

***‘Improving health is everybody’s
business’***

**A ten-year health improvement strategy
for Newcastle**

April 2007 – April 2017



FOREWORD

It's an honour to write the foreword to this ten-year strategy for Health Improvement in Newcastle.

Most of us don't think about our health until something goes wrong. However this strategy seeks to get us all thinking about our health *before* we need to use health services.

We all have a responsibility to look after our own health and to teach our children how to be healthy.

As well as offering a personal challenge to everyone who reads it, this strategy highlights the most significant health challenges facing us as a City. At times it makes uncomfortable reading but points a way forward to how agencies might work together to improve the health of every citizen in Newcastle over the next ten years.

I am grateful to all those who have given up their time to contribute to this strategy and hope that everyone will engage with it in whatever way they can.



Councillor Brenda Hindmarsh
Executive Member for
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EXECUTIVE SUMMARY

Introduction

This is Newcastle's first Health Improvement Strategy, effective from April 2007 to March 2017. It has been produced by the Newcastle Wellbeing and Health Partnership on behalf of the NHS, City Council, and the voluntary and community sectors. It is intended for all people working or living in the city with an interest in improving their own health or the health of others.

Making really significant improvements to the health of Newcastle residents requires collective action, over a long period of time, from across all society. We believe the city needs a ten-year health improvement strategy to complement the other key citywide long-term strategies such as the Regeneration Strategy, the Sustainable Communities Strategy, the Housing Strategy, the Children and Young People's Plan and the strategy for an ageing population; together they identify a long-term vision for Newcastle with actions aimed at improving wellbeing and quality of life for the city's residents. The health improvement strategy will specifically provide all partners with:

- a common understanding of wellbeing, health and health improvement
- an agreed vision and prioritised set of health improvement outcomes and targets for achievement over the long term

Our Vision and Approach

In our vision for Newcastle in 2017:

- *men and women from the range of social class, physical and intellectual ability, sexual identity and ethnicity will enjoy a long life of good quality, and life expectancy at birth for both sexes will be as good - if not better - than the national average*
- *fewer people will die prematurely from the major killers: cancer, heart disease and stroke before the age of 75.*
- *the stigma associated with mental health problems will be reduced*
- *people will feel valued and have high self-esteem, feeling part of a strong cohesive community with inclusive social networks*
- *fewer people will be overweight or obese, with more people being physically active and involved in sports, and all organisations promoting healthy eating*
- *few people will continue to smoke and most people will view smoking negatively*

- *the party image of Newcastle will be about having fun and enjoying being with people: many drinking venues will be family-friendly and the city will have lots of drink-free alternative meeting places for young people. Fewer people will drink excessively and more will be aware of safe drinking limits.*
- *All people, even those living in difficult circumstances, will be highly knowledgeable about their sexual health, and will be confident about how to manage their relationships*
- *children will experience a lower risk of being killed or seriously injured and older people a lower risk of falling at home than the national average*
- *the diversity of our population will be something we are proud of; people will be valued and respected for their differences and the diverse health needs of our population will be met.*
- *Those who need drug treatment will be able to easily access specialist support treatment services.*

Two strategic approaches have the best chance of delivering this vision over the long term:

- *all key partners collectively targeting their resources to address the underlying factors and lifestyle behaviours that directly improve physical, mental and social health*
- *a genuine community empowerment approach to developing and delivering a health improvement strategy.*

Only collective action and full partner engagement at every level, from senior management to front-line staff, will achieve success. The World Health Organisation has recently concluded that the most effective way to deliver sustainable health improvement is by local people taking ownership of the wellbeing of their communities, by involving them in local decision-making and the delivery of services

Health Improvement priority outcomes

The primary outcome of a health improvement strategy for Newcastle must be:

- *to reduce health inequalities by bringing life expectancy and premature mortality in Newcastle to the level of the rest of the country.*

To achieve this primary outcome, various areas of activity have been identified in the Department of Health white paper *Choosing health: making healthy choices easier*:

- *improving mental and emotional wellbeing*
- *reducing obesity (through diet, nutrition and physical activity)*

- improving sexual health
- reducing accidents
- reducing the number of people who smoke
- reducing the harm from alcohol and drugs.

The Newcastle Wellbeing and Health Partnership agreed these national priorities. In consultation with stakeholders across the city, ***improving mental and emotional wellbeing*** clearly emerged as the number one priority. The second clear priority is to ***reduce obesity (through diet, nutrition and physical activity)***. The consultation process also identified a number of subsidiary priorities within each main outcome, developed measurable indicators for each of these subsidiary outcomes and agreed initial three-year targets for each indicator. The subsidiary outcomes are:

Tackling health inequalities by:

- reducing the risk factors for heart disease, stroke and related diseases by reducing smoking, improving diet and increasing physical activity.
- supporting families, mothers and children
- engaging communities and individuals.
- addressing the underlying determinants of health.
- providing services that recognise the diversity of need and are responsive to the needs of disadvantaged populations

Improving mental health and emotional wellbeing by:

- reducing the stigma associated with mental ill health
- promoting self-esteem and positive mental health
- preventing the development of mental illness
- encouraging early intervention and self-help in order to prevent unnecessary distress and to prevent progression of the illness.

Tackling obesity by:

- reducing obesity levels in children
- increasing physical activity levels in children
- reducing obesity levels in adults
- increasing physical activity levels in adults
- increasing expectations of what constitutes good diet and nutrition
- improving access and better utilisation of green open spaces
- increasing consumption of good quality food products
- increased breast feeding rates
- increased breastfeeding rates in most disadvantaged 20% of neighbourhoods

Encouraging and supporting sensible drinking by:

- Changing the drinking culture of the city by modifying the party image, making drinking venues more family-friendly and providing more drink-free alternatives for young people

- Raising awareness levels of the benefits of sensible drinking and the hazards of unsafe drinking
- Increasing the number of problem alcohol users accessing treatment
- Increasing the percentage of people with alcohol problems able to access specialist treatment within five working days

Reducing the number of people who smoke by:

- Making Newcastle a smoke-free city.
- Reducing the prevalence of smoking in the population of Newcastle.
- Increasing the number of smokers who quit smoking.

Improving sexual health by:

- Improving the level of exposure and quality of SRE in schools and communities.
- Reducing the incidence of sexually-transmitted infections (including chlamydia, gonorrhoea, syphilis and HIV).
- Reducing teenage conception rates in Newcastle.
- Reducing teenage conception rates in the most disadvantaged areas.

Reducing drug-related harm by:

- Improving the ease of referral and communication between drug treatment services.
- Improving the percentage of people with drug problems able to access specialist treatment within five working days.

Reducing accidents by:

- Reducing the incidence of road traffic accidents amongst children.
- Reducing the incidence of older people falling at home.
- Raising awareness of how to prevent accidents, particularly in disadvantaged areas.

The Strategy recognises that the most effective way to improve health is by local people taking ownership of the well-being of their communities and encourages more work to build on the successful examples of community engagement already taking place in the City. Community development and involvement can do this on a collective basis – for example, by identifying barriers a particular community has in accessing services it needs – or on an individual basis – by helping a person gain skills and confidence to make positive changes to his or her lifestyle. Evidence also suggests that the very process of getting involved in community engagement activities has a beneficial impact on health.

Finally, the Strategy also proposes a way to convert the Strategy into action. It recommends that delivery groups are constituted to take each outcome area forward. Wherever possible these will be constituted from existing groups working within the city. The strong focus of these groups will be to involve

partners from across sectors and organisations that have the ability to deliver key actions within their organisation to achieve the Strategies outcomes.

CHAPTER ONE: INTRODUCTION

The Wellbeing and Health Partnership

This strategy has been produced by the Newcastle Wellbeing and Health Partnership on behalf of all those statutory, voluntary, community and private sector partners committed to promoting coordinated action to improve health and to reduce health inequalities in Newcastle. It is steered by an executive group, which includes senior representatives from the National Health Service (which includes the Primary Care Trust, The Newcastle Upon Tyne Hospitals NHS Foundation Trust, The Northumberland Tyne and Wear Hospitals Trust), Newcastle City Council and the voluntary and community sectors. This document is intended for all people working or living in the city with an interest in improving their own health or the health of others.

What is wellbeing? What is health?

Wellbeing and health mean very different things to different people, depending on their age, occupation or social background. When we talk about a person having a good quality of life or enjoying a high level of wellbeing, what we mean is that the person has the capability to do and be the things he or she values in life. In other words:

Wellbeing (or quality of life) can be defined as the gap between what a person is able to do and be in life and what they would like to do and be.

How does health relate to wellbeing? Some health professionals have tended to think of health in quite narrow terms, but The World Health Organisation uses a broader definition that links it to wellbeing:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.

So achieving good health is the means to an end – being able to do all the things we want to in life, feeling fulfilled, and in the process living a longer life.

What do we mean by health improvement?

Many social, economic, spiritual and environmental factors can have a *direct influence* on a person's wellbeing. For example someone with a good income can afford a comfortable home and get about to do the things they enjoy - the things most people value in life. But it can also *directly improve* their health by enabling them to make healthier choices about what to eat, where to live and what type of work to do. In this strategy then we will use the term health improvement to mean:

Any action taken to address the underlying factors and lifestyle behaviours that directly improve physical, mental and social health.

What do we mean by health inequalities?

Generally, the more affluent a person is, the better their health will be, so those who live in the most deprived areas suffer the poorest health. Not only does Newcastle have higher levels of ill health than other parts of the UK, but also the scale of poor health in some wards is worse than the rest of the city. The causes of these inequalities are unjust and avoidable, and unfortunately get passed on from one generation to another.

Health inequalities are also shared by groups of people with common interests and identities, such as those with physical disabilities, learning disabilities, older people, those with mental health problems, the homeless and black minority and ethnic communities. The challenge is to ensure that *everyone* in Newcastle shares future improvements in health and that action is taken to reduce the widening health gap by targeting preventative action accordingly.

Why have a health improvement strategy?

When we think about improving health, NHS organisations such as hospitals and GP surgeries usually spring to mind, but it is clear that improving health is everybody's business. The Hospitals Trusts and the PCT have the lead role in *treating illness* and in preventing ill health. However it could be argued that Newcastle City Council has the *biggest* potential to improve health, support individuals and communities to make healthy choices and influence the factors that have an effect on health inequalities.

It can do this by:

- providing services such as housing, education, social services, sports and leisure, play and youth, catering, community safety, sanitation, and cultural services
- providing services that recognise the diversity of need and are responsive to the needs of disadvantaged populations
- providing a strategic vision for the City as contained in the Regeneration Strategy which aims to improve the wider determinants of health such as housing, the environment, transport and the economy and by taking targeted action to directly influence health.
- regulation and enforcement in relation to issues such as environmental health, planning, alcohol, tobacco control and the health effects of unsatisfactory housing conditions.

- working in partnership with other agencies such as the NHS and the police, and within the local strategic partnership (Newcastle Partnership)
- the range of goods and services it purchases and procures, which can have a direct influence on health
- its role as one of the largest employers in the city.

These actions do not necessarily require additional resources or even major resource shifts across council services; they simply require a greater focus and prioritisation of existing business plans and work activities on health improvement.

Making really significant improvements to the health of Newcastle residents requires collective action, over a long period of time, from across all society. That includes business, the media, voluntary and religious organisations and the community sector. It will be the responsibility of service providers to undertake a process of involvement with local people, inclusive of race, disability, gender, age, sexual orientation and religion in order to develop and deliver action plans and services that meet their needs.

We believe the city needs a ten-year health improvement strategy to complement the other key citywide long-term strategies such as the regeneration strategy, the sustainable communities strategy, the housing strategy, the Children and Young People's Plan and the Quality of Life Strategy for Older People and an Ageing population. These all identify a long-term vision for Newcastle with actions aimed at improving wellbeing and quality of life for the city's residents.

A health improvement strategy will provide all partners with:

- a common understanding of wellbeing, health and health improvement
- an agreed vision and prioritised set of health improvement outcomes and targets for achievement over the long term

The strategy also begins to set out a common approach to implementation and proposes a delivery mechanism and accountability process through the Newcastle Partnership. To ensure delivery of the strategy, it will be the responsibility of 'health improvement delivery groups' to develop detailed action plans, to specify the precise contribution each partner is expected to make, identify designated responsible officers, and examine the resource implications for each agency. Recommendations on a timetable and framework for delivery are included in chapter 5, and an example of a completed action plan for the key outcome of obesity is included in appendix 5.

The scale of ill-health and health inequalities in Newcastle

- Newcastle is ranked 20th of 354 local authorities for multiple deprivation (where 1st is the most deprived).
- Elswick has the highest unemployment rate in Newcastle -17.3% - and parts of north Gosforth have the lowest rate - 2% - compared to the 5.2% in city as a whole and the national figure of 3.1%.
- 21% of the city's residents are amongst the 5% most deprived in England; 31% are amongst the 10% most deprived.
- 28% of dependent children aged under 16 living in Newcastle live in an income-deprived family. This ranges from 1% in North Gosforth to 99% in parts of Cowgate and Benwell.

Newcastle's public health annual report provides a comprehensive and regularly updated picture of health in Newcastle. This shows that despite improvements there is little room for complacency. The report also identifies national and international evidence for what works to improve health, but points out the lack of local evidence, and argues for more local evaluation and monitoring of current and planned interventions. Chapter three will provide more detail about the scale of ill-health in Newcastle, and describe what works.

The starkest indicator of the level of ill-health and health inequalities in the city comes from an independent research study undertaken in early 2006 (www.caci.co.uk). The health of residents in every council ward in England was assessed using four health indicators:

- obesity
- long-term illness
- participation in active sports
- spending on tobacco and alcohol.

All council wards in England were ranked from least healthy to most healthy. The least healthy wards in England were both in Newcastle (West City – Westgate; Moorside – Westgate). Byker ward also appeared in the top ten least healthy wards in the country (ranked seventh).

The next chapter will outline the vision and the approach needed to improve the health of Newcastle.

CHAPTER TWO: OUR VISION AND APPROACH

Newcastle Council's Regeneration Strategy describes a vision of a city in 2021 that is 'vibrant, inclusive, safe, sustainable and modern'. It will achieve this by: building on its heritage, cultural and economic strengths; building and supporting safe and clean neighbourhoods and communities; and improving quality of life for all people in the city. This can only be achieved if we have an equally ambitious vision for health in Newcastle in ten years' time. In our vision for Newcastle in 2017:

- *men and women from the range of social class, physical and intellectual ability, sexual identity and ethnicity will enjoy a long life of good quality, and life expectancy at birth for both sexes will be as good - if not better - than the national average*
- *fewer people will die prematurely from the major killers: cancer, heart disease and stroke before the age of 75.*
- *the stigma associated with mental health problems will be reduced*
- *people will feel valued and have high self-esteem, feeling part of a strong cohesive community with inclusive social networks*
- *fewer people will be overweight or obese, with more people being physically active and involved in sports, and all organisations promoting healthy eating*
- *few people will continue to smoke and most people will view smoking negatively*
- *the party image of Newcastle will be about having fun and enjoying being with people: many drinking venues will be family-friendly and the city will have lots of drink-free alternative meeting places for young people. Fewer people will drink excessively and more will be aware of safe drinking limits.*
- *All people, even those living in difficult circumstances, will be highly knowledgeable about their sexual health, and will be confident about how to manage their relationships*
- *children will experience a lower risk of being killed or seriously injured and older people a lower risk of falling at home than the national average*
- *the diversity of our population will be something we are proud of; people will be valued and respected for their differences and the diverse health needs of our population will be met.*
- *Those who need drug treatment will be able to easily access specialist support treatment services.*

To achieve our vision of health in Newcastle in 2017 two strategic approaches have the best chance of delivering success over the long term:

- *all key partners collectively targeting their resources to address the underlying factors and lifestyle behaviours that directly improve physical, mental and social health*

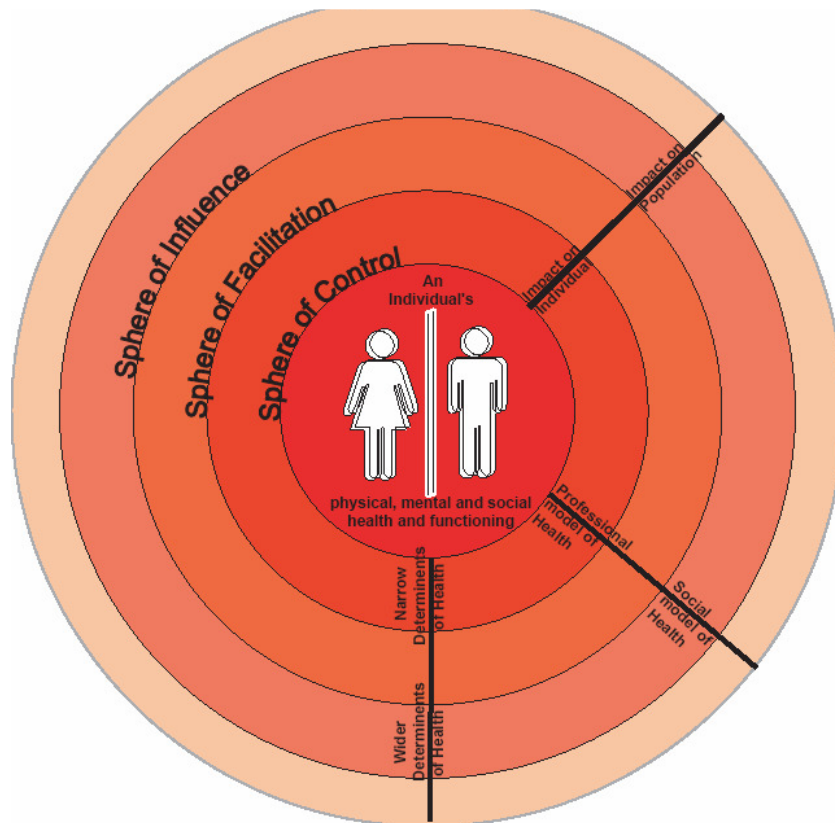
- *a genuine community empowerment approach to developing and delivering a health improvement strategy.*

An approach to collective action and full partner engagement

Only collective action and full partner engagement at every level, from senior management to front-line staff, will achieve success.

To illustrate how everyone providing a public service can contribute to health improvement, we have developed the model below.

A Model for Health Improvement



The main target of action, at the centre, is the physical, mental and social health of individual residents. Rings of decreasing influence, but increasing impact, surround it. The ring closest to the centre is the sphere of control, where actions are taken by health and social care professionals and other front-line service providers. The size of the impact on the health of the population is small but the effect is direct and often immediate.

The ring surrounding the sphere of control is the sphere of facilitation. This is the sphere where actions taken by front-line staff and managers in one area or

organisation can support staff in other areas or partner organisations that *can* directly influence health. This could be in a variety of settings such as schools, workplaces, prisons, restaurants, community centres and pubs. The size of the impact on health can be bigger. For example one sex and relationships education worker can train hundreds of teachers, play and youth workers and housing officers how to provide Sex and Relationship Education (SRE) to their clients.

Finally, the outer rings are spheres of influence. Any public servant in whatever capacity or position in their organisation can potentially influence the actions of others within their organisation or the actions of those in other organisations to improve health. Their sphere of influence could extend for example to championing fruit and vegetable provision in the local community, the commissioning of chlamydia screening in schools, or local and national policy on licensing of premises to sell alcohol. Individuals are likely to have greater influence on actions taken closer to local communities and most closely related to their job or organisation; they are likely to have less chance of influencing actions that improve health (but potentially a huge impact) at the wider policy level, unless they are a senior policy-maker.

In summary our approach to full partner engagement is simple, no matter what your job or whatever sector or organisation you work in, you can take some kind of action now to improve health in Newcastle.

A community empowerment approach to developing and delivering a health improvement strategy

The World Health Organisation has recently concluded that the most effective way to deliver sustainable health improvement is by local people taking ownership of the wellbeing of their communities, by involving them in local decision-making and the delivery of services.

The fourth chapter, *A community empowerment strategy for health improvement*, reviews in more detail the evidence for the effectiveness of community empowerment approaches, providing local examples of successful community engagement in Newcastle and how this can be built upon.

CHAPTER THREE: HEALTH IMPROVEMENT OUTCOMES, INDICATORS AND TARGETS

Identifying the community's priority health improvement outcomes

The primary outcome of a health improvement strategy for Newcastle and the surest marker of success must be:

- to reduce health inequalities by bringing life expectancy and premature mortality in Newcastle to the level of the rest of the country.

As described earlier, this strategy prioritises action that addresses the underlying factors and lifestyle behaviors that directly improve physical, mental and social health. These are the actions that require collective and full partner engagement, and that will have the biggest impact on health.

To achieve this primary outcome, various areas of activity have been identified in the Department of Health white paper *Choosing health: making healthy choices easier*.

- improving mental and emotional wellbeing
- reducing obesity (through diet, nutrition and physical activity)
- improving sexual health
- reducing accidents
- reducing the number of people who smoke
- reducing the harm from alcohol and drugs.

The Newcastle Wellbeing and Health Partnership agreed these national priorities, but decided it wanted to find out which were most important to the local community. These community priorities were identified through an extensive community consultation process and more details are provided at Annex one. The outcomes prioritised are shown at Annex two.

Of the overall priorities, ***improving mental and emotional wellbeing*** clearly emerged as the number one priority for the city. The second clear priority is to ***reduce obesity (through diet, nutrition and physical activity)***.

The consultation process also identified a number of subsidiary priorities within each main outcome. Wherever possible, the Wellbeing and Health Partnership then developed measurable indicators for each of these subsidiary outcomes and agreed initial three-year targets for each indicator. Where this was not possible, the partnership intends to explore ways of collecting new data and developing new indicators over the next two years.

Each of these outcomes will now be explored in more detail by outlining the size of the problem nationally and in Newcastle, what works, what we are doing now, what we want to achieve and the next steps. In order to see how these

outcomes relate to other local plans and strategies, please refer to appendix 3; relevant weblinks are provided for each main health improvement outcome.

TACKLING HEALTH INEQUALITIES

Newcastle men and women from the range of social class, physical and intellectual ability, sexual identity and ethnicity will enjoy a long life of good quality, and life expectancy at birth for both sexes will be as good - if not better - than the national average

The diversity of Newcastle's population will be something we are proud of; people will be valued and respected regardless for their differences and the diverse health needs of our population will be met

The UK experience of the last 100 years would seem to suggest that the major determinants of life expectancy and good health, and of inequalities in both, lie outside the remit of health care alone. Successive reports in the last 25 years have concluded that the biggest impact on health and health inequalities by government agencies comes from economic policies to redistribute wealth, reduce child poverty, improve the quality of housing, improve transport and improve education and skills.

However, there is emerging evidence that targeting specific health service interventions (e.g. smoking cessation), and interventions commissioned or delivered by other agencies (e.g. teenage pregnancy and obesity interventions) can make an impact on reducing health inequalities.

THE SIZE OF THE PROBLEM

Newcastle City Council and Newcastle Primary Care Trust (PCT) belong to the Choosing Health 'spearhead group; the 70 local authorities and 88 PCTs with the dubious distinction of having the highest levels of ill-health and deprivation in England. They are expected to set tougher targets and make faster progress in order to reduce the health inequalities gap nationally.

In Newcastle there have been some notable successes in recent years. Although female life expectancy at birth in Newcastle is less than the national average (79.8 years compared with 80.9 years), it has been improving since 1997-99 at a faster rate than the average national average improvement (1.4 years compared with 0.9 years). Within Newcastle the gap in premature death (deaths under 75 years) from cancer and circulatory disease between the most deprived fifth of the city and the city overall has reduced since 1995-97. For cancer the reduction in premature mortality in the most deprived quintile was 22% compared with 12% for the city overall; for circulatory disease the reduction in premature mortality in the most deprived quintile was 21.9% compared with 21.8% for the city overall.

Male life-expectancy at birth

- Male life expectancy at birth is less than the national average (74.4 years compared with 76.6 years).
- While male life expectancy in Newcastle has improved, it has done so by a smaller amount than the national average – so the male life expectancy gap has actually widened.

Premature death from cancer

- Mortality (under 75 years) from cancer in Newcastle fell by 12% between 1995-97 and 2001-03; however the reduction was less than the national average (12.2%).
- Approximately 25 more people under 75 years per 100,000 die in Newcastle each year compared with the national average; this gap is not closing.

To illustrate how health varies within parts of Newcastle and within different groups of common identity and interest:

- commercial data reveal an overall smoking prevalence rate for Newcastle of 26.8%, whereas within some wards prevalence is as high as 51% (Walker) and as low as 21% (Jesmond)
- people with learning disabilities have higher rates of obesity and respiratory disease
- teenage pregnancy hot-spots in Newcastle closely mirror the most deprived areas of the city: Walker and parts of Byker and Walkergate have the highest number of under-18 conceptions, accounting for 16.5% of the total for the city.

WHAT WE WANT TO ACHIEVE

To bring life expectancy and premature mortality in Newcastle to the level of the rest of the country.
To reduce inequalities in premature mortality rates between wards and neighbourhoods within Newcastle.

These can be addressed by focusing on reducing the risk factors for heart disease, stroke and related diseases by reducing smoking, improving diet and increasing physical activity.

WHAT WE WANT TO DO NEXT

Preventing health inequalities cannot be tackled by one sector alone but there needs to be a common understanding across all society of what is required:

- supporting families, mothers and children.
- engaging communities and individuals.

- preventing illness and providing effective treatment.
- addressing the underlying determinants of health.

IMPROVING MENTAL AND EMOTIONAL WELLBEING

The stigma associated with mental health problems will be reduced and people will feel valued and have high esteem, feeling part of a strong cohesive community with inclusive social networks.

Overall this was the top priority from the initial consultation on the health improvement strategy. This was because many people identified low self-esteem and poor mental health as the underlying cause of a whole range of problems including excesses in smoking, drinking, drugs and obesity. This view is supported by research evidence showing that low self-esteem leads to the poor health outcomes underpinning inequalities in health. Mental health has also been described as the biggest public health problem this country faces because of the increasing number of people who cannot work due to depression and stress. There are also clear links between domestic violence and mental distress.

THE SIZE OF THE PROBLEM

- Mental illness accounts for a third of illness in Britain. 40% of all disability (physical and mental) is due to mental illness.
- One in six of the population suffers from depression or chronic anxiety.
- About 2% of NHS expenditure goes on dealing with depression and anxiety.
- 12.8 million working days were lost to depression and anxiety in 2004/05.
- It is estimated that there are 14,000 women suffering domestic violence in Newcastle at any one time and studies show that 50% of women using mental health services have experienced domestic violence.

WHAT WE WANT TO ACHIEVE

Improve access to services aimed at mild mental health problems, raising self-esteem, self-help and early intervention.
Reduce the levels of stigma and social exclusion associated with mental health problems.
Promote partnership work around domestic violence and worklessness.

WHAT WORKS

Early intervention with psychological therapies such as cognitive behavioural therapy is effective for many people. Physical activity and activities that build social cohesion and reduce social isolation both prevent and help people to overcome mental illness.

WHAT WE ARE DOING NOW

There is not enough emphasis on preventing and treating mild to moderate mental illness. General practice provides most of the treatment and because of pressures of time and lack of any alternative this usually results in a prescription for anti-depressants. There is under-provision of cognitive therapy.

WHAT WE WANT TO DO NEXT

We need a comprehensive approach that addresses the needs of people across the life cycle and in every setting: schools, colleges and universities, the workplace, and local communities. The four key objectives should be:

- to reduce the stigma associated with mental ill health
- to promote self-esteem and positive mental health
- to prevent the development of mental illness
- to encourage early intervention and self-help in order to prevent unnecessary distress and to prevent progression of the illness.

Action on stigma

- Build on the work being done in the Healthy Schools Programme on the core theme of emotional health and well-being and extend this work into community settings.
- All employers across Newcastle, starting with the public sector, to adopt policies proposed by SHiFT in *Action on Stigma* (www.shift.org.uk/employment.)
- Depression is more common in older people than in any other group. This is because there is often a negative view of old age and older people are more likely to have a low income and to live alone and suffer from ill health. Concerted action to minimise negative stereotyping of older people and to reduce social isolation is required. Age Concern and the Mental Health Foundation have made recommendations on Mental Health Promotion in Older People as part of their Inquiry into Mental Health and Well-Being in Later Life (www.mhilli.org.)

Promoting self-esteem and positive mental health

The three biggest influences on self-esteem and positive mental health are:

- feeling valued through the ability to work and contribute
- friends and a good supportive social network
- living in a cohesive local community where people trust one another and there are low levels of crime, vandalism and discrimination.

The actions that arise from this are:

- supporting people on incapacity benefit into work
- promoting supportive social networks through activities – the Activities for Health Fishing Group in Cruddas Park is a good example (see www.wefa.on21.co.uk)
- promoting community cohesion through community development approaches at local level – WECDC, EECDA and HealthWORKS are all examples of this approach.

Preventing the development of mental illness

There is good evidence that having fun, keeping physically active and socially engaged prevents the development of depression, stress and anxiety. The activities that arise from this are:

- promoting the development of physical activity programmes in those who are least likely to participate, through physical activity coordinators and health trainers
- promoting activities (exercise, arts, singing groups, education) that help to keep isolated older people engaged
- promoting out-of-school activities for children and young people.

Early intervention, self-help and support

Early intervention with talking therapies, self-help and support can prevent the progression and recurrence of mental illness. The activities that arise from this are:

- child and adolescent mental health services, schools and colleges to devise non-stigmatising and accessible ways of identifying and supporting those most at risk of mental ill health
- wider use and early access to cognitive therapy through GPs – there is evidence that some of this can be done through self-help manuals/computer programmes, and that less complex cases can be dealt with more cost-effectively by clinician or psychology assistants – there is also an argument for increasing psychological skills in, for instance, exercise instructors running programmes for people with mental health problems
- people with long-term mental health problems and learning disabilities are more likely to smoke, eat a poor diet and be overweight and be less physically active than the general population – there is a need for a targeted approach to health promotion in these groups through health trainers and gym buddies.

HOW WE WILL DO THIS

A Mental Health Improvement Delivery Group accountable to the Well-Being and Health Partnership should be established. This group will be responsible for producing a Mental Health Improvement Strategy with clear priorities and actions.

TACKLING OBESITY AND OVERWEIGHT

Fewer people in the city will be overweight or obese, more people will be physically active and involved in sports, and all organisations will promote healthy eating.

Overweight and obesity are terms used to describe excess body fatness, which can lead to adverse effects on health and wellbeing. Improving diet and increasing physical activity can improve our health. If the physical activity is enjoyable and undertaken over time, it can also have mental and social health benefits.

- Most people are still eating less than the recommended amounts of fruit and vegetables; and more than the recommended amounts of fat, salt and sugar.
- Children and young people should achieve a total of at least 60 minutes of moderate-intensity physical activity each day and adults should achieve a total of at least 30 minutes of moderate-intensity physical activity on five or more days of the week.
- Older adults should do specific activities that promote improved strength, coordination and balance.

THE SIZE OF THE PROBLEM

- Almost two-thirds of all adults are either overweight or obese.
- Overweight and obesity are more common in lower socio-economic and socially disadvantaged groups, particularly among women, and are lowest among children in managerial and professional households.
- Obesity prevalence is almost four times more common in Asian than in white children.

IN NEWCASTLE

- One in every three children (as measured at school reception age and year six) in Newcastle is either overweight or obese.
- The number of adults eating five or more daily portions of fruit and vegetables is approximately 17% (below the estimated national rate of 24%) and in children is approximately 34% (below the estimated national rate of 38%).

WHAT WE WANT TO ACHIEVE

Reduced obesity levels in children.
Increased physical activity levels in children.
Reduced obesity levels in adults.
Increased physical activity levels in adults.
Increased expectation about good diet and nutrition.
Improved access and better utilisation of green open spaces.
More consumption of good-quality food products.
Increased breastfeeding rates in Newcastle
Increased breastfeeding rates in most disadvantaged 20% of neighbourhoods

WHAT WORKS

Action is needed to prevent obesity from occurring in the first place and to support those who already need to lose weight. NICE guidance indicates a range of interventions including

- Improving diet, by increasing fruit, vegetable and fibre consumption and reducing saturated fat, salt and sugar intake.
- Increasing physical activity and encouraging lifelong physical activity.
- Supporting individuals and families in a community-based setting.
- Involving schools, breakfast and after-school clubs in promoting healthy eating and school travel plans which can increase cycling, walking and bus use.
- Breastfeeding is known to reduce the likelihood of childhood obesity. Interventions to support mothers to initiate and sustain breastfeeding are known to increase breastfeeding.

WHAT WE ARE DOING NOW

- IMPROVING DIET

- Specialist services, which include Specialist Weight Management Service (SWIMS) and Newcastle Nutrition. Joint work between SWIMS, The Health Development Service and Community dietetics to pilot weight management courses with non-English speakers.
- School-based activities, which include the Healthy Schools Programme and multi-agency Food in Schools group.
- Community-based activities, which include the Community Food Initiative and Food Growing Project, and many other community-based food projects across the city.
- The development of a healthy-eating action plan, which aims to contribute to the improvement of the health of individuals and communities, living, working and visiting Newcastle, through enabling people to choose and eat healthier food.

- INCREASING PHYSICAL ACTIVITY

- A well used network of leisure centres, swimming pools and outdoor and adventurous activity.
- A developing physical activity team.
- 'On the Go' for children who have been identified as overweight or obese.
- Increasing activity for school-aged children through school sports partnerships and Active Kids.
- Promoting the benefits of exercise in pre-school and nursery settings.
- The development of a range of strategies to increase physical activity and improve facilities, including the strategy for sport, a playing pitch strategy and a strategy to promote children and young people's health and physical development in schools.
- Joint action to build on approaches to encourage people to be more active including the Year of Exercise and Sport 2006 and the 2012 Olympics
- A range of community and voluntary sector activities to support communities to get more active
- Increase the amount and improve the quality of parks and green spaces and through spatial planning and regeneration ensure that communities are created where walking, cycling and public transport are the predominant modes of transport.

WHAT WE WANT TO DO NEXT

A co-ordinated Obesity Strategy and set of action plans will be launched in May 2007.

Draft plans include

- Targeted interventions at those communities and individuals with the greatest need
- A further investment in a variety of community approaches to promote healthier eating e.g. Community Nutrition Assistants and health trainers—particularly in supporting schools and communities.
- The further development of accessible community facilities to support the development of cooking skills in these communities.
- Mainstreaming and expansion of the 'On the Go' programme
- Expansion of the physical activity team
- Building on the good practice learned through the Year of Exercise and Sport
- Developing more inclusive work with children's services and schools.
- Supporting and promoting breast feeding initiatives

ENCOURAGING AND SUPPORTING SENSIBLE DRINKING

The party image of Newcastle will be about having fun and enjoying being with people. Many drinking venues will be family-friendly and the city will have lots of drink-free alternative meeting places for young people. Fewer people will drink excessively and more will be aware of safe drinking limits.

THE SIZE OF THE PROBLEM

- Alcohol consumption has doubled in the UK since 1960.
- Alcohol Concern estimates that 3% of gross domestic product of the UK is through licensed premises – £23 billion per annum.
- The prime minister's strategy unit estimates that alcohol-related harm costs the national economy at least £20 billion per annum.

IN NEWCASTLE

- Government estimates suggest that Newcastle has the highest number of binge-drinkers anywhere in England. The identification of Newcastle as a party city, while bringing income, also increases the likelihood of health problems and disorder.
- Newcastle has the highest mortality rate from chronic liver disease among males in the country.
- Newcastle has the 9th highest rate in the country for months of life lost through alcohol-related harm and the 10th highest rate of alcohol-related hospital admissions in country.
- Figures from Northumbria Police showed that alcohol was felt to be a contributory factor in 21.13% of violent offences in Newcastle in April 2006. Nationally, there are 1.2m incidents of alcohol-related violence per year.

See Annex three for more information.

WHAT WE WANT TO ACHIEVE

Change the drinking culture of the city by modifying the party image, making drinking venues more family-friendly and providing more drink-free alternatives for young people.
Raise awareness levels of the benefits of sensible drinking and the hazards of unsafe drinking.
Increase the number of problem alcohol users accessing treatment
Increase the percentage of people with alcohol problems able to access specialist treatment within five working days.

WHAT WE ARE DOING NOW

- The public health and environmental protection division of the council's regeneration directorate continues to effectively manage licensed premises through measures such as test purchasing and training for door staff, and to reduce the risks associated with alcohol through raising awareness of sensible drinking and ensuring there is public awareness in licensed premises.
- Safe Newcastle continues to offer accreditation for licensed premises that encourage responsible drinking through Best Bar None scheme.
- There have been limited scoping exercises to gauge alcohol-related harm.
- Primary care screening and brief intervention initiatives identify problem drinkers and will help reduce long-term effects of alcohol. There are also treatment interventions by other agencies including counselling, residential rehabilitation, psychiatrist-led care and user-led support.
- D'n'A is the integrated young people's substance misuse team. The multi-disciplinary team involves Youth Offending Team, Educational Welfare, Educational Achievement Health Support Team, Specialist Schools Health Advisor, NECA Young Peoples' Project and Plummer Court Young People's Team. D'n'A offers young people a positive intervention to address their alcohol and related issues.
- Newcastle has representation on the North East Alcohol Advisory Group, which has circulated a draft statement of priorities recommending a coherent region-wide approach – this was launched in December 2006.

WHAT WE WANT TO DO NEXT

Improve and speed up the access to treatment services

Alcohol Concern reports that nationally only one in 18 people with alcohol problems get into treatment. In the northeast, which has fewer treatment places and higher problematic drinking, the figure is one in 102. It is unlikely that the figure is as high as this in Newcastle, as 727 people entered structured alcohol treatment in 2005-6. Figures for the first six months of 2006 indicate that there are more people in Newcastle presenting to treatment agencies for primary problems with alcohol (311) than heroin (189). **There is a clear need to scope the full extent of alcohol problems and capacity for treatment.**

Develop an alcohol strategy

In addition, it is accepted by that there should be a ***strategic approach to tackle all issues of alcohol-related harm***. There are several encouraging interventions and initiatives in Newcastle but they need to be placed in a framework that has high-level support, agreed milestones and a management system. Appropriate investment and coordinated response to alcohol will provide economic and health

gains for the community. Getting 10% of the UK's dependent drinking population to stop misuse would save the public sector almost £156 million a year.

A model alcohol strategy should focus on the three key areas identified by the North East Regional Alcohol Advisory Group (NERAAG) and will offer a strategic framework for:

- **developing a preventative approach towards alcohol misuse** – possibly led by the PCT (public health/health maintenance)
- **ensuring services are provided for harmful, hazardous and dependent drinkers and for their families and carers** - possibly led by social services (young people's and adult drug and alcohol commissioning managers)
- **promoting public protection through legislation, policy enforcement and education** – possibly led by the council's regeneration directorate (PHEPS/ Safe Newcastle).

Over the next year, a multi-agency group will develop this strategy, assess need and formulate milestones and priorities.

Terms Explained:

<u>Term</u>	<u>Definitions</u>
Binge-drinking	This can be defined as the consumption of at least eight units of alcohol for men and at least six units for women during a single session (ie double the daily recommended alcohol consumption limits).
Hazardous drinking	A pattern of heavy alcohol consumption, which carries with it a high risk of causing future damage to the medical or mental health of the drinker, but which has not yet resulted in significant medical or psychological harm.
Harmful drinking	This can be defined as heavy alcohol consumption, already resulting in significant physical or mental harm to the user. This group, as defined, does not include drinkers that develop alcohol dependence.
Moderately-dependent drinking	Drinkers in this category show moderate levels of alcohol dependence. Moderately dependent drinkers may recognise that they have a problem with drinking, even if this recognition has only come about reluctantly.
Dependent drinking	Dependent drinking is generally categorised by 'psychological dependence', with an increased desire to consume alcohol and difficulty in controlling use, in spite of the potential consequences.
Severely-dependent drinking	People in this category may have serious and long-standing problems and in older language, have included individuals described as 'chronic alcoholics'.

REDUCING THE NUMBER OF PEOPLE WHO SMOKE

Few people will continue to smoke and most people will view smoking negatively.

Smoking is the single biggest cause of preventable ill-health and premature death in the UK. It is a major contributor to health inequalities. People living in deprivation are more likely to smoke, smoke more and be exposed to second-hand smoke (SHS).

THE SIZE OF THE PROBLEM

- Commercial data reveal an overall smoking prevalence rate for Newcastle of 26.8%, compared with 25% nationally. In a number of wards and communities of interest in the city as many as 51% of the adult population smoke.
- More 25–34 year olds smoke than any other age group in the city.
- In the north east 35 people under 65 die each year, due to exposure to SHS in the workplace.
- Exposure to SHS in the workplace causes three times more premature deaths each year than all industrial accidents, with those working in the hospitality industry most at risk.

WHAT WE WANT TO ACHIEVE

Newcastle to become a smoke-free city.
Reduce the prevalence of smoking in the population of Newcastle.
Increase the number of smokers who quit smoking.

WHAT WORKS

Legislation to prohibit smoking in all enclosed and substantially enclosed workplaces and public places from 1 July 2007.

- protect non-smokers (including children)
- reduce the social acceptability of smoking
- provide a supportive environment for those trying to quit the habit
- assist in reducing smoking prevalence rates.

Tobacco control is an approach, which aims to engage both with smokers and non-smokers. Its emphasis is on making non-smoking the norm for more sections of the population so that tobacco becomes less desirable, less acceptable and less accessible. Such an approach has been shown to be effective internationally at reducing smoking prevalence. It focuses on taking

action to protect the population from the effects of SHS, undertaking education and prevention activities and providing support to those who want to stop smoking.

WHAT WE ARE DOING NOW

A multi-agency local alliance called Smoke Free Newcastle produced a tobacco control action plan for the city in 2005. It has achieved a lot to date including;

- Extensive lobbying and advocacy work towards achieving smoke free legislation.
- Supporting an increasing number of workplaces to go smoke free, including the City Council and local health services.
- Assisting 7,044 smokers in Newcastle to give up smoking (at the four week measurement point) since April 2002. A total of 14,740 Newcastle smokers set a quit date with the local NHS stop smoking service between April 2002 and March 2006.
- Carrying out 30 test purchases for illegal tobacco sales to minors and 50 routine inspections of tobacco retailers, recording compliance with statutory notices and tobacco advertising laws.

WHAT WE WANT TO DO NEXT

The tobacco control plan sets targets for each of the areas outlined below.

- **Reducing exposure to SHS** – Newcastle will work towards becoming a smoke-free city where no worker or member of the public is involuntarily exposed to the effects of SHS in an enclosed space. It will support businesses to become smoke-free and prepare them and the public for the smoke-free legislation when it is introduced.
- **Stop-smoking support** – Newcastle will further build on and develop its high-quality comprehensive services to help smokers to quit, particularly targeting those from disadvantaged areas and specific population groups such as manual workers, black and ethnic minority communities and pregnant women. We will strive to increase the number of people receiving support to quit, particularly in neighbourhood renewal areas where a fourfold increase in target numbers quitting compared to the rest of the city has been set.
- **Supporting and developing public education and media campaigns** – Newcastle will support national and regional media/PR campaigns about smoking which aim to educate the public about the dangers of SHS. It will explore and develop initiatives to prevent take-up and onset of regular smoking among young people based on evidence of what is most effective.
- **Reducing the availability and supply of tobacco products** – Newcastle will support regional initiatives with HM Customs and

Revenue to tackle tobacco smuggling and will work in partnership with the North East Trading Standards Association to reduce illegal tobacco sales to minors.

- **Reducing the promotion of tobacco** - Newcastle will work in partnership with the North East Trading Standards Association to enforce legislation on tobacco advertising. It will also investigate the public procurement policies of the NHS and City Council and take action to minimise the purchase of goods and services from companies owned by the tobacco industry.

IMPROVING SEXUAL HEALTH

Most people, even those living in difficult circumstances, will be highly knowledgeable about their sexual health, and will be confident about how to manage their relationships.

Sexual health and wellbeing is a major public health challenge. Sexual ill health is increasing. The highest burden is borne by gay and bisexual men, young people and some black and minority ethnic groups. Improving sexual health is a priority at both national and local level. Domestic Violence is known to affect women's choices about their sexual health, with studies reporting lower rates of contraceptive use and increased sexual coercion resulting in higher rates of sexually transmitted infections. Nationally and locally, teenage pregnancy and parenthood are strongly associated with deprivation, with a growing recognition that social-economic disadvantage can be both a cause and consequence of teenage parenthood.

THE SIZE OF THE PROBLEM

Reflecting the national trends in sexual health, infection rates in the north have continued to rise over time.

- In Newcastle 70% of confirmed cases of chlamydia seen at the GUM clinic in 2004 were in young people aged 15-24.
- The north east of England has experienced an outbreak of syphilis in recent years.
- Newcastle has not experienced significant reductions in teenage pregnancy, and rates have risen in some identified areas of the city.
- 54% of UK rapes are committed by a woman's current or former partner.

WHAT WE WANT TO ACHIEVE

Improve the level of exposure and quality of SRE in schools and communities
Reduce the incidence of sexually-transmitted infections (including chlamydia, gonorrhoea, syphilis and HIV)
Reduce teenage conception rates in Newcastle
Reduce teenage conception rates in the most disadvantaged areas

WHAT WORKS

The evidence from reviews suggests that the main features of effective health promotion/education interventions are:

- multi-component – information provision alone is insufficient to influence behaviour change; personal and structural factors such as attitudes

towards safer sex and condoms, motivation, the influence of significant others, wider social influences, as well as practical skills all play an important part in the ability to change behaviour

- use of peer educators, particularly with adolescent audiences
- emphasis on promoting condom use, rather than abstinence.

Interventions with men who have sex with men are more likely to be effective if they are:

- placed within the broader context of men's lives
- tailored to specific sub-populations of men who have sex with men
- multi-component, focusing on risk reduction, sexual negotiation and communication skills training and rehearsal.

WHAT WE ARE DOING NOW

Teenage Pregnancy

- *Reducing the under 18 conception rate is a key priority in the Children and Young People's Plan.*
- *The Teenage Pregnancy Partnership Board have significantly reshaped their Strategy to place greater emphasis on preventative work, this includes the development of a Sex Relationship Education (SRE) team targeting vulnerable and at risk groups, particularly targeting hotspot areas.*

Domestic Violence

- *The Newcastle Domestic Violence and Abuse Partnership has developed a Domestic Violence and Abuse Reduction Strategy to improve services for all victims of domestic violence.*

Prevention and community services

- SRE in schools and community settings linked to local sexual health services.
- Condom distribution for young people and gay and bisexual men.
- High-profile media campaigns targeting specific risk groups.
- Community development projects.
- Primary care-based services offered in each locality.
- A range of services at young people's projects.
- Emergency Hormonal Contraception EHC in community settings.
- Community chlamydia screening.

Specialist care

- Mainstream specialist sexual health services.
- HIV treatment and care.
- Complex sexually-transmitted infections (eg syphilis).
- Complex contraception and reproductive health.
- Coordination of partner notification.-

WHAT WE WANT TO DO NEXT

A sexual health strategy for the city exists and is currently being implemented.

Prevention and community services

- Increase the capacity of the school health advisor (SHA) service.
- Train SHAs to provide SRE and drop-in services in schools.
- Prioritise services for gay and bisexual men.
- Further develop GP and pharmacy services by establishing locally-enhanced services for sexual health.
- Establish a facilitator role for general practices.
- Implement a chlamydia control plan across the city.
- A coordinated plan that meets the needs of excluded groups, and groups of common interest.

Specialist services

- A full redesign of the service after a review of the services provided through GUM and contraceptive services.
- Transfer some of the activity presently undertaken to community-based settings.
- Clarify HIV treatment and care pathways.
- Reconfigure complex contraception and psychosexual medicine services.
- Extend nurse-led termination of pregnancy services.
- Improve waiting times for termination of pregnancy services.

REDUCING DRUG-RELATED HARM

Those who need drug treatment will be able to easily access specialist support treatment services.

THE SIZE OF THE PROBLEM

- The latest British Crime Survey estimates that 4.5 million 16-59 year olds will have used a Class A drug in their lifetime.
- Recent estimates suggest that the amount of problematic users of Class A drugs in Newcastle is between 2,100 and 2,700 adults (no comparable estimate exists for under 18s), of whom 1,415 entered treatment by March 2006.
- While overall numbers who have used drugs in the northeast is below the national average, the region has the second highest use of Class A drugs in England.

WHAT WE WANT TO ACHIEVE

Improve the ease of referral and communication between drug treatment services.

Improve the percentage of people with drug problems able to access specialist treatment within five working days.

WHAT WE ARE DOING NOW

There are many local examples of effective and innovative interventions reducing drug-related harm in Newcastle, which draw on national good practice.

- **Lifeline open access and harm reduction service** provides needle exchange, vaccinations and healthcare assessments for up to 800 people and also offers constructive activity and referral into structured treatment.
- **PROPS** is a service for carers of those with substance misuse – over 130 families are offered support and the service undertakes awareness-raising with communities and professional groups.
- Over 1,400 people last year attended **drug-awareness training** organised by the Drug Support Unit. This training equips them with the skills to intervene and/or appropriately refer users to treatment and helps to increase community resilience against drugs.
- **Another Way** is a project to reduce the likelihood of family breakdown through the effects of substance-misuse by intensive work with family units. This will start in early 2007.
- **D'n'A** is the integrated young people's substance-misuse team that launched in October 2006. This is a multi-disciplinary team involving a range of children's services. It provides a single point of access for all structured services.

- **Positive Futures East Newcastle** is an activity-based programme for young people with drug problems who may also be disengaged from education or likely to become involved in crime. The programme provides opportunities for young people to develop skills and also promotes volunteering and sport coaching qualifications.
- **Trading Places** is a peer-led drop-in service, which started in June 2006, run by volunteers who themselves have experienced drug problems. It operates two days a week at a homeless day centre and attracts up to 75 attendees a day.

WHAT WE WANT TO DO NEXT

Each year Safe Newcastle produces annual plans in collaboration with users, carers and key stakeholders. There are key messages from the government that underpin these plans as well as local input. Priorities for forthcoming plans are set out below.

- Introducing an effective system of care-coordination developed in consultation with users and carers. This is to ensure individuals can access appropriate treatment quickly – ideally within one week – and then be directed to the appropriate treatment agency. Outreach services are to be extended to ensure all areas have equity of access to harm-reduction and treatment.
- The development of a city centre resource for young people in partnership with Streetwise, which would provide a one-stop-shop-style of health provision, support and participation opportunities and young people-friendly premises for D'n'A.
- An increase in harm-reduction interventions to maximise public health gain – development of pharmacy-based harm-reduction services, more readily-available contraception, increased testing and vaccinations and continued multi-agency responses to avoid drug-related deaths and ensure we learn lessons from past deaths.
- Identification and targeting of health promotion material to groups of young people at particular risk of developing problematic drug-use. Particular groups include club-goers and steroid-users.

REDUCING ACCIDENTS

Newcastle's children will experience a lower risk of being killed or seriously injured and older people a lower risk of falling at home than the national average.

THE SIZE OF THE PROBLEM

Every year 10,000 people die from accidental injury. It is the main cause of death among children aged 0-14 years. In addition, there are many millions of non-fatal accidents each year. Around 2.8 million of them occur in the home, many caused by falls. Over 300,000 people are hurt in road traffic accidents, 5% of them children. In these ways accidental injury takes a heavy toll of society, particularly children and older people. And it strikes hardest at the most disadvantaged.

WHAT WE WANT TO ACHIEVE

Reduce the incidence of road traffic accidents.
Reduce the incidence of older people falling at home.
Raise awareness of how to prevent accidents, particularly in disadvantaged areas.

WHAT WORKS

Accidental injury in children

On the road

There is good evidence for the benefits of:

- 20mph zones
- cycle helmet education campaigns and legislation
- child-restraint loan schemes and legislation.

In the home

There is good evidence for the benefits of:

- smoke-detector programmes
- child-resistant packaging.

Accidental injury in older people

In reducing falls, there is evidence for the benefits of:

- single and multi-faceted intervention prevention including handyperson schemes and trades registers.
- home and residential institutions assessment
- hip protectors.

WHAT WE ARE DOING NOW

Children

- Your Homes Newcastle provides safety equipment to families with children under 4.

- SafetyWorks provides Crucial Crew educational visits for schoolchildren.
- Road Safety provides cycling proficiency training, school travel plans, school crossing patrols, speed bumps, speed cameras, road safety education and training.
- The fire service fits free smoke alarms and exchanges old chip pans for safe electric ones. The Environmental Protection Division of the City Council uses its enforcement powers to compel owners of tenanted property to install fire safety equipment and operates two accreditation schemes to encourage landlords to meet the same standard.
- St John's Ambulance provides first aid training that incorporates accident prevention.
- Health visitors provide information on safety in the home and also help parents to access free safety equipment.

Older people

- A falls prevention plan has been developed through:
 - a mapping exercise
 - a gap analysis
 - a listening event with older people
 - joint older people and staff action planning.
- Falls prevention project – a single-person project developing a range of preventative initiatives.
- Exercise – a well-established physiotherapy-run exercise programme provides follow-on from the falls and syncope service in hospital. Progression programmes in the voluntary sector follow on.
- Telecare pilot scheme - the council's community care alarm scheme incorporates a range of measures to assist fallers.

WHAT WE WANT TO DO NEXT

Targetted action at groups most at risk for example older people, people living on their own, those on multiple medication and users of alcohol.

In particular:

Children

Reduce the number of accidental injuries in children by:

- developing recommendations arising from the child accident equity audit (Child Accident Prevention Group)
- developing a draft *Safe Children, Safe Families* award for parents' training programmes (Child Accident Prevention Forum)
- delivering a Crucial Crew programme in March/April 2007.

Older people

Reduce the number of falls in Newcastle through the provision of preventative falls services.

- Ensure the falls prevention plan is implemented.
- Increase awareness of falls prevention.
- Promote a coordinated approach to falls identification, assessment, referral and treatment.
- Promote the primary prevention of falls.
- Promote grants for falls prevention and encourage increased investment.

Generally

- To progress the licensing of houses in multiple occupation and accreditation schemes to increase the fires safety of tenanted dwellings
- To utilise the enforcement provisions of the hazard rating system provided for within the Housing Act 2004 to minimise the danger of falls and trips in dwellings.

CHAPTER FOUR: COMMUNITY EMPOWERMENT

WHAT WE WANT TO ACHIEVE

There is plenty of evidence to suggest that empowerment and involvement make a real difference to health. This can be on a collective basis – for example, by identifying barriers a particular community has in accessing services it needs – or on an individual basis – by helping a person gain skills and confidence to make positive changes to his or her lifestyle. Evidence also suggests that the very process of getting involved in community engagement activities has a beneficial impact on health.

We want to achieve the following objectives:

- Communities are actively engaged in identifying and tackling health inequalities and improving health in their area.
- Communities are actively engaged in shaping public services to reflect local needs and circumstances.
- There is increased understanding by health service and local authority professionals of community needs and priorities.
- There is increased understanding of health-related activities and planning processes across all sectors.

While it is not stated explicitly in earlier chapters, we think these objectives should be applied to every area of work done around priorities identified in this strategy.

WHAT WORKS

Community development is proven to work in increasing empowerment and involvement activity. There are lots of definitions of community development. In the context of health improvement, this one is probably the most useful:

Given the fluid nature of communities, the purpose of community development is to help groups and networks of people to take joint action on matters that concern them for the public good. Effective joint action is built on forming group relationships, and often needs to engage with agencies that deliver public services. The work usually has a local focus, through communities of interest such as faith groups as well as local communities¹.

¹ Community Development Foundation

Community development should be seen as an investment; to be effective it needs to be given time and adequate resources for relationships to be developed.

WHAT WE ARE DOING NOW

There is a range of organisations in Newcastle supporting community development and empowerment activities. These include:

- local networks and projects specific to particular areas of the city – eg New Deal for Communities, West End Community Development Consortium (WECDC), East End Community Development Alliance (EECDA)
- city-wide networks and projects working across most or all of the city – eg Community Action on Health (CAH), HealthWORKS, Community Empowerment Network (CEN), Newcastle Council for Voluntary Service (NCVS), Quality of Life Partnership, Health and Race Equality Forum
- statutory agencies and projects working across all of the city – e.g. Newcastle City Council's community development section, patient and public involvement forums.

A number of organisations (NCVS, CEN, WECDC and EEDCA) are working together to support community involvement and engagement in the local strategic partnership (Newcastle Partnership). Together they are called the INFRANET. NCVS and CAH are currently developing a wider reference group for the Wellbeing and Health Partnership. In the future, Local Involvement Networks (LINKs) will replace patient and public involvement forums – giving stronger structures for people to comment on health and social care delivery across the city, rather than having to relate to individual NHS organisations as at present.

WHAT WE WANT TO DO NEXT

We think there needs to be:

- Greater understanding of community involvement and empowerment as a whole-system process, rather than being viewed as a stand-alone activity;
- A firm commitment from all organisations involved in the health improvement strategy to ensure that involvement and engagement activities lead to real changes;
- A community development strategy for the city, which maps resources committed, areas of expertise and good practice and current activities.
- Stronger links between work done around health inequalities and other plans, such as the city's Regeneration Strategy.

A POTENTIAL WAY OF EMPOWERING COMMUNITIES

Many services, including a lot of NHS and Local Authority services, are planned on a citywide basis with limited opportunity for people to get involved at a more local level. One idea we want to look at further is whether area-based social enterprises, consisting of partnerships between local people and service planners and providers, could have greater commissioning responsibilities for some services. This approach could enable local communities to determine their own priorities and then ensure that services delivered in the area meet these priorities. By developing a model of “empowered citizenship” we would be ensuring that real decision-making is in the hands of local people.

CHAPTER FIVE: IMPLEMENTING THE STRATEGY

This strategy is intended to provide all partners with a common understanding of wellbeing, health and improvement, and an agreed vision and prioritised set of health improvement outcomes and targets for achievement over the long term. The strategy also begins to set out a common approach to implementing action to achieve these outcomes. A delivery mechanism and accountability process is now required that will translate this health improvement strategy into detailed action plans identifying how each outcome will be achieved, the precise contribution each partner is expected to make, and that will ensure actions are successfully implemented. In this chapter we propose such a mechanism and process and we also set out a timetable to achieve this.

Health Improvement Delivery Groups

The recent government white paper, *Strong and Prosperous communities*, proposes to legislate for a new statutory partnership for health and well-being under the Local Strategic Partnership (LSP). The legislation will propose 'a new duty to cooperate for PCTs and local authorities, in order to enable local partners to agree shared outcomes, a common assessment framework, single budgets (where appropriate), joint commissioning and planning, the delivery of joint LAA targets (both those agreed with central government and those agreed locally), the development, implementation, monitoring and evaluation of the reports of Directors of Public Health, and a consistent approach to patient and public involvement.'

In anticipation of this legislation, we propose that in Newcastle the existing Wellbeing and Health Partnership's Executive Group, supported by a wider reference group, will be held accountable by the LSP for the implementation of the City's Health Improvement Strategy. The Wellbeing and Health Partnership (WB&HP) Executive Group will in turn establish the following Health Improvement Delivery Groups:

- Mental Health Improvement Delivery Group
- Reducing Obesity Delivery Group
- Improving Sexual Health and Wellbeing Delivery Group
- Reducing Smoking Delivery Group
- Reducing Alcohol Harm Delivery Group
- Drugs Delivery Group
- Reducing Accidents Delivery Group

Wherever possible these delivery groups will be constituted from existing groups working within the city; for example the Smoke Free Newcastle Plan delivery group, and the Newcastle Sexual Health Group. The Teenage Pregnancy Partnership Board will deliver the strategy's priority outcomes around teenage pregnancy, which will be jointly accountable to the WB&HP and the Children and

Young People's Partnership (C&YPP). Similar arrangements may need to be put in place to deliver other priority outcomes shared with other partnership groups (e.g. the obesity and breastfeeding outcomes).

They may also be formed by absorbing two or more existing groups. Membership of delivery groups will largely be determined by members' ability to implement key actions within their respective organisations. To this end it will be necessary to draw membership from other LSP themed partnerships and from the WB&HP reference group; however the size of each group will need to be kept to less than 10 people where possible, if it is to remain effective. This should not preclude co-opting temporary members to address specific actions when required.

All delivery groups will report to the WB&HP (and where relevant to the C&YPP) on progress in implementing their respective action plans on a quarterly basis, and on progress in achieving LAA outcome targets. These themed partnerships will in turn provide quarterly performance reports to the LSP. The Director of Public Health's Annual Report will in future, as recommended in the white paper, be developed with input and support from the WB&HP and its delivery groups; at the same time the report will provide an independent evaluation of progress towards agreed LAA outcomes. The partnership will in turn be expected to consider and evaluate the findings of the Annual Report and to respond formally with recommendations to the LSP, its partner organisations, and the Health and Adult Services Scrutiny Panel.

In developing this strategy, the WB&HP has undertaken extensive consultation with voluntary and community groups across the city. This level of community engagement will need to be maintained by delivery groups in the development of implementation plans; however a far greater level of direct engagement with communities themselves is required, along the lines outlined in the previous chapter. The Community Empowerment and Reducing Inequalities Delivery Group's implementation plan will be crucial in advising other delivery groups, and other LSP theme partnerships, on how this can be achieved. The group will also be responsible for monitoring progress in this area.

Timetable for action

The following timetable for action is proposed:

April to August 2007

Health Improvement Strategy launched
Delivery groups constituted
Obesity Strategy and Implementation Plan launched
Sexual Health and Wellbeing Implementation Plan launched
First quarterly progress report to WB&HP of Teenage Pregnancy Partnership Board

First quarterly progress report to WB&HP of Smoke Free Newcastle Delivery Group

September to December 2007

Mental and Emotional Wellbeing Improvement Strategy and Implementation Plan launched

Alcohol Strategy and Implementation Plan launched

Reducing Accidents Strategy and Implementation Plan launched

Breastfeeding Strategy and Implementation Plan launched

Reducing Drug Misuse Strategy and Implementation Plan launched

First quarterly progress report to WB&HP of Obesity and Sexual Health and Wellbeing Delivery Groups

Annual Director of Public Health report published

January 2008 onwards

All implementation plans in place

All delivery groups reporting to WB&HP or other relevant LSP theme group on a quarterly basis

WB&HP reports regularly to LSP and constituent partner organisations

APPENDIX 1: How the priorities were identified

It was a simple matter for the Newcastle Wellbeing and Health Partnership, on behalf of the Newcastle Partnership, to agree these overall priorities. The more difficult challenge was to identify which of these overall priorities were most important to the local community, and within each of the main outcome headings, to identify the community's key subsidiary outcomes and indicators of success. These community priorities were identified through an extensive community consultation process, which is briefly described below.

The process began with a stakeholder event on 4 August 2006, attended by over 100 people from a range of public, private and voluntary organisations. They identified a number of additional key outcomes and a range of subsidiary outcomes or outcome indicators that related to the main outcome headings already identified. These outcomes were mapped across any other mandatory or existing local authority or primary care trust (PCT) outcomes to produce a draft list of possible health improvement outcomes.

The list was circulated to all Wellbeing and Health Partnership members and all stakeholder event attendees. Using a points-scoring system all participants were asked to rank-order their top priorities. The results were analysed and the top 25 areas were ranked by score. CAH, in partnership with NCVS and CEN then carried out four events with community-based workers in the east, west, north and city-wide. Attendees were asked to generate their own subsidiary outcomes and outcome indicators under the key outcome headings, in addition to new outcomes. They then undertook a similar points-scoring prioritisation of these outcomes, alongside those included in the draft list of possible outcomes arising from the stakeholder event. The Wellbeing and Health Partnership then mapped the 25 ranked areas identified from the stakeholder event against the ranked priorities arising from the community-based events.

Of the overall priorities, one health improvement outcome clearly emerged as the number one priority for the city: **improving mental and emotional wellbeing**. Another health improvement outcome emerged as the second clear priority for the city: **reducing obesity, through diet, nutrition and physical activity**.

Within each of the main overall priorities, key subsidiary outcomes and indicators of success emerged. The Wellbeing and Health Partnership then developed measurable indicators and agreed three-year targets for each indicator. A second round of community events took place during November 2006 in order to validate the selection of priority outcomes, indicators and targets. At these events, participants were also invited to identify short, medium and long-term actions to achieve the agreed outcomes. A final set of priority outcomes, measurable indicators and targets were agreed by the Wellbeing and Health Partnership and approved by the Newcastle Partnership, the City Council, and the PCT board.

The three-year outcomes, indicators and targets were included in the 2007 Local Area Agreement (LAA).

APPENDIX 2: WELLBEING and HEALTH OUTCOMES

Main Outcome	Subsidiary Outcome	Indicator	Baseline	Targets		
				2007/08	2008/09	2009/10
Tackling health inequalities	Reduce the gap in all ages, all cause mortality between Newcastle and England	All-age, all-cause mortality rate for Newcastle - Males	2002-04: 917.12	2006-08: 819	2007-09: 796	2008-10: 774
		All-age, all-cause mortality rate for Newcastle – Females	2002-04: 608.09	2006-08: 545	2007-09: 530	2008-10: 515
	Reduce the gap in premature mortality rates from heart disease, stroke and related diseases between Newcastle and England	Reduce directly standardised mortality rates from circulatory diseases in people under 75, so that the absolute gap between the national rate and the rate for the district is narrowed, at least in line with LDP trajectories by 2010.	2002-04 122.20	2006-08 79.6	2007-09 69.0	2008-10 60.14

	Reduce the gap in premature mortality rates from heart disease, stroke and related diseases between the most deprived 20% of neighbourhoods and the Newcastle average.	Narrow the gap in premature mortality rates from heart disease, stroke and related diseases by 40% between the 20% most deprived neighbourhoods (Super Output Areas) and the Newcastle average.	2002-04 Newcastle = 122.2 Most deprived quintile = 207.1 Absolute Gap = 84.9	2006-08 Newcastle = 79.6 Most deprived quintile = 151.7 Absolute Gap = 72.1	2007-09 Newcastle = 69.0 Most deprived quintile = 137.9 Absolute Gap = 68.9	2008-10 Newcastle = 60.14 Most deprived quintile = 125.8 Absolute Gap = 65.7
Improving mental health and emotional wellbeing	Improve access to services aimed at mild mental health problems, raising self-esteem, self help and early intervention	Indicators and targets to be developed				
	Reduce the levels of stigma and social exclusion associated with mental health problems.	Number of positive move-ons from adult mental health day care services	Baseline to be established by March 2007	Baseline + 2%	Baseline +4%	Baseline +6%
	Further indicators and targets to be developed					
Tackling obesity	Reduced obesity levels in children	Percentage of children under 11 years with height and weight recorded who are obese	12.0% (2005-06)	12.4%	12.7%	12.7%

	The percentage of all schools with National Healthy School Status in the National Healthy School Programme	68 schools (Old Healthy School Status which is current until July 2007) 5 schools New Healthy School Status September 2006	Without stretch – 59% or 55 schools: December 2007	Without Stretch 69% or 64 schools With stretch – 94.6% (approx. 88 schools) April 2008	86% or 80 schools
Increased physical activity levels in children	Percentage of children and young people who take part in organised out of school sporting activities	44%	47%	49%	51%
Reduced obesity levels in adults	Indicators and targets to be developed				
Increased physical activity levels in adults	The percentage of resident adults in Newcastle participating in at least 30 minutes of moderate-vigorous physical activity and sport on 3 or more occasions per week	January / February 2005 – 20%	Without stretch – 24% With stretch – 29%	31%	33%
Increased expectation about good diet and nutrition	Indicators and targets to be developed				

	Improved access to and better utilisation of green open spaces	The number of Green Flag accredited parks and open spaces	21% (2005-06)	49%	56%	63%
	More consumption of good-quality food products	Indicators and targets to be developed				
	Increased breastfeeding rates in Newcastle	Percentage of mothers known to have initiated breastfeeding	54% (2005-06)	58%	60%	62%
		Percentage of mothers known to be breastfeeding at 6 – 8 weeks	25% (2005-06)	29%	31%	33%
	Increased breastfeeding rates in the most disadvantaged 20% of neighbourhoods	Percentage of mothers known to have initiated breastfeeding in the 20% most deprived Super Output Areas in Newcastle	39.6%	46.6%	50.1%	53.6%
		Percentage of mothers known to be breastfeeding at 6-8 weeks in the 20% most deprived Super Output Areas in Newcastle.	20% (2005-06)	25.5%	28.5%	31.5%

Encouraging and supporting sensible drinking	Change the drinking culture of the city by modifying the party image, making drinking venues more family-friendly and providing more drink-free alternatives for young people	Percentage of unsuccessful test attempts to purchase alcohol by minors	80% (2005-06) 2006-07 target = 85%	90%	95%	96%
		Number of young people, as part of substance misuse treatment, issued with a City Card.	210 (Nov 2005 – Oct 2006)	Baseline + 25% (i.e. 263)	Baseline + 50% (i.e. 315)	Baseline + 75% (i.e. 368)
		Further indicators and targets to be developed.				
	Raise awareness levels of the benefits of sensible drinking and the hazards of unsafe drinking	Percentage of licensed premises displaying (a) 'safe limits' of alcohol consumption	60%	66%	73%	80%
		(b) alcohol content of drinks information	To be established by end of 2006/07	100%	100%	100%
		Number of licensed premises to achieve Best Bar None accreditation	51	57	60	63
		Further indicators and targets to be developed				
	Increase the number of problem alcohol users accessing treatment.	Number of problem alcohol users accessing treatment.	2005-06 = 727 2006-07 = 237 up to 31 July 06. End year figure to become baseline	+5%	+5%	+5%

	Increase the percentage of people with alcohol problems able to access specialist treatment within five working days.	Indicators and targets to be developed				
Reducing the number of people who smoke	Newcastle to become a smoke free city	The number of test purchases carried out	35 (2005-06)	50	50	50
		The percentage of unsuccessful attempts to purchase cigarettes by minors as part of the test purchase programme	80% (2005-06) 2006-07 Target = 85%	90%	95%	95%
	Reduce the prevalence of smoking in the population of Newcastle	Adult smoking rates	2004: 26.8% (as per Acxiom National Shoppers Survey)	25%	24%	23%
		Proportion of women continuing to smoke throughout pregnancy	21.6%	19.6%	18.6%	17.6%
	Increase the number of smokers who quit smoking	Number of 4-week smoking quitters, who attend NHS Stop Smoking Services, per 100,000 population	1054 (2005-06)	1719	2000	2300

Improving sexual health	Improve the level of exposure and quality of Sex and Relationship education in schools and communities.	The percentage of all schools with National Healthy School status in the National Healthy Schools Programme.	See above under 'Tackling Obesity'			
		The number of young people in both schools and communities in teenage pregnancy Hot Spot areas who are provided with an intensive programme of Sex and Relationship' education from the SRE Outreach Team	0 (2005-06)	780	590	400
		The number of practitioners who will be provided with quality Sex and Relationship' training from the SRE Outreach Team	0 (2005-06)	84	56	56

	Reduce the incidence of sexually-transmitted infections (including chlamydia, gonorrhoea, syphilis and HIV)	Good access to sexual health services as evidenced by the percentage of patients offered an appointment in a Genito Urinary Medicine clinic within 48 hours of contacting the service	47% (April 2006) April 07 target = 70%	100% (by April 2008)	100% (by April 2009)	100% (by April 2010)
		Reduced incidence of sexually transmitted infections through the provision of a Chlamydia screening programme for 15-24 year olds (% Coverage)	Approx 3% (Difficulty with separately identifying opportunistic and diagnostic screening tests, as is the case nationally with Chlamydia screening programmes. Currently working to resolve this)	15% (subject to Department of Health LDP guidance)	30% (subject to Department of Health LDP guidance)	50% (subject to Department of Health LDP guidance)
	Reduced teenage conception rates in Newcastle	Number of conceptions per 1,000 females aged 15 - 17	52.8 (1998)	34.6 (calendar year 2007)	Newcastle = 30.9 (Calendar year 2008)	Newcastle = 28.5 (Calendar Year 2009) Note that the 2010 target for Newcastle is 23.8 which will be reported on for 2010/11

	Reduce teenage conception rates in the most disadvantaged areas	Reduction in the under 18 conception rate in the neighbourhoods (Super Output Areas) within Newcastle that are amongst the 10% most deprived in England	2001-03 baseline = 102.6	68.0 (calendar year 2007)	56.5 (calendar year 2008)	44.9 (calendar year 2009)
Reducing drug-related harm	Improve the ease of referral and communication between drug treatment services	Indicators and targets to be developed				
	Increase the percentage of people with drug problems able to access specialist treatment within 5 working days	Percentage of referrals assessed in 5 working days for substitute prescribing	100% seen within 10 working days	85%	85%	85%
Reducing accidents	Reduce the incidence of road traffic accidents	Number of people Killed or Seriously Injured in road traffic collisions	105	104	99	94
	Reduce the incidence of older people falling at home	Reduce the incidence of older people falling and being admitted to hospital as measured by the age-standardised hospital admission rate per 100,000 population aged 65 and above.	1619 (2005 calendar year)	1603 (1% reduction from baseline)	1571 (3% reduction from baseline)	1538 (5% reduction from baseline)

	Raise awareness of how to prevent accidents, particularly in disadvantaged areas	Indicators and targets to be developed
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APPENDIX 3: Related Strategies and Weblinks

Publication	Published by	Date of publication	Weblinks
Choosing Health White Paper: Making healthy choices easier	Department of Health	2005	http://www.dh.gov.uk/assetRoot/04/12/07/92/04120792.pdf
Community Development Strategy	Newcastle City Council	2007	http://www.newcastle.gov.uk/wwwfileroot/cxo/cd/DraftComDevStrategy.pdf
Community Engagement Strategy (Draft)	Newcastle City Council	2007	To be published
Newcastle's Housing Strategy: Homes for a Sustainable Future	Newcastle City Council and The Housing Partnership	2006	http://www.newcastle.gov.uk/wwwfileroot/regen/housingstrategy/HousingStrategyFinalVersion.pdf
Public Health Annual Report : Improving Health in Newcastle	Newcastle PCT and Newcastle City Council	2006	http://www.newcastle.gov.uk/wwwfileroot/cxo/publichealth/PublicHealthAnnualReport.pdf
Newcastle Plan for Children and Young People	Newcastle Children and Young People's Partnership	2005	http://www.newcastle.gov.uk/wwwfileroot/socialservices/children/TheNewcastlePlanforChildrenandYoungPeople.pdf
Local Delivery Plan Newcastle Primary Care Trust	Newcastle PCT	2005	http://www.newcastlepct.nhs.uk/downloads/ldp05-08.pdf
Quality of Life Strategy for Older People and an Ageing Population (Draft)	Quality of Life Partnership	2006	http://www.newcastle.gov.uk/condiary.nsf/all/8994ACEB88D695A88025725F00410662/\$FILE/Full Strategy - draft Quality of Life Strategy for Older People and an Ageing Population.pdf
Regeneration Strategy	Newcastle City Council	2007	http://www.newcastle.gov.uk/wwwfileroot/regen/ppi/RegenStrategyFinalDoc.pdf
Safer Communities Strategy 2005 – 2008	Safe Newcastle	2005	http://www.newcastle.gov.uk/wwwfileroot/regen/ppi/SafeNewcastleStrategy.pdf
Sustainable Communities Strategy and Local Area Agreement	Newcastle Partnership	2007-	http://194.61.175.66/newcastleplan.nsf/48f0f02a7e08705780256bea0035df1c/9ace8dd2ff473caa80257261003e22ca/\$FILE/Newcastle LAA NARRATIVE - FINAL SUBMISSION 19.1.07.pdf http://194.61.175.66/newcastleplan.nsf/48f0f02a7e08705780256bea0035df1c/9ace8dd2ff473caa80257261003e22ca/\$FILE/Newcastle LAA Final Outcomes Framework 19.1.07.pdf

The Health Survey for England 2002.	National Centre for Social Research	2003	The Stationery Office
The Partnership Approach to Local Neighbourhood Renewal in East Newcastle	East End Partnership/East End Community Development Alliance	2006	http://www.eastendalliance.org.uk/lrsrep.doc
Domestic Violence and Abuse Reduction Strategy	Newcastle Domestic Violence and Abuse Partnership	2006	http://www.newcastle.gov.uk/ssacpc.nsf/a995f08678e0882f80256688005190dd/20b61705a218915c8025721e00460e8b/\$FILE/DomesticViolence_final.pdf

Mental Health and Emotional Well-being

Publication	Published by	Date of publication	Weblinks
Draft 'Improving Mental Health and Emotional Well-Being' Strategy	Newcastle PCT	2007	To be published

Tackling Obesity

Publication	Published by	Date of publication	Weblinks
Breast feeding Strategy	Newcastle PCT		DOES ONE EXIST????
An Obesity Strategy for Newcastle Upon Tyne	Newcastle PCT and Newcastle City Council	Expected 2007	
Physical Activities Strategy	Newcastle City Council		LINK ????????
Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children	National Institute for Health and Clinical Excellence (NICE)	2006	http://www.nice.org.uk/guidance/CG43#documents

Healthy Eating Action Plan	Newcastle PCT		LINK ??????
Newcastle's Green Spaces Strategy	Newcastle City Council	2004	http://www.newcastle.gov.uk/wwwfileroot/regen/plantrans/Landscape-GreenSpaceStrategy.pdf

Encouraging and Supporting Sensible Drinking

Publication	Published by	Date of publication	Weblinks
Alcohol Harm Reduction Strategy for England		(2004)	http://www.cabinetoffice.gov.uk/strategy/downloads/su/alcohol/pdf/CabOfficeAlcoholHar.pdf
Alcohol Needs Assessment Research Project	Department of Health	(2004)	http://www.dh.gov.uk/assetRoot/04/12/22/39/04122239.pdf
North East Alcohol Misuse Statement of Priorities	North East Regional Alcohol Advisory Group	2006	http://www.go-ne.gov.uk/497489/docs/communitysafety/alcohol_misuse.pdf
Models of Care for Alcohol Misusers (MoCAM)	Department of Health	2006	http://www.dh.gov.uk/assetRoot/04/13/68/09/04136809.pdf

Reducing the number of people who smoke

Publication	Published by	Date of publication	Weblinks
A Smoke Free North East. Regional Tobacco Control Strategy	Smoke Free North East	2005	https://www.freshne.com/content/reports/FINAL_STRATEGY.doc
Public Health Interventions for the prevention and reduction of exposure to second hand smoke: a review of reviews. Evidence Briefing	National Institute for Health and Clinical Excellence	2005	http://www.nice.org.uk/download.aspx?o=513311

Smoke Free Newcastle Tobacco Control Action Plan	Newcastle PCT and Newcastle City Council	2005	http://www.freshne.com/content/pdf/Smoke Free Newcastle Action Plan April 2005 (final version).pdf
The prevalence of smoking in the north east. Occasional paper No 23 August 2006	North East Public Health Observatory and Fresh, 2006. Chappel, D, Walrond, S and Bailey, K (2006) Data analysed from Acxiom National Shoppers Survey 2004	2006	http://www.nepho.org.uk/view_file.php?c=1476
Smoking cessation; Brief interventions and referral for smoking cessation in primary care and other settings.	National Institute for Health and Clinical Excellence	2006	http://www.nice.org.uk/guidance/PHI1/?c=296726
The Smoking Epidemic in England Twigg L., Moon G and Walker	Health Development Agency	2004	http://www.nice.org.uk/page.aspx?o=502813

Improving Sexual Health

Publication	Published by	Date of publication	Weblinks
Sexual Health Strategy	Newcastle PCT		LINK TO FOLLOW
Teenage Pregnancy Strategy	Teenage Pregnancy Partnership Board		LINK TO FOLLOW

APPENDIX 4: Government Guidance and further information

Action on Smoking and Health	www.ash.org.uk
Smoke Free North East	www.freshne.com
Smoke Free	www.givingupsmoking.co.uk
Smoke Free England	www.smokefreeengland.co.uk
North East Public Health Observatory	www.nepho.org/svg/ward_lifestyle_data_synthetic/map.htm
Department of Health	www.dh.gov.uk
NWPHO Local Alcohol Profiles	www.nwpho.net
Shift – (Action on Mental Health at Work)	www.shift.org.uk/employment
The UK Inquiry into Mental Health and Well-Being in Later Life	www.mhilli.org
National Institute for Health and Clinical Excellence	www.nice.org.uk

APPENDIX 5: Example of a completed priority outcome action plan - Obesity

TO BE INSERTED