as the source of cholera or Joseph Bazalgette constructing the London sewers, for example.

1.1.8 The problems we face today are partly at a different level of need. But there are still major changes that can be achieved in the manner of the great pioneers. Perhaps the most outstanding example in recent years is the legislation on smoking in enclosed public spaces. An immense step forward for public health, and a change that has been supported in exemplary fashion by the people of the North East. More responses to the government consultation were sent in support of legislation by people in this region than any other part of the country, and the latest statistics show implementation and compliance to be better in this region than anywhere else.

1.1.9 Our challenge now is to identify where else there are changes that can be made that will have such far reaching benefits to our population – and this does not mean simply seeking further changes to laws, but thinking more broadly about the factors that lead to population-wide problems.

1.1.10 As an example, we are suffering an epidemic of obesity across the country and the statistics suggest that this problem is a particular one for the North East. Too often the solution to obesity is presented as if it were simply a personal choice. As though, with enough lecturing and finger-wagging, individuals would see sense and sort themselves out. It is as if the solution to cholera in Victorian London had been to say that drinking a particular water supply was a personal choice, and if people would just have the sense to live in a house with a different water supply everything would be resolved. It wasn't the case then and it isn't the case now; the answer was to alter the water supply not the drinkers. The epidemic of obesity isn't simply a lifestyle choice. It is a consequence of our environment, and if we are to find a solution to the epidemic we will find it in alterations to the environment.

1.2 Why do we need a strategy?

1.2.1 The first question that deserves to be addressed in proposing a strategy is whether we should be doing so at all. The region has many strategies already, most of which are unknown to, and, even when effective, unnoticed by the public. We should note that a national strategy for health already exists, individual local authorities and primary care trusts have theirs and it is legitimate to ask whether a region requires anything in addition.

1.2.2 Our response is that a strategy should only proceed from this consultation if it genuinely offers something in addition to those that already exist. It must add value. Whether it does so will be judged on the basis of responses to this consultation, and if it does not add up to a programme that will improve health and well-being in the North East it will go no further.

1.2.3 The second question is whether improving health is not a responsibility of the NHS. Indeed, the formal responsibilities of Primary Care Trusts (PCTs) explicitly include improving the health of their population as do those of local authorities.

1.2.4 There are two responses to this. Firstly, there is a need to define how local authorities and PCTs should act *collectively* in pursuit of improved health and well-being, as well as acting singly for the benefit of their residents. Some of this will emerge from bilateral and cooperative agreements, but it is useful to provide a forum in which the debate can take place. A regional strategy can be that forum. Secondly, some actions affecting health extend well beyond health care and the remit of local authorities. Housing and transport policies for example. We need to find a way of describing desirable change that can cut across sectors.

1.2.5 Some might argue that ultimately health improvement depends mainly upon improving the economy.

1.2.6 This is partly true. Wealth does matter. The rich are generally healthier than the poor, though whether they are necessarily happier is arguable. It is not a simple equation. Divisions in society may matter as well as absolute levels of wealth; social standing, esteem and networks of support can be underestimated in its calculation.

1.2.7 These are important issues. The economy may not be the only or the best measure of a society's quality, and without a focus for discussion of well-

being, where else can the case be put for a different way of describing the success or failure of our region?

1.2.8 However the most compelling arguments for an ambitious strategy for health and well-being in the North East are those that justify the title of this document. The North East needs **better health** because, measured by life-expectancy and rates of major diseases, it is the worst of any region in England. In itself this seems cruelly unfair, but the argument for **fairer health** is made more strongly, both in the North East and in the country as a whole, by the even larger differences in health that exist between groups within regions. Establishing a regional approach to rectify these injustices is central to the purpose of this consultation.

1.3 Avoiding pitfalls

1.3.1 In preparing this document for consultation, quite a lot of material has been excluded that one would normally expect to see in a health and well-being strategy. In particular, efforts have been made to avoid some specific pitfalls listed here:

- a) Strategic documents are frequently inflated with elaborate descriptions of the problems of a population. We have avoided this, though details of health status for all parts of our region are readily available at:

<http://www.communityhealthprofiles.info/>

A strategy should not about be where we are. It should be about what we intend to do.

- b) It should be recognized that there is already an immense amount of action to improve health and well-being under way within the region. There is no point in documenting all of this again. We do not wish to produce a strategy that is simply an inventory of current business.
- c) There is a peculiar tendency in official documents to engage in what might be termed 'ugly contests' in relation to health and deprivation. These are a particular instance of problem description identifying usually why we are the worst / sickest / poorest in the country. In fact almost any part of England can produce some kind of evidence that 'our region has some of the worst wards in the country', and this fact emphasises that much of the discrepancy in distribution happens within rather than between regions, and within rather than between districts. This document mostly, though not entirely, avoids such statements – in general we have confined them to comparisons between regions.
- d) We have tried also to avoid exhortations to do better to workers and organizations where there is only a marginal chance of improvement. If an action to improve health already has 95% coverage, there is limited value in seeking the other 5%.
- e) We have also avoided excessive description of structure and process. In reviewing examples of health strategies from elsewhere we found that many focused excessively on the infrastructure of

committees and modes of discussion. These things matter, but they have no purpose without a clear direction of travel.

- f) A particular problem when working in public health, and in challenging organizations to make progress in key areas is that of being presented with 'fig leaves' – gossamer thin tapestries of small projects designed to preserve the modesty of the organization, but which, if stripped away, reveal little of real substance. The evidence-base for these is often thin, and evaluation is rarely adequately funded. Frequently, they survive on short-term non-recurrent grants and are sustained by the enthusiasm of specific individuals in whose absence they collapse. It is quite easy to construct a supposed strategy by assembling lists of such projects, but it is an option that we have tried to avoid. It should be noted, though, that this is not a criticism of those small projects themselves – they have an important part to play – but they do not comprise a systematic approach to improving health and well-being.
- g) In the face of problems that are clearly of great importance to a population's health, even in the absence of any evidence of effective interventions, and for fear of appearing indifferent to suffering, there is a temptation to fall into the trap of doing anything rather than nothing. This is often worse than doing nothing at all since it creates a spurious impression of effect, may actually be damaging in its process, and has the cost of diverting people and money from those things that do work. In this strategy we aim to avoid this, recognizing that some areas of concern will seem neglected. However, this should be qualified by the intention of working closely with the region's universities in developing properly evaluated approaches to those seemingly intractable problems.
- h) In public debate, and in many official documents, there is a confusion of the two terms 'equality' and 'equity'. We hear often of inequalities in health and health care, opportunities, wealth and so on. In this document we have tried consciously to separate the importantly different meanings of these two words. Equality is taken here to be a measure of sameness – for example, that everybody gets the same amount of treatment. Equity, on the other hand, is taken to be a measure of fairness – that everybody gets, for example, the amount of treatment that they need. Quite often the word equality is used with an implication of equity, so it is helpful to keep the meanings apart.
- i) Finally, we are keen to negotiate carefully the problem of excessively prioritizing equality, or even in some cases equity, over opportunities for improvements to the population's health as a whole. It would be possible to achieve more equal and (arguably) fairer health by making everyone's health equally bad, but it would not be a very desirable outcome. Our aim is to reduce both absolute and relative inequalities in health, but we should be conscious that a significant absolute gain for all, even in the presence of relative worsening of inequality, may well be worth taking.

Questions for consultation

- Q1. Should a regional health and well-being strategy for the North East exist and how can it add value?**
- Q2. Do you agree with the restrictions that have been placed around the development of this strategy, or is there a need to explore some of the pitfalls at greater length?**

1.4 Principles underlying this strategy

1.4.1 In considering what to include in this strategy, we suggest a number of positive criteria that should be considered. These are listed below:

- a) Anything that is included should add value to that which is already a commitment at more local or national level. There is no point in including anything that is already a commitment, and those things that are included should make clear what it is that needs to be done. Regional action will sometimes be necessary for local commitments to be met.
- b) Any proposal for action should provide a longer view than would be the case for most institutional planning cycles. While it is appropriate to spell out immediate needs, there should also be consideration of aspirations for the region over the next 25 years or more. What kind of region do we expect the North East to be in 2032? What will the style of life be?
- c) Crucially for a region that is in so many ways behind the rest of the country, we must put in place actions that allow us to travel further and faster than other parts of the country. Reducing regional disadvantage requires us to be the best in implementing change to remedy disadvantage. It also requires that when we are the best in a particular field of action (and there are many areas where this is already the case) we must continue to strive to become better still.
- d) Where possible, our proposals should provide a broader view than would be taken by any single organisation or group of similar organisations. A regional strategy offers an opportunity to define priorities shaping behaviour of many different bodies across the sectors.
- e) However, where existing actions by individual organisations or sectors falls short of regional aspirations it may be appropriate to identify these as regional priorities.
- f) A regional strategy should also be able to provide a deeper view of necessary change – addressing more fundamental causes than can be dealt with elsewhere, considering the rights that individuals have or might seek, and fostering aspirations for a better future.
- g) We should aim to provide consistency over time. A serious criticism, particularly of public sector organisations, is that they are reorganized too frequently to allow coherent pursuit of policies over a long period. We should aim to put in place actions that can

remain robust in the face of continuing organisational and political change.

- h) We need to focus on evidence-based change - doing better those things that work, stopping those that don't and not wasting time on those that are merely worthy.
- i) Where evidence does not exist, we must collaborate to obtain it.
- j) Our aim should be to obtain value for money in all we do. We should not pursue change that is not cost-effective.
- k) Any additional commitments should be few in number, recognising that many of the people and organisations affected have only limited capacity for extra. But they should be of sufficient importance to expect their prioritisation as key determinants of progress.
- l) Finally, in terms of style and presentation, our documentation should be as brief and direct as possible. It should be easily articulated and understood with a core of action sufficiently memorable that one would not normally need to consult the strategy in order to describe the main thrust of any key area.

Question for consultation

- Q3. Are the principles outlined the correct ones upon which to base a health and well-being strategy? Are some over-restrictive? Are there other principles that should be observed?**

2. Better and fairer health

2.1 Reducing inequalities

2.1.1 The reasons for the differences in health between North East residents and the rest of England, and between residents within the North East, are complex, but they can be summarised as:

- Inequalities in behaviour – for example in smoking, physical activity, consumption of food, drugs, alcohol and sexual activity
- Inequalities in opportunity – through, for example, poverty, expectation, education, employment and environment
- Inequalities in access – to services for those who are already ill or at risk

The proposals made in this consultation address all three of these areas – some specifically within one area, others cutting across all three.

2.1.2 In all cases the proposals have been chosen because they have the greatest likelihood of impacting both upon overall health of the population and of decreasing the disadvantage of the groups suffering greatest risk and disadvantage.

2.2 Changing the North East 'life-course'

2.2.1 In recent years, an increasing amount of research has focused on the ways in which health and life expectancy can be altered by events, choices and behaviours that happen long before illnesses develop. These might be habits acquired in adult life or earlier, infections suffered in infancy, the circumstances of a person's birth, the diet and habits of that person's mother when she was pregnant, or even the behaviours of parents before conceiving their child. The name given to the science of these factors is 'life-course epidemiology'.

2.2.2 In taking a strategic approach to improving health in the North East, we need to be aware of these influences and to prioritise action in those parts of the life-course that will impact most on the future health of people in the region. If we aim to have the best health in the country, we need to consider actions affecting people of all ages.

2.2.3 Figure 2 is a representation of the life course for an individual, the large arrow broadly indicating increasing age. It includes along its length a list comprising events (eg conception, birth, death) periods of life (eg infancy, frailty and illness), processes – some of which are lifelong – (eg learning, risk-taking, wear and tear) and qualities (eg quality of life). It is an imperfect model, but one which usefully allows us to think broadly about where we can act to make changes and the impact of those changes.

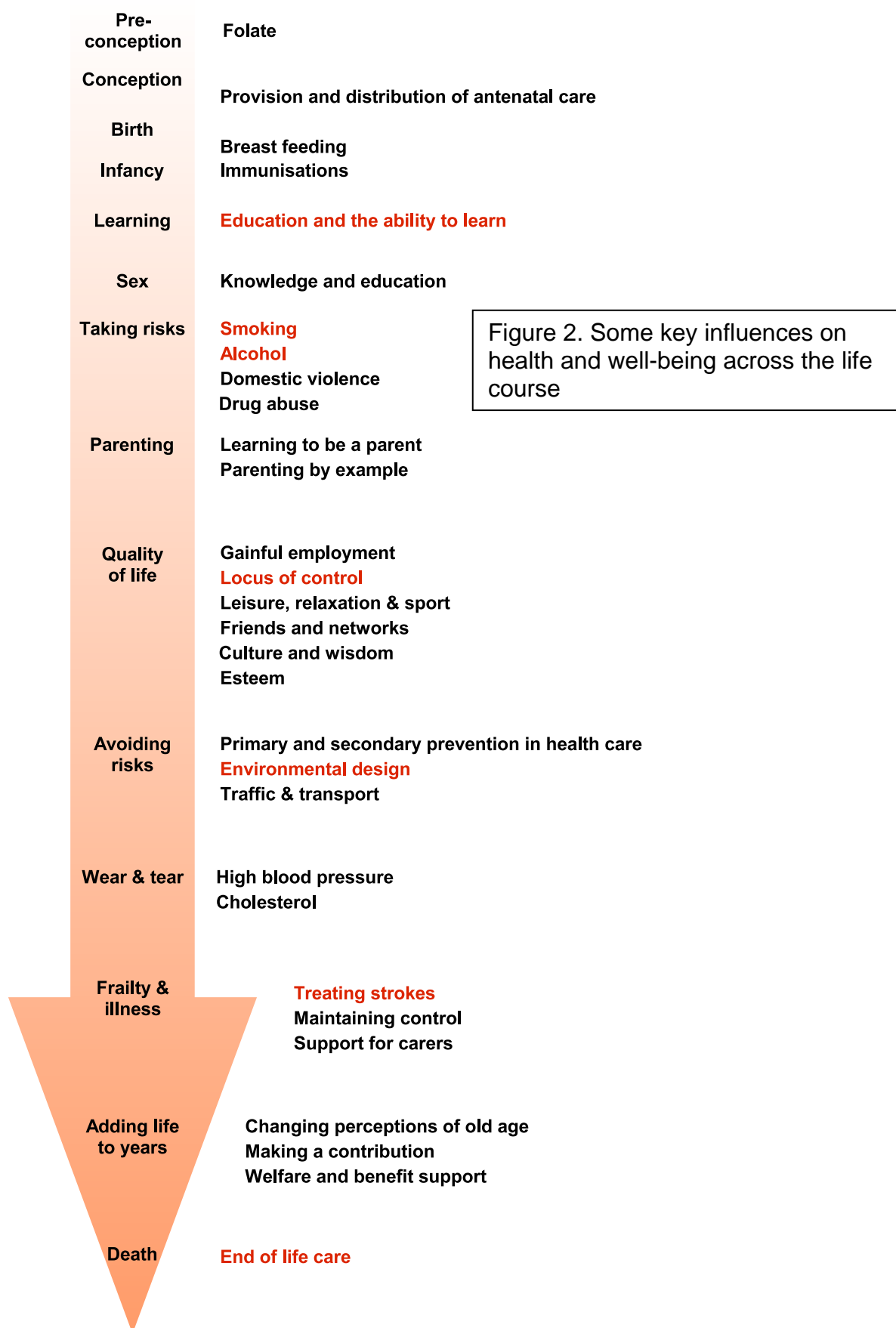


Figure 2. Some key influences on health and well-being across the life course

2.2.4 Alongside this arrow of life are listed a number of areas in which we could or do act specifically to improve health and well-being. The list is far from comprehensive. Instead, it is an attempt to identify interventions that might be expected to demonstrate a marked and measurable impact on the general health and well-being of our population. This is why the list doesn't include high-tech medical interventions or other actions that may have a big effect for specific individuals.

2.2.5 For example, while cardiac bypass surgery can significantly affect the quality of life and life expectancy of particular individuals with heart disease, even a ten-fold expansion of our capacity for heart surgery would have a negligible effect on death rates for the population as a whole. Of the enormous fall in deaths from heart disease that we have seen in the North East in recent times (rates more than halved in the last 12 years), no more than a maximum of 1-2% resulted from heart surgery. In contrast, roughly 50% of that fall resulted from changes in smoking. Nonetheless, we expect a parallel development of strategy for NHS services that similarly looks at needs and opportunities along the life-course.

2.2.6 Some of the areas of intervention are highlighted in red. These are suggested to be areas which fall particularly within the ambit of a regional strategy as it was defined in section 1. These are explored in more detail in section 3.

Questions for consultation

- Q4. Are there other life-course events, periods, processes or qualities of the life-course that should be considered?**
- Q5. What is missing from the 'menu' of areas in which we could act?**

2.3 Key focus areas

2.3.1 Section 3 looks at a series of key areas that should or might form the core of regional health and well-being strategy. Those that are covered here are:

- 3.1 Smoking
- 3.2 Specific action on diet and obesity
- 3.3 Physical activity
- 3.4 Alcohol
- 3.5 Achieving better health through broader action and achieving broader aims through better health
- 3.6 Receiving help at the earliest opportunity
- 3.7 Improving mental health
- 3.8 Achieving a good death

2.3.2 Of course the problem with selecting any set of areas for action is that others must be neglected, otherwise priorities do not exist. We consider that

these are the most appropriate areas upon which to focus, given the principles outlined in section 1, and that they are those most likely to deliver better and fairer health both for and within the North East.

Question for consultation

- Q6. Are these the most significant and alterable of areas that influence health and well-being? What others would you advocate?**

3. Specific areas of action

3.1 Smoking

3.1.1 Smoking is outstandingly the single most important of all factors impacting adversely on the health of the North East. It is implicated in a fifth of all deaths. It accounts for as much as half of the total inequality of health between the richest and poorest groups in the population.

3.1.2 The impact of smoking is so varied that it cannot easily be confined to one area of the life course. As figure 3 illustrates, there are potentially devastating effects at all stages.

3.1.3 Although the introduction of comprehensive smoke-free legislation was an extraordinary step forward, and is likely to remain a touchstone event in public health improvement, the temptation to believe that having gained this law we have solved the problem should be resisted. There is far more that needs to be done.

3.1.4 There are a number of key regional objectives in tobacco control policy that must remain at the heart of our collective efforts. These include the areas listed in the following paragraphs.

Coordination of regional activity

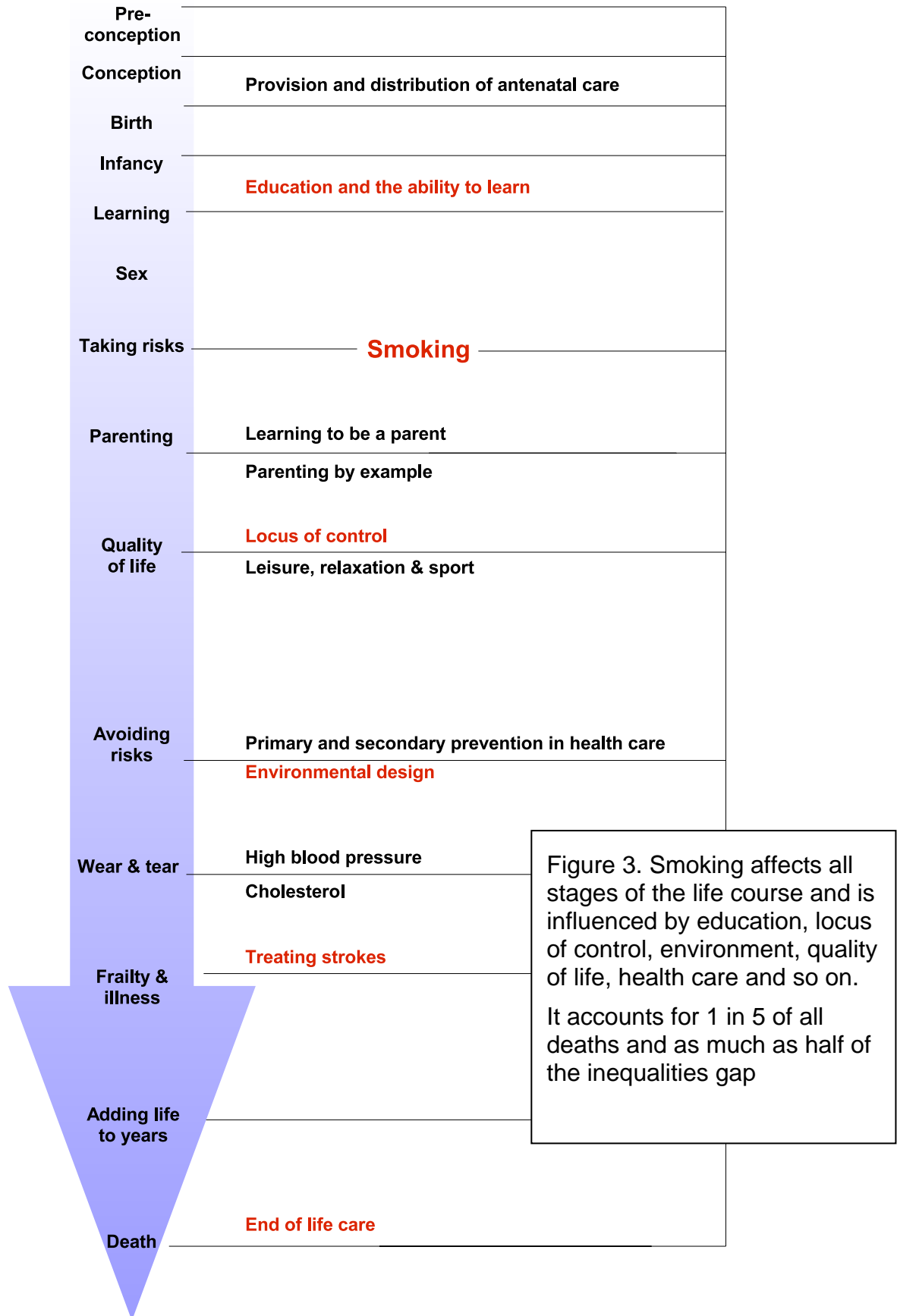
3.1.5 Regional activity will continue to be coordinated by FRESH: The Campaign for a Smoke-free North East, this will include support for:

- Infrastructure, skills and capacity
- Reducing exposure to secondhand smoke
- Helping smokers to stop
- Work to reduce smoking before, during and after pregnancy
- Media, communications and education
- Reducing the supply of smuggled and counterfeit tobacco products
- Reducing the availability and supply of tobacco products to children
- Reducing tobacco promotion
- Regulating tobacco
- Research, monitoring and evaluation

A number of the most important regional issues are identified in the following paragraphs.

Stop smoking support

3.1.6 The North East as a whole has the best performing Stop Smoking Services in the country. But this hides a large variation between areas within the region. Hartlepool, for example, has twice the rate of supported quitters as Derwentside.



3.1.7 It is **proposed** that there should be regional standards for levels of service that require the less well performing areas to increase their activity to match those achieved by the best, and to continue improvement in all services to ensure that those in the North East continue to be the most effective in the country.

Smoking in pregnancy

3.1.8 Reducing the rate of smoking in pregnancy is a key priority. At present around 25% of babies in the North East are born to mothers who have smoked throughout pregnancy. As a consequence, birth weights are lower, and infant mortality is higher than it would otherwise be.

3.1.9 It is **proposed** that we should collate on a six-monthly basis statistics on smoking in pregnancy in the region and publicise these widely as part of a broader marketing campaign to highlight the dangers to babies of smoking during and after pregnancy.

Media and communications

3.1.10 Publicity and reinforcement of the messages behind the recent legislation on smoking have been shown elsewhere to help in maximising and maintaining the benefits of smoking legislation. Therefore, it is **proposed** that the regional campaigns on this issue will be sustained for the foreseeable future.

3.1.11 It is further **proposed** that these campaigns should be assessed formally to test for added value over and above implementation elsewhere in the country.

Further legislation

3.1.12 It is **proposed** that lobbying and campaigning on content of cigarettes and the availability of alternative delivery modes of tobacco will become a greater focus for campaigning work on the legislative front.

3.1.13 It is further **proposed** that lobbying should be undertaken to ensure that the UK adopts Reduced Ignition Propensity (RIP) cigarettes, which would reduce the impact of smoking-related fires and cut down on deaths and severe injury.

Targets

3.1.14 The nature of national targets for reduction in smoking prevalence are such that the North East is currently envisaged to continue to have a smoking rate worse than the rest of England for many years to come. We consider this to be unacceptable in view of our aspirations for the health of the North East population.

3.1.15 In 2003-4 discussion among primary care trust chief executives and Local Authority leaders endorsed an aspiration to bring the prevalence of smoking in the North East into line with the national average by 2010. This was not binding and was not incorporated into plans by local organisations.

3.1.16 Official statistics suggest that the prevalence of smoking in the North East lagged behind the fall that had been occurring nationally between 1998 and 2004 – notably because of the pattern of smoking in younger women in

the region. Although we cannot yet be sure, there is evidence that prevalence of smoking has since fallen in the region.

3.1.17 It is **proposed** that a formal regional smoking prevalence target should be adopted – aiming for an overall regional prevalence of no more than 23% by the end of 2010, and of 20% or a level below the national average by 2015 and an absolute level of only 10% by 2032.

3.1.18 These targets should be **measured** against registration of smoking status by GPs in their practice registers, with an appropriate region-wide quality control standard for registration.

Questions for consultation

- Q7. What other regional action should be taken on smoking?**
- Q8. Is it appropriate to set a regional smoking prevalence target? Is this the right level and timescale? Should we also set a long-term regional target for the reduction of lung cancer deaths as an indicator of overall smoking prevalence?**

3.2 Specific action on diet and obesity

3.2.1 After smoking, the second most important threat to the population's future health is probably the rise of obesity. Tackling this is far more complicated than combating tobacco. The problem arises from a combination of behaviours rather than one specific action, few foods are unequivocally 'bad' for you, and much can be attributed to lack of exercise and general physical activity rather than any deliberate act.

3.2.2 Infectious diseases are commonly considered as an interaction between a host (the individual with an illness), an agent (such as a virus) and the environment (predisposition to illness because of cold weather for example). Obesity can be seen in the same way, with a host (the person with excess weight), an agent (calorie intake in excess of expenditure) and the environment (which predisposes to excess calories). Tackling all three components is wise in both cases, but the greatest changes with obesity, as with infections are likely to arise from attacking the environment and the agent rather than altering the host (see figure 4).

3.2.3 Guidance on best practice in tackling obesity is available from the National Heart Forum, Department of Health and Faculty of Public Health. It is expected that this will form the basis of action to be undertaken under the banners of Local Area Agreements and Local Delivery Plans. However, it is important to note that there is little evidence to date of structured attempts to alter obesity levels in a population resulting in changes in prevalence of obesity in that population.

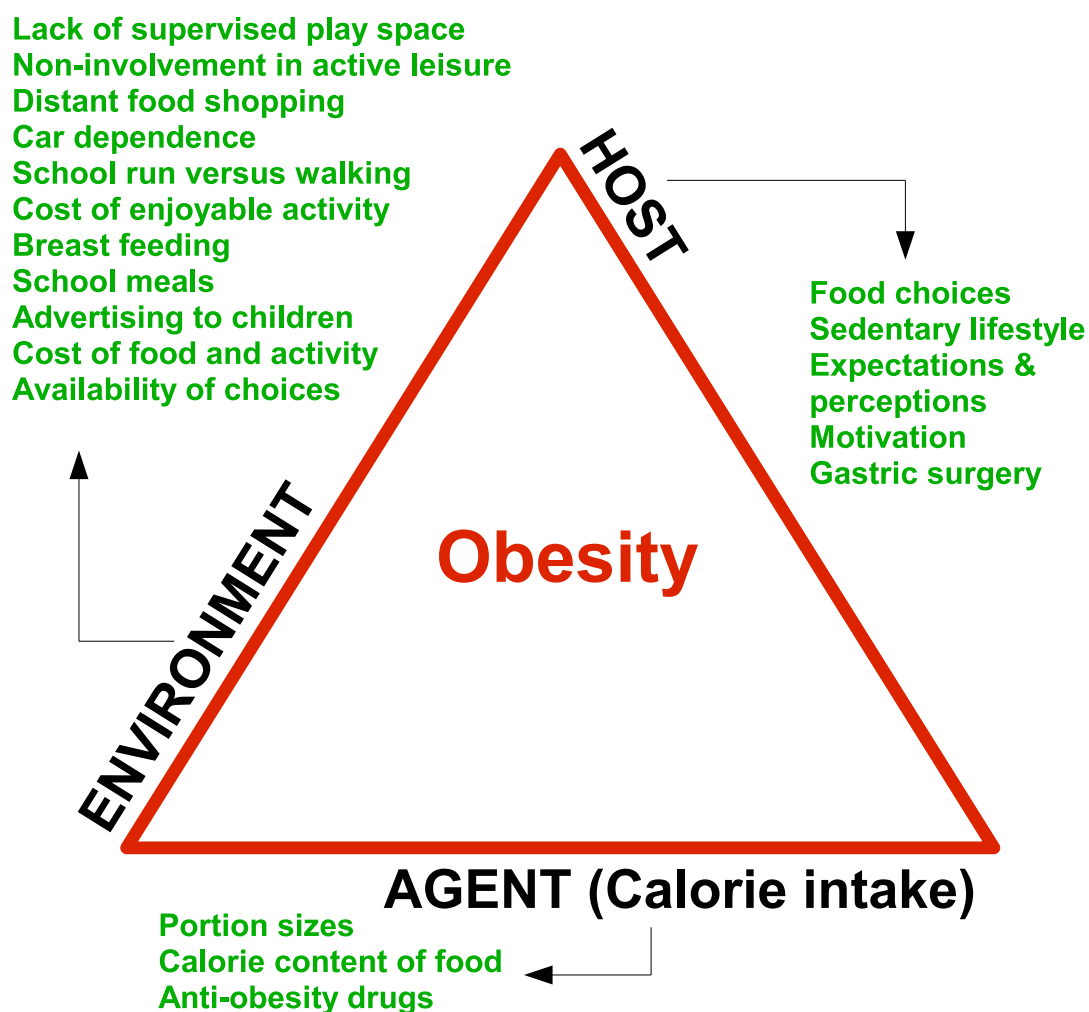


Figure 4. Obesity may be regarded, like an infectious disease, as an interaction between host (the individual with excess weight), agent (excess of energy intake over energy expenditure) and environment (which influences this balance). Although host choices have a role to play, many of the factors that may be altered lie with the agent and the environment.

3.2.4 In general terms, regional action on obesity and overweight appears likely to have the greatest life course impact if it is focused upon:

- Maternal diet and avoidance of obesity
- Effective action in schools
- Lobbying for legislation and action on standards
- Implementation of interventions that are supported by strong evidence

3.2.5 In conjunction with the proposed social marketing campaign relating to smoking and pregnancy (section 3.1.9), the **region should conduct similar work** to influence pre-conceptual diet and diet during pregnancy.

3.2.6 The added benefit of action at regional level relating to schools is limited. However, regular reporting on a set of health related standards for schools, and league tables of schools reporting their relative performance within the region are **proposed** as a means of encouraging adoption of best practice.

3.2.7 It is **proposed** that specific and funded lobbying of MPs, MEPs, ministers, commissioners and the Food Standards Agency should be undertaken regarding:

- increasing the availability of healthier foods (including reducing the levels of salt, added sugars and fat in prepared and processed food and drinks, and increasing access to fruit and vegetables)
- reversing the trend towards bigger portion sizes
- adopting consistent and clear standards for information on food, including signposting
- the promotion of healthy food to children

3.2.8 A particular concern in relation to food is whether specific vulnerable individuals and groups are unable to access healthy food at appropriate and fair prices. This may apply to whole communities (so-called 'food deserts') or to those who are housebound or poorly mobile. It is **proposed** that research should be commissioned to assess the potential impact of home delivery options of healthy food to those with access difficulties.

3.2.9 It is **proposed** that the region should measure the degree to which access to healthy and reasonably priced food is dependent on car journeys, with the aim of maximising the degree to which healthy food can be obtained without car usage.

Treatments for obesity

3.2.10 All parts of the region **should establish** comprehensive, integrated, community-based obesity treatment and support services. These should be established to a regionally agreed specification of best practice.

3.2.11 An infrastructure across the region **should be established** to support family interventions for seriously obese children and families, together with a clear specification of best practice in delivering these.

3.2.12 Access to bariatric surgery, orlistat and sibutramine at rates that **should be greater than the national rates** of uptake of those treatments, exceeding the proportional excess of obesity and overweight within our region.

Question for consultation

- Q9. Are the proposed initiatives the most appropriate regional actions to tackle diet and obesity? What other actions would you advocate.**

3.3 Physical activity

3.3.1 Physical activity is clearly an inseparable component of action to tackle obesity, but is addressed separately in this strategy because of its much broader relevance to health and well-being.

3.3.2 With regard to action on physical activity we can identify two major categories of our population:

- **Current risk: those who have signs, symptoms, established risk factors or manifest disease which may be altered by activity-based changes**
- **Future risk: those who do not have those characteristics**

3.3.3 Both categories are likely to benefit from altered activity, but our strategic approach to the two groups differs. The *current risk* group should be offered support and intervention by the NHS, provided the available interventions are evidence-based and cost-effective. For this group a change in lifestyle is not just prevention but may also be a treatment, even a cure. Importantly, this implies a funding commitment by the NHS for individuals defined within the *current risk* group – a commitment that is suggested not to apply to the *future risk* group. This is a pragmatic division, since we need a clear rule for defining what is and what is not an NHS funding responsibility.

Current risk

3.3.4 For *current risk* individuals it is **proposed** that we should aim to establish a formal referral system for individuals from the NHS to registered, licensed, performance-monitored deliverers of 'lifestyle alteration packages of care' across the public, private and voluntary and community sectors, setting in place an appropriate, accompanying per-patient payment by the NHS to those providers.

3.3.5 It is further **proposed** that the region should expect a broadening of rehabilitation services to establish an entitlement to access that goes beyond the current provision which is focused on patients who have suffered a heart attack. This implies ready access to formal, exercise-based rehabilitation to individuals suffering from a range of conditions including:

- Diagnosed psychiatric illness
- Chronic angina
- Post-cardiac surgery
- Diabetes
- Peripheral vascular disease
- Chronic obstructive airways disease and asthma
- Stroke
- Hypertension

Future risk

3.3.6 The *future risk* group should be encouraged and assisted in making choices to improve their lifestyle, but it is important that we should not 'medicalise' this aspect of life.

3.3.7 For the general population of *future risk* individuals it is **proposed** that we should sustain across the public, private, voluntary and community sectors a formal network of health trainers to assist individuals and groups in improving their health related behaviours. At present Health Trainers are predominantly employed by the NHS, but it is rational both that the future base of these workers should be much more diverse, and that NHS funding should be concentrated on *current risk* individuals. In line with this, it is proposed that any future recruitment of health trainers should be through local authorities and other sectors, with training and network support provided by the NHS to assure an appropriate level of health competence.

3.3.8 Our principal way of influencing the lifestyles of the *future risk* group will be through a programme of interagency work to design physical activity into the environment. See section 3.6.

Question for consultation

Q10. Is the division of physical activity current and future risk groups understandable and rational? What other conditions should be addressed specifically?

3.4 Alcohol

3.4.1 Our region has a particular problem with alcohol. We drink too much, and too often we do so by binge drinking rather than enjoying alcohol in moderation. We have high levels of alcohol related disease, and not just among those who are recognised to have an 'alcohol problem'.

3.4.2 If solutions were readily available for resolving this problem, they would already be in widespread use. So it is essential that any commitments are carefully evaluated to ensure their effectiveness.

Prevention

3.4.3 Earlier this year, the North East Regional Alcohol Advisory Group published a statement of priorities in relation to alcohol misuse. This defined the priorities of agencies within the region, and its framework for action outlined how these might be progressed.

3.4.4 However, the mechanism by which some of the actions would be implemented was unclear, and some potential broader actions clearly fell outside the remit of any of the partners. The framework did not set hard targets or embody new commitments. Recognising this, a proposal was made to explore the establishment a regional 'Office for the Safe Consumption of Alcohol'. Subsequently, there has been growing support for this concept, and as a consequence it is **proposed** that the region should establish such an

office to coordinate social marketing, lobbying and collective action in relation to alcohol for the North East.

3.4.5 A **proposed** central message in this process will be to build through social marketing approaches the conceptual link between alcohol and violence, domestic or public. Our aim will be to establish strongly in the perception of the region's population the importance of that connection as part of a broader understanding that alcohol is not merely a choice of one's own poison, but also a poison that damages those around you.

3.4.6 The longer term aim will be to build public antipathy to drunkenness, to promote an image of it as both unhealthy and uncool.

Treatment services

3.4.7 There is strong evidence for the effectiveness of brief interventions to reduce alcohol abuse, but the availability of such services in the North East remains low and patchy. It is **proposed** that there should be ready availability of brief interventions in all parts of the region.

3.4.8 It is further **proposed** that by 2010, the North East should have the highest per capita availability of brief interventions in the country.

Legislation

3.4.9 It is **proposed** that the office should undertake lobbying for an increase in taxation on alcohol, particularly to reduce excess usage. It will also lobby for greater regulation of alcohol outlets and restriction on cut-price sales.

3.4.10 The **proposed** office should also produce an annual report which will highlight on a local basis the levels of investment and action in these areas. In particular, it should highlight the relative provision of treatment across the region and between this region and the nation as a whole.

Question for consultation

Q11. Are these the best available actions to tackle alcohol? Are there others that should be evaluated? How far should we go in advocating and lobbying for increased restrictions through legislation and statutory regulation?

3.5 Achieving better health through broader action and achieving broader aims through better health

Economic development and regeneration

3.5.1 The Review of Sub-National Economic Development and Regeneration, published in July 2007, paves the way for unification of the Regional Economic and Spatial Strategies within a Single Integrated Regional Strategy (IRS). The IRS is described as one which "*sets out the economic, **social** and environmental objectives for each region*" (our emphasis).

3.5.2 Although the restructuring of administrative bodies and strategic responsibilities described in this review is quite complicated, it will clearly

create a significant opportunity to debate and influence some of the broader influences on health and well-being. And critical to this debate is our shared understanding of the relationship between health and well-being and economic performance.

3.5.3 Under the integrated strategy, progress against the over-arching objective of growth will be measured against Gross Value Added (GVA) per hour, employment rate, skills attainment, R&D spend and business start up rates. The Regional Development Agency, developing this in its proposed new guise as the 'Regional Planning Body', must also have regard to five principles of sustainable development; specifically *"living within environmental limits, ensuring a just society, achieving a sustainable economy, using science responsibly and good governance, and ensuring that all sub-regions and localities can achieve their potential, consistent with the Government's objectives on creating opportunities for all and tackling spatial concentrations of deprivation"*.

3.5.4 From a health and well-being perspective, skills attainment is certainly a key indicator. But increased productivity, crude employment rate and business start up rate do not specify the type of work or quality and experience of working. They do not, for example, indicate the degree to which individuals have 'locus of control' influence on their employment. While employment and economic growth tend to have positive effects on health, it is also quite clear that alone, better economic performance is neither necessary nor sufficient to deliver improved health.

3.5.5 The Sub-National Review itself recognises this, stating that *"GVA per head may not necessarily reflect disparities in people's overall welfare, or standard of living"*. This may result from differing costs of living between places, but also because *"measures of income [may exclude] important factors such as social networks and the quality of the local environment, which can significantly affect people's standard of living and quality of life"*.

3.5.6 Under the new structure, local authorities will be responsible for agreeing the Integrated Strategy with the Regional Planning Body and for scrutiny of its performance. The IRS itself will contain *"a clear and succinct set of priorities for the region"*.

3.5.7 The North East already has a track record of working to integrate the way that its constituent bodies work. Its Integrated Regional Framework (IRF) – in some respects a precursor for an IRS – draws together objectives for sustainable growth across agencies and policy areas. Its vision states *"The North East will be a region where present and future generations have a high quality of life. It will be a vibrant, self reliant, ambitious and outward looking region featuring a dynamic economy, a healthy environment, and a distinctive culture. Everyone will have the opportunity to realise their full potential."*

3.5.8 A revision of the IRF is currently out to consultation. It contains a section on Health and Well-Being which includes as potential areas for action: *"Developing a Regional Health Strategy, creating cross sector commitment and fostering collaboration in order to maximise focus and action needed to address the wider determinants of health"* and *"Implementing National Institute for Clinical Excellence objectives to tackle obesity by changing diets,*

promoting exercise, encouraging healthy lifestyles and creating safe spaces for activity".

3.5.9 These are very welcome, and are reflected in this consultation. However, other aspects of the IRF illustrate why debate about the primacy of health and well-being is needed, and provide, perhaps, a perspective on the current positioning of health and well-being in public policy.

3.5.10 The objective to "improve health and well-being whilst reducing inequalities in health" currently appears in the IRF as the sixth objective out of ten. This may not be a conscious ranking, but it implies, perhaps inadvertently, a lower priority. Its opening line states that "*Improving public health is vital for enhancing the economic capability and social well-being of the North East*". Similarly, the current action lists first "*working with GPs and other health partners, seeking to increase and improve joint working to maximise the economic contribution of health*".

3.5.11 Health is thus positioned as a means of achieving economic growth rather than as a goal which economic choices might assist in achieving. And this is not a trivial issue. It is commonly observed that in discussions relating to, for example, transport policy the drive for economic growth tends to trump all other considerations.

3.5.12 In the context of IRS development, and more immediately in response to the revision of the IRF, we would like to **propose for regional debate** the contention that the *primary* purpose of the North East economy should be to improve the health and well-being of its population, and that the region's "clear and succinct set of priorities" for the IRS should reflect this. As a consequence, those priorities might include **measures** such as 'Gross Quality of Life', employment quality in terms of locus of control, social capital and employer / workplace health improving behaviours.

Question for consultation

Q12. Do you agree that health and well-being should have this status within a regional integrated strategy? What other measures might be taken?

Education and ability to learn

3.5.13 Among the most potent of all measures to promote health and well-being is improved educational attainment. This is not only because of its inherent impact upon lifestyle choices but because of a cascade of benefits arising from improved earning power, greater self-determination, ability to properly access and use health care services and so on.

3.5.14 An important distinction should be made between educational attainment as a mechanism for better health, and the educational curriculum as a vehicle for delivering health messages. It is assumed far too often that health issues can be addressed through the latter rather than the former. As a result, any health problem tends to lead to calls for more curriculum time to be spent on physical activity, cooking or in specific health education.

3.5.15 There is copious evidence that greater educational attainment leads to better health. As a pertinent example, there are plenty of studies demonstrating an inverse relationship between more education and the probability of obesity. But this relationship is based on the generality of education, not on specific health education or the content of school curricula. In contrast there is little if any persuasive evidence that additional curriculum-based sport and physical education has any effect at all on obesity. What evidence does exist is generally equivocal, negative, poor in design or based on levels of intervention that would be unsustainable in practice.

3.5.16 A balanced regional approach to improving health and well-being should recognise this and acknowledge that precedence belongs to those parts of education that best serve the interests of the child as a whole.

3.5.17 It is **emphasised** that improving educational attainment should be seen by all public sector organisations as a shared goal. In particular, the engagement of health services with education should pursue a primary goal of assisting children to achieve their personal, academic and skills potential.

3.5.18 That is, health services should primarily support the academic curriculum and the ability of children to learn. Using the curriculum as a means of delivering health messages should be a secondary consideration.

3.5.19 SATs results for children in the North East at Key Stage 1 are as good as (and usually better than) the national average for boys and girls. By Key stage 3 they are almost the worst of any region.

3.5.20 But as with other indicators of health and well-being, there is some evidence of an important shift. Between 2000 and 2006, the proportion of children gaining five or more GCSEs at grades A-C in the region rose faster in the North East than in any other region in England. Starting from the worst position in the country, we passed four other regions to sit in 2006 about 1% below the national average. If this pattern could be maintained, the North East would have the highest figure nationally by 2011.

3.5.21 Unfortunately, the same cannot be said of the proportion gaining no GCSEs, which remains worse in the North East than any other region and has fallen more slowly than most.

3.5.22 The proportion of school leavers staying in full-time education has also been rising faster here than anywhere else. But the gap between best and worst started wider for this measure and the region remains near the bottom of the list, despite its progress. In London and the South East some 77-78% stay in full-time education, whereas here it remains just 68%.

3.5.23 It is **proposed** that a key strand of cross-agency social marketing in the North East should be to build aspirations and expectations of our children's potential. The aspiration of achieving the highest educational attainment for all children should be seen as an inseparable prerequisite for the aspiration of delivering the best health. Our priority should be to become the region with the greatest educational attainment, with the fewest possible left behind. For health services and other agencies working with schools and educational bodies this should be the first consideration in improving health.

Question for consultation

Q13. What do you think about the prioritisation of educational attainment? How would this work in practice for organisations other than schools?

Environmental design and physical activity

3.5.24 As noted in section 3.2.1 the epidemic of obesity that we are seeing in developed countries is one of the most substantial risks to public health for the coming century. And it is increasingly apparent that the solution to this may lie less in personal choice than in environmental change. Some of that change will relate to the availability and nature of foods, but much will be related to the behaviour of individuals in relation to their environment.

3.5.25 In January 2008, the National Institute for Health and Clinical Excellence will publish its guidance on physical activity and the environment. This is currently available in draft form for consultation. It is **proposed** that the North East, as the region with the greatest burden of obesity and health disadvantage should aim to achieve the most comprehensive and rapid implementation of the final version of this guidance once it is available.

3.5.26 However, in keeping with the principles outlined in section 1 we should also plan as a region to go beyond these recommendations. If we consider how this might be achieved within the five headings for recommendations used by NICE in their draft guidance, this could include the following:

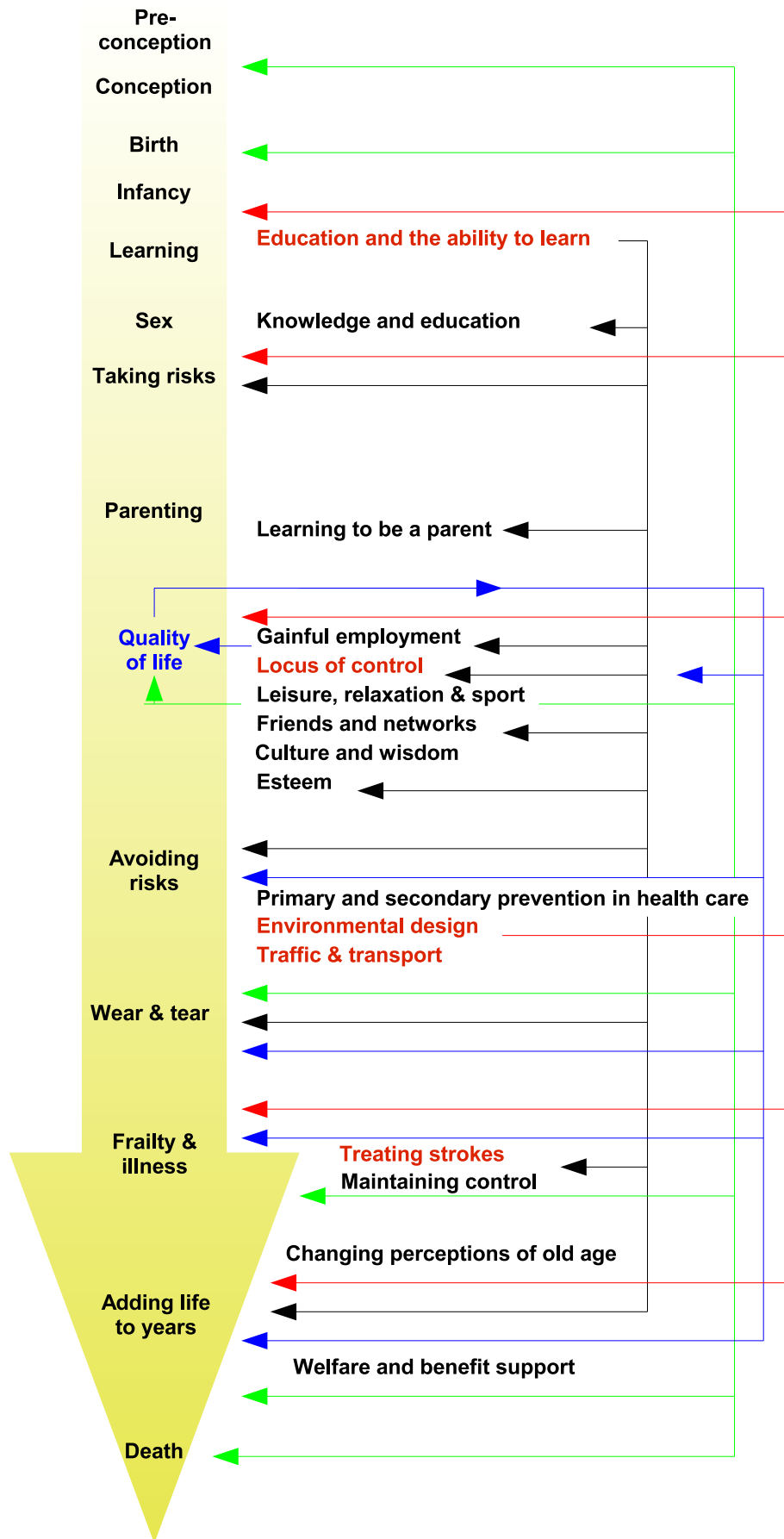
3.5.27 Strategies, policies and plans –we **propose** that regional targets should be developed to increase walking, cycling and use of public transport, and that within the IRS strong priority should be given to developments that increase these modes and discourage car usage.

3.5.28 Strategies, policies and plans – it is **proposed** that all public sector bodies should develop personnel and estate plans for increasing physical activity, to include promotion of walking, cycling and public transport as the normal mode of travel, with advice, support and financial incentives to discourage car usage, and targeted behavioural change support.

3.5.29 Transport – it is **proposed** that measures used to assess the cost-effectiveness of road and traffic schemes should be determined by a regional protocol that allocates values in accordance with health and well-being objectives, removing the current tilt toward car usage in assessments.

3.5.30 Transport – it is **proposed** that legislative lobbying should be undertaken for cycle lanes to be given ‘double yellow line’ status to prevent their obstruction by parked vehicles; for the norm in road building within the region to develop separate cycle lanes alongside motor vehicle provision.

3.5.31 Public open spaces – a regional policy is **proposed** for increasing access to casual opportunities for non-school based, safe, supervised play – for example, access to garden space, or access to supervised play space



close to home – and to develop a regional programme of returning ‘domestic’ streets to their former use as communal areas and not merely thoroughfares.

3.5.32 Buildings – regional strategies **should specify** that all new buildings should be constructed with prominence and preference given to design aspects that will favour physical activity – notably in the placement and accessibility of stairs in preference to lifts.

3.5.33 Schools – in keeping with the principles outlined in the previous section on education, it is **proposed** that options for altering school facilities to promote physical activity should not compromise the priority of improving educational attainment. Budgets that support teaching, learning and the curriculum should not be compromised by such physical design changes. Instead, it is proposed that the region should establish an external, charitable and sponsorship based collaboration to support and fund the governing bodies of all the region’s schools in improving their play areas and in other design activities that will increase physical activity.

3.5.34 Given the need for better and more reliable evidence to steer future environmental change, it is **strongly recommended** that these activities are conducted in close collaboration with evaluation programmes in the region (see section 4).

Question for consultation

Q14. Are these the most important measures for modifying physical activity through the environment? What other approaches might be used? How else might we go beyond the likely NICE recommendations?

Excess winter deaths

3.5.35 In recent years, the arrival of each summer has been marked in the NHS by the onset of ‘heatwave plans’, designed to prepare services against the risk of excess deaths in sudden heat. This has been shown in many places to be an issue of serious concern. In Northern France during 2003 some 15,000 additional deaths occurred because of two weeks of excessive heat. In London in August 2003, deaths among people aged over 75 rose by 60%. However, during the same period in the North East excess deaths were calculated to have been 12 – a figure, in statistical terms, that is indistinguishable from zero.

3.5.36 This does not mean that heatwaves will not be a problem for the North East in the future. However, they should be seen in contrast to the number of

Figure 5 (opposite). Education and ability to learn (black lines), quality-of-life-based economic and spatial strategy (blue lines), environmental design for physical activity (red lines) and targeted winter warmth and energy efficiency (green lines) impact upon health and well-being across the entire life-course.

excess deaths which occur in winter – according to the Office for National Statistics these numbered 1100 in the North East in 2005-6.

3.5.37 Before leaping to any conclusions about this figure, it is important to note that this was the second lowest rate of excess winter deaths of any region in England, and that the regional rate had been the lowest of any in the previous year – a testament to tremendous work already done to protect the vulnerable. But it is still 1100 too many. Most of these deaths are not from hypothermia but from causes that are not immediately recognised as ‘cold’ deaths. The rate of deaths from heart disease is nearly doubled by cold, and even brief exposures to cold may trigger heart attacks and strokes.

3.5.38 It is **proposed** that the North East should develop an interagency annual winter health protection plan. This should look at personal protection against cold; at the warnings and campaigns that should be conducted; how to alert behaviour change in cold snaps; what further action should be taken in insulation and housing design; how to further promote access to relevant benefits and so on.

3.5.39 If we were taking a balanced approach in terms of impact, we should consider that heatwaves don’t happen every year, but winter does. As such, we should presumably invest at least 200 times as much effort in winter prevention of excess deaths as we do in heatwave protection

Warmth, design, and energy

3.5.40 The risks of winter death are related to inequalities in health and wealth, and measures to impact on both may be possible in this context. A North East consortium recently lost out narrowly to the Midlands in bidding for a £900 million investment in a National Energy Technologies Institute. But the skills and industry that made that bid viable remain in the region with a claimed £6bn being invested in novel energy projects in the region over the next few years. The energy sector remains one of three key areas for development in the North East over the next 20 years, with the potential to generate around £2bn for new economic growth.

3.5.41 We suggest that a powerful corollary to that ambition would be to establish regional energy goals, related to the alleviation of fuel poverty, inequalities in health and wealth and excess winter deaths.

3.5.42 Despite the North East’s record on insulation and winter warmth, our housing stock remains highly energy inefficient. This is not only bad for the environment, but expensive for individuals and families.

3.5.43 As part of the Winter Health Protection Plan we **propose** far more active promotion of Warm Front Grants with targets for uptake across the region.

3.5.44 In January 2007 it was announced that 500 homes in Northern Ireland would have water-heating solar panels fitted free of charge as part of a government initiative. These are expected to cut each household’s heating bills by about £120 a year.

3.5.45 The UK as a whole lags far behind in the use of other forms of solar panels, such as the ‘photovoltaic’ type which generate electricity rather than

hot water and can both save money and generate it by selling electricity back to the national grid. In 2005 Germany, with a population less than twice that of the UK fitted 130 times as many panels. Yet Durham hosts one of one of the largest producers of photovoltaic modules in Europe.

3.5.46 It is **suggested for debate** that the region consider initiatives that go significantly beyond national schemes for deprivation-focused spread of energy efficient houses, not only maximising the uptake of Warm Front Grants through explicit and high profile regional targets, but considering also options such as a regional target for electricity-generating solar panelled roofs, targeted similarly to reduce costs (or even generate electricity profits) to poorer households.

3.5.47 It is clear that technologies and cost would limit the rate of progress, but we **suggest also for debate** that a goal over several decades, as technologies and their efficiency improve, might be to achieve partial or even total energy-independence for households in the North East. This could contribute to poverty reduction, winter warmth promotion, generation of work and be part of a radical modernisation of the North East. It could place health and well-being of individuals at the heart of policies for regional sustainability in place of more abstract aims of improving regional energy efficiency and conservation.

3.5.48 Although hugely ambitious and long-term, it is surely the case that a regional strategy should think in such terms if we are to achieve the best possible future. The concept of energy-independent households as a public health goal may, in truth, prove no more extraordinary than would have been the idea of an indoor toilet in every house at the beginning of the 20th century.

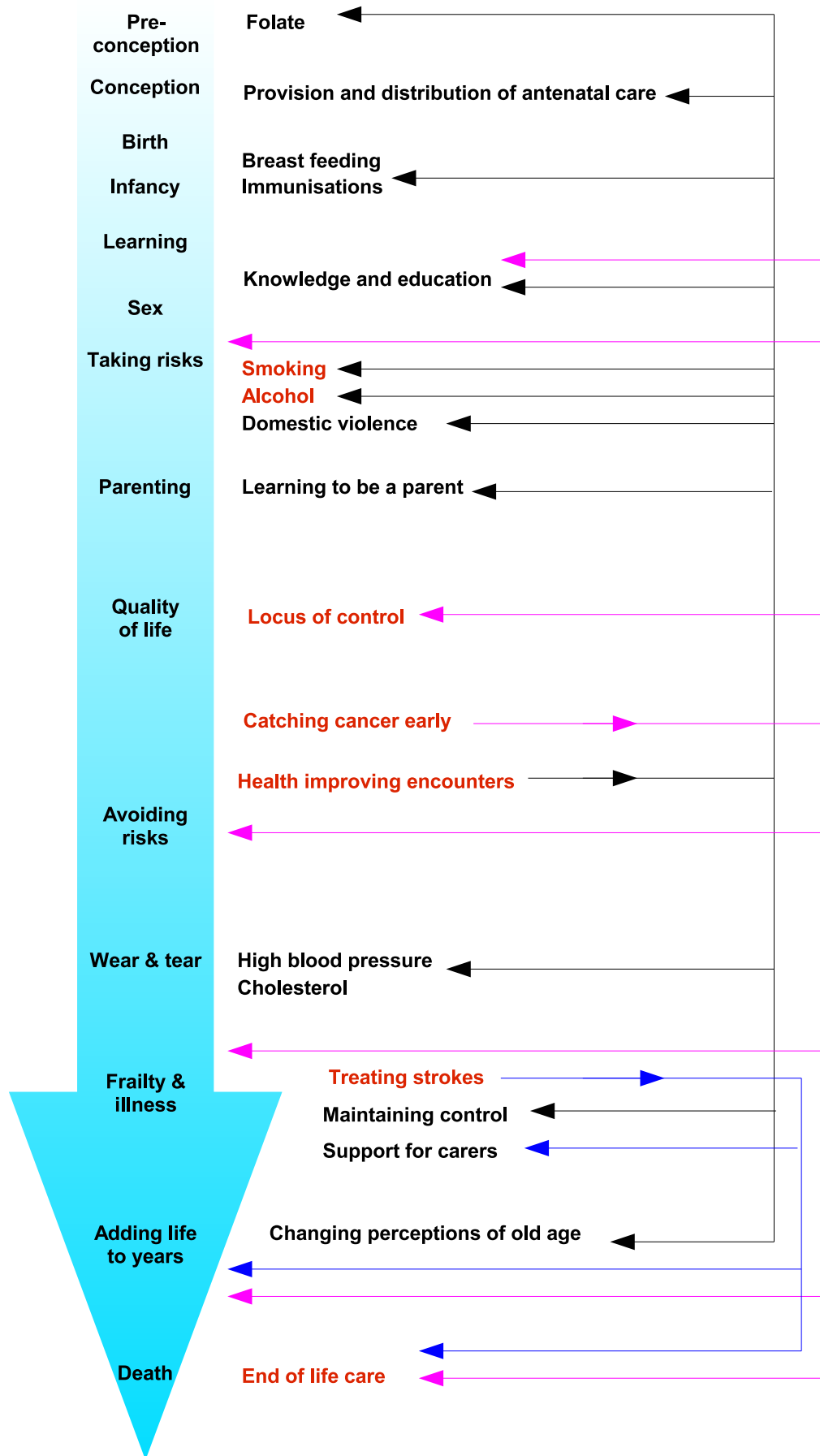
Questions for consultation

- Q15. Should a winter health protection plan be a priority for the region? What elements should it contain?**
- Q16. Is an aspirational target like energy-independence appropriate? What other approaches might we adopt in terms of redesigning our environment to improve health?**
- Q17. Considering section 3.5 as a whole, do you consider the selected areas to be the most important in which we might act? What others might we consider?**

3.6 Receiving help at the earliest opportunity

3.6.1 This is the most *health care* oriented of the areas selected for specific attention in this consultation. It reflects a particular regional problem that is manifest notably in our cancer statistics, but also in other aspects of health and health care. There are two components:

- People in our region fail to seek help for serious problems sufficiently early
- Despite good standards and progress on delivering high quality services, there are still treatments that are not systematically delivered to the best possible standards



Catching cancer early

3.6.2 The establishment of a substantial social marketing campaign is **proposed**, which will promote cancer awareness in the North East. This will focus upon those cancers for which there is evidence of poorer outcomes as a result of late presentation to health care services.

3.6.3 It is further **proposed** that there should be developed with the Cancer Registry an indicator of average stage at diagnosis of cancer for patients presenting in the North East and elsewhere, against which we can measure progress in improving early presentation.

Surviving stroke

3.6.4 We have seen very marked improvements in recent years in death rates from stroke in our region. Whereas the North East had the worst mortality of any region in England from this cause of death in the middle 1990s, we have moved up the scale since that time. Although the figures remain worse than the national average, the excess of deaths is now around 10%, having fallen from over 16% in 1993.

3.6.5 Surviving stroke, however, is not the only objective; surviving with as little damage as possible is crucial. Modern treatments are transforming the way that we see stroke. In the past there was little that could be delivered but supportive care and rehabilitation, whereas new drug treatments can limit the damage and reduce its consequences.

3.6.6 As a result we need a shift in public perception. In the same way that the public understand a heart attack and the need for immediate action, we need to spread understanding of stroke as a 'brain attack' that should be treated with similar urgency.

3.6.7 To this end, **it is proposed** that we should set a regional target ahead of national action to ensure that all stroke sufferers can receive rapid, damage-limiting treatment, building on regional stroke services that are already among the best in the country.

3.6.8 This should be **supported** by a sustained campaign to raise stroke awareness and to develop public understanding of symptoms and appropriate response.

Delivering health-improving encounters

3.6.9 The national strategy for health raised the prospect that every health service encounter should be a health promoting encounter. This remains very far from the case. Primary care trusts across the region should agree with the strategic health authority an **action plan** to put this commitment into effect, putting in place the necessary education and support to allow this to become standard practice.

Figure 6 (opposite). Health improving encounters (black lines), catching cancer early (magenta lines) and rapid treatment of strokes (blue lines) can impact across the life-course but their effects are concentrated most strongly in old age.

Question for consultation

Q18. The set of issues listed under 'receiving early help' is diverse and has a stronger health care focus than other parts of this strategy – do you agree that these should be specified? What would you add to or remove from this list?

3.7 Improving mental health

3.7.1 The importance of improving mental health is often understated in policies, yet it is probably the single most essential element of well-being, and an enormous influence more broadly on health.

3.7.2 Despite the many indicators of regional disadvantage, there continue to be many signs of happiness and satisfaction in the North East. As a region, it retains an identity and sense of community that has been lost in many places. In policies and strategies, it is too easy to slip into the trap of seeing areas only in terms of their disadvantages and not in terms of the resources and potential that they contain. There are many problems, but that potential should be part of the solution.

3.7.3 It is suggested that all Local Strategic Partnerships in the region should have a clear focus on social capital in their Community Strategies, and policies for maximising this, and it is **proposed** that there should be an annual regional progress report on social capital in support of this.

3.7.4 It is also **proposed** that the region should develop a clear focus on valuing and improving individual mental health. This relates partly to the proposed objectives in section 3.5.12, and advocates the routine use of measures that indicate the quality of life and 'happiness' of the region.

3.7.5 Tied to this is the need for action to support sufferers of mental ill-health, and to vulnerable individuals which should be effected through:

- Access to individually funded physical activity support (section 3.3.5)
- Access to bereavement counselling and support (section 3.8.7)
- Support for parenting and specified best practice in relation to prevention, recognition and response to post-natal depression (relating also to sections 3.1.9 and 3.2.5)
- Media **campaigning** to promote recognition of depression and suicide risk, together with the establishment of routes of action for concerned 'recognisers' of such problems.
- A sustained **campaign** and programme of professional education to increase recognition of domestic violence, coupled with a cross-agency funded programme of evidence based preventive interventions.

Question for consultation

Q19. Do these proposals capture the key actions in support of improving mental health at a regional level? Is the focus correct? What is missing?

3.8 Achieving a good death

3.8.1 It may seem a little strange to include this within a health and well-being strategy. Yet of all elements of the life course this is the most unavoidable of all. Until now there has been no clear regional policy on provision and entitlement in terminal care or for the availability of hospices. It is an anomaly of current service provision that these services remain so heavily dependent on charity.

3.8.2 Nationally, the Department of Health has launched a three year, £12 million programme of investment in end of life care, within which Strategic Health Authorities are tasked to identify clinical priority groups and care settings at a local level. Realistically, the national budget implies an investment within the North East of around £200,000 per year. Spread across all of our districts, this is useful but will not effect great change.

3.8.3 The North East is now home to a major centre for the study of Ageing and Health, with a national and international reputation. This reflects a strong community of services, carers and researchers seeking not only to tackle diseases and causes of ageing, but also to improve quality of life in old age. Excellent end of life care should be inseparable from our efforts to extend life and cure or prevent disease, and our region should aim to be exemplary in this regard.

3.8.4 It is **proposed** that the region should establish a charter for end of life care, with a statement of the rights and entitlements that we consider should be honoured both for the individual preparing for death, and for their carers and families. This should relate not only to medical and nursing care, but to the behaviours of all agencies and sectors who deal with these issues.

3.8.5 This should **establish** an agreement between health and social care providers specifying the level of public sector funding that should be regarded as appropriate in support of terminal care services.

3.8.6 It should also **establish** standards and expectations of training and education for those who deal with end of life and bereavement issues.

3.8.7 It is **proposed** that this charter should define also entitlement to bereavement support/counselling available to all who need it especially following anniversary of loss and other significant dates, and that this should form a key component of action to safeguard mental health in a very vulnerable group.

Question for consultation

Q20. Do you agree that end of life care should be a focus of a regional strategy? Are these the right commitments? What others should be included?

4. Making change happen

4.1 A matrix of action

4.1.1 It may be useful in considering responses to this consultation to view the areas covered in section 4 as a set of themes and the issues touched upon in this section as modes of intervention, thus:

	Research & Development	Social Marketing	Lobbying / legislation	Service changes & funding	Links with other strategies	Measurement & standards	Governance
Smoking							
Diet & Obesity							
Physical activity							
Alcohol							
Mental health							
Broader action							
Early help							
A good death							

Figure 7. Matrix of proposed themes and modes of implementation for a health and well-being strategy.

4.1.2 For any of the theme areas, it is useful to consider whether action is necessary and important within each of those modes. In the following sections, the proposed action within each of the modes is considered.

4.2 Finding out what works when we don't yet know

Research for public health and well-being

4.2.1 Research and development are crucial to health improvement since in so many cases the evidence base for intervention is weak. In the context of health and well-being it is wise to be conscious of the old adage that absence of evidence is not necessarily evidence of absence – because particular interventions have not been proven to work does not mean that they do not work. However, the principle that one should act only in the presence of evidence, or within a framework of evaluation is both useful and important.

4.2.2 A general strategic aim for health improvement in the North East will be to integrate public sector health and well-being R&D with regional needs, so that we pursue a common agenda across organisations.

4.2.3 In pursuit of this, the five universities in the region have jointly submitted a detailed £5 million application to establish a 'North East Centre of Public Health Research Excellence' to the United Kingdom Clinical Research Collaboration. We will know if this has been successful by the end of 2007, but irrespective of success or failure in this bid, achieving a collaborative, regional approach is an important strategic goal.

4.2.4 NHS commissioners across the region have strongly supported this approach and are committed to ensuring long-term support and financial viability for a regional research programme to support health and well-being.

4.2.5 It is **proposed** that there should be a collective, annually renewable, contract to specify regional research work geared to public health delivery needs. This will be a formal commissioning agreement comprising an infrastructural (people and support) and activity (specific projects) element based on full economic costing.

4.2.6 These commissioning agreements will be tied closely to the aims of Local Strategic Partnerships and the setting of Local Area Agreements. In doing this it will be possible to embed evaluation and research into policy initiatives that seek to improve health and reduce inequalities.

4.2.7 It is essential that we build open channels between the front line of practice and policy-making and research, since it is generally held that a research-involved front line will be one that respects and implements evidence-based practice. Moreover, that front line will help to define the questions that really matter in improving health and health care.

4.2.8 Some specific elements of research needed in the region, and arising from areas already touched upon in this consultation, might include:

- Impact of tobacco campaigns and action (section 3.1.11)
- Potential impact of home delivery of healthy foods (section 3.2.8)
- Relationship of food access to car journeys (section 3.2.9)
- Impact of built environment actions to increase physical activity (section 3.5.34)

4.2.9 It is **proposed** that an initial regional programme of public health and well-being research will be agreed in the development of this strategy.

Health care research in the region

4.2.10 Health care research within the NHS has many important implications for the region, but there are two aspects which are outstanding:

- In the context of the economy, expertise, funding and knock-on impacts for the region are potentially of great significance as generators of wealth.
- In relation to quality of health care, it is clear that involvement in clinical studies drives up health care standards.

4.2.11 At present the North East attracts a far smaller share of NHS and other health-related research and development funding than would be

predicted by, for example, our share of the national population. In fact, the entire North East receives only a fraction of the NHS R&D funding assigned to the Hammersmith Hospital in London on its own. This is unacceptable. It is **proposed** that the NHS should aim to at least double its share of national health and health care-related R&D investment over the next five years.

4.2.12 Since involvement in clinical studies improves clinical standards, such involvement should be available to all patients in all health care facilities in the region. It is **proposed** that NHS chief executives in the region should set standards to ensure that this becomes the case.

4.2.13 Although the North East has good universities and NHS trusts, their size and national or international clout is limited. Durham and Newcastle Universities appear in 132nd and 133rd place in the Times Higher Educational Supplement ranking of world universities – neither reaching even the top 50 in Europe. Of our near neighbours, Edinburgh, York, Leeds, Glasgow and Manchester all rate higher. Yet with a population of 2.5 million, and the resources available within the region, the North East has a comparable base to many of the greatest international medical centres. There is no good reason why the North East should not be able to sustain a world-class health and health care research base. But to achieve this would require the regional NHS and all five universities to collaborate far more closely around a shared agenda than they have done in the past.

4.2.14 It is **proposed** that as part of the new Integrated Regional Strategy for the North East, there should be developed between the universities and the NHS a formal, single, collaborative strategy to achieve world-class health and health care research status for the North East.

Research governance

4.2.15 A single governance structure for R&D within the NHS (broader than, but including the R&D funded within the NHS by the National Institute for Health Research) is being established for the region. At a strategic level, this will help to ensure close alignment between the five Universities and the regional NHS R&D agenda.

Question for consultation

Q21. Do you agree that there needs to be an integrated North East approach to public health research? What specific areas of research are most urgently needed? Should there also be an integrated approach to all health care research in the region?

4.3 Culture change in the North East

4.3.1 If the North East is to achieve levels of health and well-being that are the best in the world – and there is no reason why we should not aim for this – there are key changes in our culture that will be necessary. One could, of course, take the view that these things are immutable – that there is nothing we can do to effect a change in culture. Yet clearly this is not the case. The shift in attitudes to smoking is perhaps a case in point; a critical change in understanding and behaviour that came about after many years of

campaigning and debate. And throughout this document, there have been identified a series of areas in which we might mount similar sustained campaigns.

4.3.2 We can divide approaches to cultural change actions into two parts:

- formal campaigns to alter public (or target group) perceptions, expectations and perceived norms
- specific lobbying and work to bring about changes in the law at local or national level to enhance health and well-being in the North East

We will refer to the first under the general heading of 'social marketing' and the second under 'legislation'.

4.4 Social marketing

4.4.1 A regional infrastructure for social marketing, providing expert support and an administrative infrastructure for coordination is being established. This will be linked closely to the National Social Marketing Centre, which will be a partner in this collaboration.

4.4.2 This will formally support a network across the region of those interested and active in the use of social marketing techniques in improving health and well-being.

Campaigns

4.4.3 We propose to establish specific regional campaigns in a number of key areas. These will be designed and planned to run over periods of years – in cases, possibly, of up to a decade or more – in order to influence public opinion.

4.4.4 An initial set of priority areas is proposed, including:

- Sustaining the impetus on tobacco control (section 3.1.10)
- A focus on smoking in pregnancy and in the company of children (section 3.1.9)
- Pre-conceptual diet and diet during pregnancy (section 3.2.5)
- Secondary harm of alcohol and unacceptability of drunkenness; domestic violence and its links to alcohol (section 3.4.5 & section 3.4.6)
- Debate about health and well-being criteria to be used in assessing regional economic and structural developments (section 3.5.12)
- Annual Winter Health Protection Plan and campaigns (section 3.5.38)
- Building educational aspiration and expectation of the region's children (section 3.5.23)
- Getting help early – in screening, cancer treatment, stroke (sections 3.6.2, 3.6.8)

- Depression and suicide risk recognition (section 3.7.5)
- Recognition of domestic violence (3.7.5)

4.5 Legislation

4.5.1 We propose also to lobby actively for particular changes in legislation that would deliver significant health and well-being benefits to the North East. These are suggested to include:

- content of cigarettes and the availability of alternative delivery modes of tobacco (section 3.1.12)
- Alterations to food content, limitation of portion sizes, consistent labelling, promotion of food to children (section 3.2.7)
- Increased taxation on alcohol, greater regulation of outlets, restricted cut-price sales (section 3.4.9)
- Alterations to the ways in which costs and benefits of new traffic schemes and other urban design issues are calculated, to remove biases and perverse incentives that obstruct shifting priority to walking, cycling and public transport (section 3.5.29)
- Changes to the way in which regional success is measured to facilitate prioritisation of health and well-being
- Cycle lanes to have double-yellow line status, separate lanes to be the developmental norm (section 3.5.30)
- Changes to building regulations to prioritise stairs and activity promotion (section 3.5.32)

Questions for consultation

- Q22. Are the social marketing and campaign issues listed the most important that should be pursued at a regional level? What is missing? What should not be a priority?**
- Q23. Are the legislative objectives appropriate? What other changes to law and current practice might enhance health and well-being in the North East?**

4.6 Significant service changes and funding

4.6.1 The areas that have been covered in this consultation cut across agencies and have implications well beyond the NHS. But there are a series of significant changes to health service configuration outlined in the proposals. The most significant of these are:

- Community-based obesity treatment services (section 3.2.10)
- Family interventions for obesity (section 3.2.11)
- National best rates of surgery and drug management of obesity (section 3.2.12)

- Funded referral for physical activity in current risk individuals (section 3.3.4)
- Expansion of rehabilitation entitlement (section 3.3.5)
- Establishment of an office for the safe consumption of alcohol (section 3.4.4)
- Increased availability of brief interventions for alcohol (section 3.4.7)
- Most rapid implementation of NICE guidance on physical activity and the environment (section 3.5.25)
- Collaboration to fund schools in improving play areas (section 3.5.33)
- New services to support victims of domestic violence (section 3.7.5)
- Programme for implementing 'Health Improving Encounters' (section 3.6.9)
- NHS funding for hospice and terminal care services (section 3.8.5)
- New structure for Social Marketing (section 4.4.1).

4.6.2 However, there are also significant implications arising from proposals for campaigns, marketing and lobbying which will have substantial cost implications.

4.6.3 In taking forward the recommendations of the White Paper '*Our Health, Our Care, Our Say*' the government has established a body under the title 'Health England' (www.healthengland.org). Its terms of reference include a mandate to 'make recommendations on developing a 10-year programme for preventative spending, based on a comparison with other OECD countries'. In pursuit of this it has published a provisional report called 'Definitions and Measures of Preventative Health Spending' which suggests strongly that English spending falls well short of the OECD average.

4.6.4 It is **proposed** that the North East should establish a measure both of regional preventative spend (in line with Health England recommendations) and of the cross-agency health and well-being revenue spend.

4.6.5 It is **proposed** that the region should set targets for preventative spend and for overall spend on health and well-being across agencies in excess of proportional targets set nationally, reflecting the worse health of the region and the greater need for investment in preventative action.

4.6.6 It is further **proposed** that there should be established agreed norms for the proportion of health care spend that should be devoted to programmes in each area of the region and that these should be publicised and reported upon on an annual basis.

4.6.7 It is also **proposed** that there should be formal agreements established between Local Strategic Partnerships and regional bodies identifying appropriate shared funding for agreed collective goals for health and well-being.

Questions for consultation

- Q24. Are the proposed NHS service changes justified and necessary?**
- Q25. Do you agree that there should be clear regional spending targets for health and well-being? Should these apply across sectors?**

4.7 Linking with other strategies and plans

4.7.1 It is essential that in proposing a regional health and well-being strategy we do not simply add greater confusion to an already extensive collection of regional plans. And the results of this consultation should feed smoothly into the processes of development that are mandatory for local organisations. These include:

- Local Delivery Plans for PCTs are being developed to cover the period from 2008-10 and these need to make provision for action on health and well-being
- Similarly Local Area Agreements are to be developed over the coming six months and will define the relationship between government and local areas
- The Darzi review of the NHS is currently in progress and is taking a parallel, life-course view of health care services.
- We are awaiting guidance on the requirement for PCTs and local authorities to produce joint strategic needs assessments for their populations
- Consultation is currently underway on the North East Integrated Regional Framework which includes public health objectives

4.7.2 In the longer term, implementation of the Sub-National Review and development of the IRS will be critical for the future of our population. A key theme of this consultation is that health and well-being objectives should be significant factors in this development.

Question for consultation

- Q26. In order to be effective, a regional health and well-being strategy must influence all other planning processes – do you think that this can be achieved?**

4.8 Measuring progress

4.8.1 It is important to stress that any standards and targets that are set within a regional health and well-being strategy are not mandatory. They will not be supported by law or governmental guidance since, by their very nature, they go beyond what is required in national plans. However, targets and standards agreed within the region can have moral weight, and provide a clear indication of what we are collectively trying to achieve.

4.8.2 In the main, it is **proposed** that formal assessment of any agreed measures will be undertaken by the regional Public Health Observatory working in conjunction with the Government Office Analysis Network and North East Regional Information Partnership.

4.8.3 Regional standards are proposed for:

- Quality standards for Stop Smoking Services (section 3.1.7)
- Reducing smoking in pregnancy (section 3.1.9)
- Regional targets for smoking prevalence reduction and quality control for its measurement via GP Registers (sections 3.1.17 & 3.1.18)
- Regional performance tables for schools in relation to health standards (section 3.2.6)
- Entitlement to rehabilitation (section 3.3.5)
- Highest per capita availability of brief interventions for alcohol of any region by 2010 (section 3.4.8)
- Measures and targets of 'Gross Quality of Life', Locus of Control, Social Capital, and Workplace Health-Improving Behaviours to be established for the region (section 3.5.12).
- Regional targets for increases in walking, cycling and use of public transport (section 3.5.27)
- Regional standards for assessment of road schemes that incorporate health and well-being objectives (section 3.5.29)
- All public sector bodies to produce plans for increasing walking, cycling and public transport (section 3.5.28)
- Integrated regional strategy to incorporate standards and targets for creating supervised play space, including domiciliary road usage (section 3.5.31)
- Regional target for uptake of Warm Front Grants, and debate over solar panelling and practicality of partial energy independence for households (sections 3.5.46 & 3.5.47)
- Improved educational attainment to be a key objective for all public sector organisations (section 3.5.17)
- Stage at presentation of cancer (section 3.6.3)
- Rapid access to emergency treatment of stroke (section 3.6.7)
- Regional charter for end-of-life care, and for bereavement counselling at death and around anniversaries of death (section 3.8.4 & 3.8.7)
- Regional preventive spend and allocation, beyond national norms (sections 4.6.4 to 4.6.7)

4.8.4 Specific reporting is proposed in relation to:

- Smoking in pregnancy (section 3.1.9)
- Assessment of added value of regional tobacco campaigns (section 3.1.11)
- Annual State of Alcohol Consumption in the Region report (section 3.4.10)
- Stage of presentation of cancer (section 3.6.3)

Question for consultation

Q27. Do you agree with the set of targets and standards in section 4.8? What is missing? What should not be included?

4.9 Governance and ownership

4.9.1 The aim of a regional health and well-being strategy is that it should be 'owned' collectively by the region; that all agencies in the region would recognise it as a guiding set of principles in all that they do. This is a tall order, but we have to start somewhere.

4.9.2 More formally, there must be a structure to sustain and develop such a strategy and to oversee its implementation. This structure outlined in appendix 1 is being set in place to coordinate public health and health improvement efforts within the North East.

4.9.3 At the top of the structure are two bodies – the North East Public Health Board and the Health Forum – which will provide leadership and strategic direction. The first of these will be chaired by the Chief Medical Officer, Professor Sir Liam Donaldson, preserving his longstanding links with and passion for the region. As a body it will focus strongly on professional leadership, strategy and outcomes.

4.9.4 The Health Forum is a broader and more delivery-oriented group, chaired by Sir Peter Carr, embracing political representation and strong links to all three sectors. It will have an oversight and scrutiny role. It is **proposed** that this will be the key forum for involvement of non-NHS/non-Department of Health agencies in steering future health and well-being strategy.

4.9.5 Shared secretariat functions between these groups and the administration of the North East Public Health Network will tightly link governance and oversight functions with management of the workforce in the region, and also with the commissioning processes of the NHS.

4.9.6 The Regional Director of Public Health will maintain close links with the governance structures for research and development, monitoring and intelligence, teaching and skills development.

4.9.7 An annual conference will encourage broader participation and provide a focus for feedback and discussion of progress on agreed strategic goals for health and well-being.

Question for consultation

Q28. Is this governance framework appropriate? Will there be sufficient and appropriate representation for concerned parties?

5. A regional voice for health and well-being

5.1.1 The post of Regional Director of Public Health (RDPH) is a curious one since formally it sits between the civil service and the NHS, serving both as an office of the Department of Health and as part of the management of local services. As a consequence the staff of the office of the RDPH are also drawn from the civil service and NHS.

5.1.2 Yet it is clear that a third and much older role also exists, which has its origins in local government dating back to the 19th century in the form of the 'Medical Officer of Health' (MOH). This tradition embraced monitoring local population health, acting as a public interface between health services and the community, facilitating cooperation to improve health, advocating and championing change, and confronting vested interests that stood in the way of health improvement.

5.1.3 Although the Local Authority post of MOH was technically abolished in 1974 to be replaced by the NHS Director of Public Health, there has been a recognition over recent years that a significant part of the role was lost in that change. As a consequence, we now see joint appointments between PCTs and Local Authorities as the norm for Directors of Public Health across the North East. This has the purpose both of bringing better local accountability to health services, and of allowing public health advice to have a greater influence over local decisions.

5.1.4 There has been, however, a deficit at the regional level of planning, policy and implementation. The RDPH role, as either civil servant or health service manager, has not accommodated the older tradition of the MOH, which was based on city and county administrations. There is no elected body at a regional level to which a MOH could be appointed, but the need for a monitor, public interface, facilitator, advocate, champion and challenger is marked.

5.1.5 The proposals made and questions raised by this consultation argue the case for this third role at the regional tier of government and administration in the North East. It is **proposed** that with a clear programme of work at this level, there should also be a clearly identified and recognisable office that is responsible for driving its implementation, which should be the office of the RDPH. In view of this, we would **welcome views** on whether it would be appropriate to brand and promote the office of the RDPH – to build recognition, facilitate implementation, and position the role more clearly with the public as a champion and advocate.

5.1.6 In this context, the title Regional Director of Public Health may be unwieldy, suggesting more strongly a functional environmental health role than the broader role outlined above. At a national level, the senior exponent of this function is known as the Chief Medical Officer and we would also **welcome views** on whether an alternative title such as Regional Medical Officer would enhance understanding of the regional role described by this consultation.

Questions for consultation

- Q29. What are your thoughts on the branding and public recognition of the office of the Regional Director of Public Health? Would it be useful in improving health and well-being to build 'brand recognition' of its roles and functions?**
- Q30. To enhance recognition of the role and identity of a regional office and programme to press for improvement of health and well-being, should the title 'Regional Medical Officer' be used to signal the link with the role of the Chief Medical Officer? Is there a better title that could be used? Or is Regional Director of Public Health sufficient?**

Reporting

5.1.7 The outcome of this consultation will be a regional strategy that will, among other things, define a work programme for the office of the RDPH. As such, future annual reports will be prepared that reflect its contents and priorities. These will summarise and provide commentary on the indicators collated in section 4.8.

Review

5.1.8 It is **proposed** that the strategy itself should be subject to review on a three-yearly basis. This does not imply that a new strategy should appear, but experience demonstrates that circumstances change and modification may be needed. In 2003 within the North East we aimed to achieve smoke-free status in all workplaces and enclosed public spaces by 2009, yet it was achieved by 2007. It would be wonderful to find also that our ambitions in other areas are too timid instead of too bold.

Question for consultation

- Q31. Is a three-yearly cycle of review for a health and well-being strategy appropriate?**

6. Key facts, milestones and timeline

6.1 Some key facts and indicators

6.1.1 This section contains a selection of indicators that are both important and also interesting in terms of setting our sights on future improvement. More detail is readily available, particularly at:

<http://www.nerip.com/indicators.aspx> and

<http://www.nchod.nhs.uk/>

Life expectancy and all-cause mortality

- ✘ The 2003-2005 directly standardised all-cause all-age mortality rate for North East men was 862 per 100,000 population (England 760)
- ✘ The 2003-2005 directly standardised all-cause all-age mortality rate for North East women was 604 per 100,000 population (England 532)
- ✓ Between 1993 and 2005 all-cause all-age mortality in the North East fell by 25% (England 23%)
- ✓ Between 1993 and 2005 below the age of 75 all-cause mortality fell by 31% (England 28%)
- ✘ From 2002-2004 life-expectancy at birth for men in the North East was 75.0 years (England 76.6)
- ✘ From 2002-2004 life-expectancy at birth for women in the North East was 79.6 years (England 80.9)
- ~ Between 1993 and 2005 male life-expectancy in the North East rose by 6.3 hours per day (England 6.3 hours per day)
- ✓ Between 1993 and 2005 female life-expectancy rose in the North East by 5 hours per day (England 3.9 hours per day)
- ➔ Life-expectancy in Japan is now 78.7 years for men and 85.6 years for women

Infant mortality

- ✓ In 2005 the North East infant mortality rate was 4.5 per 1000 live births (England 5.0 per 1000). Below 7 days, the North East had the lowest rate of any region
- ✓ The rate of deaths in the first 28 days of life was 2.8 per 1000 live births (England 3.4)

- ✓ The rate of deaths in the first 7 days of life was 2.1 per 1000 live births (England 2.6)
- ✗ In 2005 the North East stillbirth rate was 5.7 per 1000 births (England 5.4 per 1000)
- ➔ The infant mortality rate in Iceland in 2001-2003 was 2.4 per 1000 live births

Major diseases

- ✗ In 2003-2005 the North East had a mortality rate for circulatory disease per 100,000 of 309 for men and 196 for women (England 275 and 175)
- ✓ Between 1993 and 2005 all-age mortality from circulatory diseases fell by 55% (England 51%)
- ✗ In 2003-2005 the North East had a mortality rate for cancers per 100,000 of 252 for men and 176 for women (England 217 and 154)
- ✓ Between 1993 and 2005 all-age mortality from cancers fell by 20% (England 17%)
- ➔ If regional improvements in mortality from coronary heart disease and stroke continued on the linear trends that occurred from 1993 to 2005, the North East would have the lowest rates of any region by 2017 and 2027 respectively

Smoking

- ✗ The General Household Survey reported smoking prevalence in 2004 for North East men to be 28% and women 30% (England 26% and 23%)
- ✓ In 2003 support in the North East for a comprehensive smoke-free work place law including pubs and clubs was about 35%. Today it is nearer 70%, and our region has the highest rates of compliance in the country
- ✓ The North East has the highest rate of NHS Stop Smoking Service quitters of any region, even allowing for regional prevalence.
- ➔ Prevalence of smoking in California by 2006 had dropped to 13.3%

Diet and obesity

- ✗ In 2000-2002 obesity affected 24.7% of men in the North East (England 20.8%)
- ✗ In 1994-1996 the equivalent figure had been 14.7% (13.1%)

- ➔ In Japan, obesity affects 2.9% of the male and 3.3% of the female population, in Italy 9.3% and 8.7% respectively.

Alcohol

- ✗ North East mortality rates for chronic liver disease including cirrhosis rose by an average of 7.24% per year from 1993 to 2005 (England 5.3%)

Education

- ✗ In 2004-5, 5.1% of boys and 3.5% of girls gained no passes at GCSE or equivalent in the North East (England 4.4% and 2.8% respectively)
- ✗ In 2006 52.9% of boys and 61.9% of girls gained 5 or more grade A* to C GCES (England 53.8% and 63.4%)
- ✓ From 2000 to 2006 the proportion of children gaining 5 or more grade A* to C GCES increased faster in the North East than in any other region – if those rates of improvement were sustained, the North East would have the highest of any region by 2010

Winter warmth

- ✓ The average number deaths per month in December to March expressed as a percentage of the average number of non-winter deaths (in the preceding autumn and following summer) is called the Excess Winter Deaths Index (EWDI). For the North East The EWDI has been, on average, the lowest of any region in England since 2002 at 14.3% (England 16%)
- ✗ However, this represented, in 2005-6, an excess of 1100 avoidable deaths. In context, the annual excess of deaths in the North East resulting from all causes compared to the national average is about three times this number

6.2 Timeline for a regional strategy

6.2.1 Throughout this strategy, we have tried to push at the edges of current activity and thinking, to encourage debate about moving further and faster in delivering improved health, greater fairness and fewer inequalities. We would like to set some aspirational targets for health and well-being in the region. The table on the next two pages is full of question marks, but the ideas in the grid represent some of the things for which we should surely aim.

6.2.2 We **invite** thoughts and suggestions on what should be appropriate aspirations for the region for health and well-being over the coming 25 years. What timescale should these have? How ambitious should we be? We look forward to hearing from you.

- 2008** •
- 2009** •
- 2010** • North East has the highest per capita availability of brief interventions for alcohol in the country?
 - Smoking prevalence of 23% or lower?
- 2011** •
- 2012** • Smoking in pregnancy < 12%?
- 2013** • North East the first region with systematic availability of NHS funded physical activity support for current risk patients?
- 2014** • Highest GCSE attainment of any region?
 - Lowest rate of children leaving school with no GCSEs?
- 2015** •
 - Smoking prevalence below the national average?
- 2016** • Rising trend in obesity reverses?
- 2017** • Suicide in young people reduced by 50%?
 - Lowest CHD mortality of any region in England?
- 2018** • Regional all-cause mortality to fall below England average?
- 2019** • Infant mortality to fall below 2 per 1000 live births?
 - No excess winter deaths?
- 2020** • Target for all journeys self-propelled / public transport?
- 2021** • All-cancer mortality 5% better than England average?
- 2022** •
- 2023** •
- 2024** • Lowest stroke mortality of any region in England?
- 2025** • Obesity in children returns to pre-1995 levels?
- 2026** •
- 2027** •
- 2028** •
- 2029** •

- 2030** • Household energy independence?
- 2031** • Smoking prevalence < 10%?
- 2032** • The North East is the healthiest region in England?

Question for consultation

Q32. Are the provisional timeline targets right? What others should be included or used instead of these? Are the timings realistic or too ambitious?

7. Summary of consultation questions

- Q1. Should a regional health and well-being strategy for the North East exist and how can it add value?
- Q2. Do you agree with the restrictions that have been placed around the development of this strategy, or is there a need to explore some of the pitfalls at greater length?
- Q3. Are the principles outlined the correct ones upon which to base a health and well-being strategy? Are some over-restrictive? Are there other principles that should be observed?
- Q4. Are there other life-course events, periods, processes or qualities of the life-course that should be considered?
- Q5. What is missing from the 'menu' of areas in which we could act?
- Q6. Are these the most significant and alterable of areas that influence health and well-being? What others would you advocate?
- Q7. What other regional action should be taken on smoking?
- Q8. Is it appropriate to set a regional smoking prevalence target? Is this the right level and timescale? Should we also set a long-term regional target for the reduction of lung cancer deaths as an indicator of overall smoking prevalence?
- Q9. Are the proposed initiatives the most appropriate regional actions to tackle diet and obesity? What other actions would you advocate.
- Q10. Is the division of physical activity current and future risk groups understandable and rational? What other conditions should be addressed specifically?
- Q11. Are these the best available actions to tackle alcohol? Are there others that should be evaluated? How far should we go in advocating and lobbying for increased restrictions through legislation and statutory regulation?
- Q12. Do you agree that health and well-being should have this status within a regional integrated strategy? What other measures might be taken?
- Q13. What do you think about the prioritisation of educational attainment? How would this work in practice for organisations other than schools?
- Q14. Are these the most important measures for modifying physical activity through the environment? What other approaches might be used? How else might we go beyond the likely NICE recommendations?
- Q15. Should a winter health protection plan be a priority for the region? What elements should it contain?
- Q16. Is an aspirational target like energy-independence appropriate? What other approaches might we adopt in terms of redesigning our environment to improve health?

Q17. Considering section 3.5 as a whole, do you consider the selected areas to be the most important in which we might act? What others might we consider?

Q18. The set of issues listed under 'receiving early help' is diverse and has a stronger health care focus than other parts of this strategy – do you agree that these should be specified? What would you add to or remove from this list?

Q19. Do these proposals capture the key actions in support of improving mental health at a regional level? Is the focus correct? What is missing?

Q20. Do you agree that end of life care should be a focus of a regional strategy? Are these the right commitments? What others should be included?

Q21. Do you agree that there needs to be an integrated North East approach to public health research? What specific areas of research are most urgently needed? Should there also be an integrated approach to all health care research in the region?

Q22. Are the social marketing and campaign issues listed the most important that should be pursued at a regional level? What is missing? What should not be a priority?

Q23. Are the legislative objectives appropriate? What other changes to law and current practice might enhance health and well-being in the North East?

Q24. Are the proposed NHS service changes justified and necessary?

Q25. Do you agree that there should be clear regional spending targets for health and well-being? Should these apply across sectors?

Q26. In order to be effective, a regional health and well-being strategy must influence all other planning processes – do you think that this can be achieved?

Q27. Do you agree with the set of targets and standards in section 4.8? What is missing? What should not be included?

Q28. Is this governance framework appropriate? Will there be sufficient and appropriate representation for concerned parties?

Q29. What are your thoughts on the branding and public recognition of the office of the Regional Director of Public Health? Would it be useful in improving health and well-being to build 'brand recognition' of its roles and functions?

Q30. To enhance recognition of the role and identity of a regional office and programme to press for improvement of health and well-being, should the title 'Regional Medical Officer' be used to signal the link with the role of the Chief Medical Officer? Is there a better title that could be used? Or is Regional Director of Public Health sufficient?

Q31. Is a three-yearly cycle of review for a health and well-being strategy appropriate?

Q32. Are the provisional timeline targets right? What others should be included or used instead of these? Are the timings realistic or too ambitious?

Appendix 1. Proposed governance structure for public health in the North East

