Top tips for health in Local Authorities

Full report

Janet Ubido, Lyn Winters, Cath Lewis,
Matthew Ashton, Alex Scott-Samuel.

Observatory Report Series No. 65
Published December 2007

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Liverpool Public Health Observatory
and Cheshire and Merseyside Public Health Network

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Acknowledgements

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ChaMPs PublicHealth Network
Cheshire and Merseyside Partnerships for Health (ChaMPs for Health) is a public health network for primary care trusts, local authorities, NHS trusts and wider organisations.

The network's mission is to build partnerships to promote and protect public health and well-being, and develop capacity and capability in the public sector.
www.champsfor-health.net
0151 488 7776.

Liverpool Public Health Observatory
Liverpool Public Health Observatory is an NHS research and development unit based in, and closely integrated with, the Division of Public Health at the University of Liverpool. The observatory was founded in 1990 and was the model for the regional public health observatories established across England in 1998. Its staff consists of a part-time director, three researchers, and an administrator.

The principal purpose of the Observatory is the analysis, synthesis, and interpretation of health relevant information for those who make or influence policies affecting public health, whether they be in the public, private, or voluntary sectors.

www.liv.ac.uk/PublicHealth/obs
0151 794 5570

Foreword

Local authorities are rediscovering their roots as champions of health and well-being. Whether it be in schools, social care, the environment, transport or leisure services, local authorities and primary care trusts are
increasingly working together to meet the health needs of their communities.

Top tips for health in local authorities helps public sector partners focus on the actions they can take, drawing together evidence, national policy and practical examples of what works in a simple, easily digestible format. It is a welcome stimulus which everyone should use to improve the health of the North West.

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Introduction

In producing Top tips for health in local authorities, our aim is to enable local authorities within Cheshire and Merseyside to focus on actions they can take to promote the health of local people and their employees. Linked closely to the Choosing Health White Paper[1], it draws together evidence, national policy and targets for each Choosing Health priority area. Examples of good practice can be found in the full report, along with further details and examples of the impact and benefits of interventions given for each priority area. The evidence for this report was collated up to July 2007. Quantifying costs and benefits is more difficult as evidence is not always available at a local level; however, where it exists it has been included.

Improving health in local authorities can be achieved through effective partnership working, particularly between directors of public health, children's services, adult social services, planning and environmental health, as well as through local strategic partnerships .

Local authorities' duties of well-being and partnership working have been strengthened by recent government policy. In 2006, the Department of Health published Our Health, Our Care, Our Say[2], the White Paper which sets a new direction for social care and community health services, with four main goals:

- better prevention and early intervention for improved health, independence and well-being
- more choice and a stronger voice for individuals and communities
- tackling inequalities and improving access to services
- more support for people with long-term needs.

Local authorities have the potential to make a substantial impact on health, given the size and diversity of their workforce and their influencing role within local strategic partnerships and local area agreements.

This document is the second in the series of Top Tips to promote public health in a setting. The first was Top tips for healthier hospitals that can be accessed on line at: http://tinyurl.com/ydxjat. Work has now commenced on the third top tips report on healthy workplaces.

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1. Department of Health. Choosing Health making healthier choices easier. London: The Stationery Office, 2004.
2. DoH. Our health our care our say: a new direction for community services: Department of Health, January 2006.

EXECUTIVE SUMMARY

1. Reducing health inequalities

"Those individuals living within the most deprived areas experience the poorest health and shortest life expectancy."

"If health inequalities were reduced there would be longer, healthier lives for all, fewer working days lost to business and reductions in pressure on healthcare in the future."

Community

Inequality in health refers to an unacceptable gap in health status and access to health services or other influences on health. To reduce health inequalities requires effective partnership action on the wider determinants of health such as poverty, the urban environment, housing, employment and education. The other sections of this report will also have a major impact on reducing inequalities in health.

Top tips for effective interventions

Children

Reducing child poverty

- Ensure every Children's Centre has, as a minimum:
  - a 'warm' phone (that puts callers straight through to a Jobcentre Plus contact centre)
  - relevant leaflets on benefits, employment and training opportunities
  - job notice boards
  - desk space – for reading and writing, applying for posts
  - IT access
  - a designated employment adviser
  - a Job Point.
- Ask all parents on Welfare to Work programmes about their childcare needs and offer help with securing childcare.

Children's Centres

- Address the needs of groups at risk of being overlooked, for example:
  - identify under-represented groups within the area
  - bring together groups of people such as fathers, families with disabled children and smaller ethnic groups, to establish whether they have specific unmet needs
  - directly consult these groups on which services are the most valuable to them

- engage parents and children in sensitive and subtle ways, such as through community cafes, informal social groups and volunteering.

Looked after children
- Prepare young people for leaving care
- Ensure all young people in care and on leaving care have access to safe and effectively supported accommodation.

Involving young advisors
Young Advisors have a fundamental role in engaging other young people and also ensuring that strategies relevant to young people are accessible to them, particularly in terms of language and design.
- Follow the recommendations for involving young advisors made by the Neighbourhood Renewal Unit in 2006 after an evaluation of four pilot schemes.

Autistic children
- Consider introducing early intensive behavioural intervention with autistic pre-school children.

Adults
Neighbourhood renewal
- Use rapid health impact assessments (HIAs) at an early stage in regeneration schemes
- Use prospective HIAs and Equality Impact Assessments to engage a range of stakeholders in making decisions about different interventions
- Combine a range of approaches in neighbourhood renewal programmes
- Strengthen community involvement in decision making

One-stop shops
- Continue the multi-agency centre approach, such as providing welfare benefits advice in primary care settings.

Housing and homelessness
- Use a range of interventions that are proven to be effective in preventing homelessness
- Enter partnerships with private landlords and voluntary organisations to offer tenants greater security and support
- Incentivise private landlords to offer longer-term tenancies and more affordable rents, by offering management solutions
- Use empty homes powers to encourage better use of available stock
- Create incentives to reduce under-occupation of social housing.

Race equality
- Follow the Statutory Code of Practice on Racial Equality in Housing
- Develop with partners an anti racist strategy
- Follow the Institute for Public Policy Research 2007 guidance for the successful integration of new migrants, as part of a broader process of integration for all in society.

Disabled people

- Promote equal citizenship for disabled people by following the recommendations of the Department of Communities and Local Government.

Senior managers and elected members in LAs to:

- Address discrimination that stems from both attitudes and structures
- Promote the involvement of people, across the spectrum of disability, in all areas of policy through an increased range of mechanisms
- Ensure disability equality strategies recognise the impact of negative attitudes for different groups of disabled people including those with complex needs
- Adopt a formal change strategy to implement the disability equality agenda. Include an understanding of the skills and resources necessary to achieve change combined with incentives for staff and members to achieve it.

All local authority staff to

- Ensure attitudes and behaviour give important messages to enhance the confidence of disabled customers
- Not assume that one disabled person is able to represent all disabled people
- Think about the type of relationship to be established, when working with disabled people and their organisations. For example, when is it useful to work together and when do you need to ensure independence to promote a constructive challenge? Ensure that these debates are reflected in contracts or partnership documents
- Work towards introducing a contract with the local community and voluntary sector and respect it where it does exist
- Be clear about the terms on which expertise is requested and ensure that adequate reward is made
- Recognise that achieving disability equality is ‘work in progress’.

Responding to the wider agenda

- Adopting coherent change strategies which emphasise the importance of achieving well-being for all citizens: local area agreements provide a mechanism through which this could be addressed.

Tackling age discrimination and inequality

- Follow the guidance from the Joseph Rowntree Foundation task group on housing, money and care for older people:
  - support an approach which underpins the rights of all older people as citizens
  - value and support the contribution older people can make to society
  - give active and more vulnerable older people greater choice and control over their lives and decision-making.

Improving men's health

- Ensure Local Strategic Partnerships and other multi-agency initiatives have a specific brief to tackle men's problems.
- Address men's health issues in partnership with local PCTs and other agencies involved in delivering services.

Workplace

Promoting the rights of vulnerable groups and supporting them in the workforce and working with Jobcentre Plus on recruitment could significantly impact on reducing inequalities in health.

Top tips for effective interventions

- Help staff who are single earners to progress in work through career advice and skills development
- Promote the rights of disabled employees by identifying in job descriptions the roles and responsibilities of all officers in relation to access and monitoring through employee performance frameworks
- Develop support for staff who have basic skills
- Utilise Jobcentre Plus who provides a free recruitment service and specialist help and advice on training, rates of pay, equal opportunities and employing people with disabilities or from overseas.

All the supporting evidence and local examples of good practice are detailed in the main report.

2. Tackling obesity: Creating opportunities for healthy eating

"The prevalence of obesity has tripled since the 1980s, with more than one in five adults now classified as obese."

"In one study involving 55 vending machines, reducing the prices of low fat snacks by 10%, 25% and 50% increased the number of items sold by 9%, 39% and 93% respectively."

Community

Local authorities are encouraged to promote safe, sustainable and nutritious food to improve the health and well-being of local people. Approaches include not only providing information and education about healthy eating but also setting an example in local authority facilities.

Top tips for effective interventions

Joint action

- Via LSPs, ensure a co-ordinated approach is taken to improving nutrition and health within a community, involving working with strategic health authorities, PCTs, industry and the private and voluntary sectors
- Involve local authority departments, including planning, environmental health, regeneration, transport, leisure, youth and community work and housing, in food initiatives

Improve access to healthy food

- Encourage food co-ops, local markets, farmers markets and food delivery schemes
- Consider encouraging the placement of supermarkets in low-income areas, accessible without cars
- Encourage the development of local shops, especially in food deserts
- Improve public transport access to food retailers and consider subsidised transport in some areas
- Provide financial, technical and legal incentives to encourage the above schemes
- Develop breastfeeding policies for local authority premises.

Ensure local procurement

- Procure food locally and use seasonal produce in local authority premises such as leisure and community centres, where possible.

Provide information and education campaigns

- Encourage local shops and caterers to promote healthy food and drink choices via signs, posters and pricing
- Continue with the '5 a day' initiative
- Encourage 'community cook' or 'cook and taste' sessions in community centres and schools
- Advertise healthy food in local authority facilities
- Address people's concerns regarding mixed messages in the media about weight and diet
- Endorse weight loss programmes and slimming clubs that meet best practice standards.

Set an example in local authority facilities

- Set up healthy eating cafes in community centres
- Provide healthy snacks in all facilities, such as leisure and community centres
- Ensure healthy eating in residential homes and day centres
- Provide healthy meals on wheels.

Ensure community involvement

- Involve the community in identifying the limitations and possible solutions relating to local food needs.

Workplace

Workplaces are an ideal setting to promote healthy eating as many people spend most of their day at work and have at least one meal there. Employing more than two million people, local government is one of the largest employers in the UK.

Top tips for effective interventions

Set up a healthier workplace food policy

- Actively and continuously promote healthier choices in staff restaurants and vending machines
- Offer health checks for staff to encourage monitoring of weight and diet and provide ongoing support to enable healthy lifestyle changes
- Introduce incentive schemes offering lower priced healthy food and drinks
- Deliver tailored educational and promotional programmes to improve food provision.

All the supporting evidence and local examples of good practice are detailed in the main report.

3. Tackling obesity: Creating opportunities for physical activity

"Protective effects from cardiovascular-related death can be seen with as little as one hour of walking per week."

"A new traffic free cycle and walking path alongside a main road has seen an increase in use from 17,000 trips in 2004 to 63,000 in 2005."

Community

Physical activity should be encouraged so that it becomes part of a daily lifestyle, whether it involves walking or cycling to work or increasing sport and recreational activity.

Top tips for effective interventions

Joint planning

- Work with strategic health authorities, PCTs, industry and private and voluntary sectors to promote physical activity
- Encourage joint planning and action from senior managers and budget holders in the areas of urban planning, regeneration, the natural environment, transport, leisure services, education, environmental health, children and young people's services, engineering services and building design
- Work with the local community to identify barriers to physical activity, ideally using audits and health impact assessments.

Promote walking and cycling (for transportation as well as leisure)

- Carry out improvements to the environment by:
  - improving the safety of pedestrians and cyclists; giving them priority, taking measures to reduce vehicle speeds and traffic volume, improving street and park lighting, introducing neighbourhood wardens and Home Zones
  - making public spaces and parks more attractive
  - upgrading existing walking and cycling routes and providing new ones
  - providing signed routes and maps
  - ensuring facilities are accessible by foot or bicycle (for example by encouraging more local shops)
  - encouraging stair use in existing buildings, and in the design of new buildings
- Support schemes that encourage people to cycle and train them how to ride and look after their bikes.
- Involve existing cycling and walking groups in planning processes
- Provide facilities for walkers and cyclists, such as covered cycle storage spaces
- Provide targeted information about travel choices, health benefits and recreational opportunities
- Improve public transport
- Work with schools on developing school travel plans and secure permanent funding for school travel advisors.

Promote sport and recreation

- Use multi-sectoral partnerships to plan and finance the development of sports and recreational facilities, providing new facilities where needed.
- Protect existing facilities such as parks and school playing fields
- Encourage the increased use of sports and recreational facilities such as swimming pools and sports pitches
- Encourage access for all, for example with transport for disabled people, free access for certain groups and women-only swim sessions
- Provide ranger and park-keeping schemes to improve safety and encourage use of parks and open spaces
- Encourage innovative and alternative approaches to physical activity, such as green gyms, urban dance and skateboarding

Promote exercise and activity referral

- Increase exercise and activity referral by GPs, and encourage self-referral.

Workplace

Workplace travel plans offer a range of benefits including encouraging physical activity, improving social inclusion and interaction and reducing staff turnover. They also reduce parking costs for local authorities; the median annual running cost of a travel plan is £47 per full-time equivalent employee, compared to £300 - £500 per car parking space.

Top tips for effective interventions

Healthy travel plan

- Draw up and implement a healthy travel plan with policies to encourage walking and cycling and restrict workplace parking.

Health checks

- Offer health checks to address physical activity and provide ongoing support.

Promotion

- Actively promote physical activity through changes to the physical environment, incentive schemes and promotional programmes.

Facilities

- Provide physical activity programmes
- Provide facilities such as showers and cycle storage space.

Incentives

- Pay adequate cycle mileage rates of at least 20p per mile.

All the supporting evidence and local examples of good practice are detailed in the main report.

4. Improving mental health and well-being

"Mental illness accounts for as much suffering as all physical illnesses put together and the bulk of these mental illnesses are depression and anxiety."

"A positive working environment and appropriate support at work has a significant impact on stress related sickness absence and long term outcomes for council employees experiencing mental distress."

Community

In addition to the tips suggested below, actions relating to other sections of this report - physical activity, healthy nutrition, encouraging sensible drinking of alcohol and reducing health inequalities - will also promote mental health and well-being.

Top tips for effective interventions

Children

- Develop closer working relationships between key children's services and housing services
- Improve the support given to young carers and their families
- Develop and adopt programmes in schools, designed to promote emotional and social competence and well-being
- Ensure key agencies have an officer with designated responsibility to provide support for homeless children.

Adults

Policy making

- Strengthen community involvement in decision making, governance and democratic renewal. For example, support to voluntary and community groups, and local people's participation in policy processes and health impact assessments (HIAs)
- Reduce fear of crime and enhance social cohesion by involving residents in democratic decision-making, through frontline workers
- Ensure data on anti-social behaviour is reliable and easily accessible and use enhanced scrutiny powers to support improved performance in crime and disorder reduction partnerships
- Subject regeneration schemes and other policies, programmes and projects to prospective HIAs which include a mental well-being impact assessment
- Follow the guidance from Urban Green Spaces Taskforce to promote green spaces and make them accessible to all communities
- Ensure that public spaces are accessible to all communities.

Information

- Provide free access in libraries to written and multimedia information on mental health
- Ensure that information on gambling addiction, treatment and services is provided by gambling operators as well as service providers
- Ensure carers are aware of their entitlements by conducting regular information campaigns, through as many means and formats as possible including ethnic minority languages, large print etc.

Targeted approaches

- Develop gender sensitive services for homeless women

- Ensure stable, appropriate accommodation for asylum seekers and refugees, with support services to enable integration, following the guidance of the Joseph Rowntree Foundation and Royal College of Psychiatrists
- Develop a corporate response on domestic violence
- Adopt an inter-agency collaborative approach to suicide prevention
- Encouraging prisoners to write story CDs to their children can improve links with families and develop skills that will facilitate future employment
- Follow the guidance from Carers UK to promote better health of carers, in particular that carer's assessments address health issues, wider concerns and planning for predictable problems and emergencies
- Ensure as much flexibility in services for disabled people and carers as possible in order to minimise negative health impacts. For example, direct payments, vouchers, not having to travel long distances, etc.
- Recognition of carers as an at-risk group in public health and social inclusion strategies and support provided at high-risk times (e.g. at the beginning of caring and following bereavement).

Using the arts

- Develop community arts opportunities which promote the life satisfaction of all residents
- Provide art on prescription as an alternative or in addition to medication.

Workplace

Organisational changes have greater impact on decreasing adverse psychosocial work factors than individually focused interventions and may have more lasting effects. Helping staff to identify and solve work based psychosocial factors has beneficial results for staff well-being.

Top tips for effective interventions

Policy at work

- Assess job demands, increase job control and decision making latitude
- Develop an effective response to bullying and harassment
- Enhance team working
- Promote a positive approach to employing people with mental health problems
- Develop a human resource policy to respond to domestic violence
- Redress effort/reward imbalance by involving staff in identifying what kinds of benefits or recognition they would value
- Employers to follow the six principles to reduce stigma:
  - Making employees aware of steps they can take to preserve and maintain their own and others mental well-being
  - Promote a culture of respect and dignity for everyone, ensuring that staff are trained to recognise and be sensitive to mental distress or disability in others, whether they are workplace colleagues or customers

- Encourage awareness of mental health issues, so that employees are aware of the danger signs and understand the importance of seeking help early
- Demonstrate that no one is refused employment on the grounds of mental illness or disability
- Make reasonable adjustments to the work environment for people with mental health problems so that they can continue working
- Demonstrate that they take positive steps to ensure that people with mental health problems are not disadvantaged, in relation to the availability of their goods and services.

Culture

- Develop a culture in which staff are valued; consult and listen to staff
- Improve two way communications and staff involvement.

Information and support

- Increase social support by making available clear, consistent information and enhancing support from line managers
- Offer assistance, advice and support to staff experiencing mental health problems at work and for those returning to work
- Adopt strategies to ensure that working age carers are helped to remain within the workforce.

All the supporting evidence and local examples of good practice are detailed in the main report.

5. Promoting sexual health

"Poor sexual health can lead to a range of health problems including pelvic inflammatory disease, infertility, ectopic pregnancy, cervical cancer, unintended pregnancies, abortions, neonatal disorders and neonatal death."

"If local authorities focus on the young, this is likely to yield the most benefit since there is the potential to establish healthy patterns of behaviour."

Community

The promotion of sexual health involves preventing the damaging effects of poor sexual health and establishing healthy patterns of behaviour. It is felt that

most benefit can be achieved by local authorities and health services working together to provide holistic services to vulnerable groups and young people.

Top tips for effective interventions

Children

In care and on leaving care

- Provide children and young people with long-term, stable, secure and loving care.

Reducing unwanted teenage pregnancy

- Follow best practices of some local authorities, including:
  - targeted interventions with young people at greatest risk
  - giving high priority to personal sexual and health education in schools
  - a well resourced youth service
  - a senior champion driving the local strategy
  - active engagement of key delivery partners
  - availability (and consistent take-up) of sex and relationship education training for professionals working with vulnerable young people
  - provide contraception and sexual health services with a young person focus
  - ensure best practice continues to be identified and shared
  - all stakeholders to understand the actions required – from senior managers to front line professionals
  - a senior official from each stakeholder to be accountable for delivery.
  - consider the participation of young people in teenage pregnancy work, as proposed by the Teenage Pregnancy Unit and National Children's Bureau.

Effective school-based sex and relationship education

- Focus on reducing sexual behaviours that lead to unintended pregnancy, HIV and other sexually transmitted infections (STIs)
- Base programmes on theories which explain what influences people's sexual choices and behaviour
- Give clear messages about using contraception
- Include activities to help with resisting social pressures.
- Give examples of, and practice with, communication, negotiation and refusal skills
- Ensure goals, teaching methods and materials are:
  - appropriate to the teaching group
  - of adequate and substantial duration
  - led by those who believe in the programme and receive training
  - participatory
- Signpost young people to sexual health advice and specialist services.

School based services

- Consider introducing school-based health advice services with a strong emphasis on sexual health.

Young offenders

- Provide training for staff in youth offending services so they can offer support to young fathers, as well as young mothers, and provide sexual health advice to young offenders.

Adults

To reach vulnerable groups

- Make STI information available through a range of locations including workplaces, youth and community settings
- Consider the suggested policy responses to street sex work in local neighbourhoods:
  - Develop strategic, city-wide, multi-agency practical responses. For example targeted action against drug suppliers, balanced with harm reduction, support to help sex workers move on
  - Designated contact for residents to raise immediate concerns
  - Communication strategy at strategic partnership level, including raising awareness among communities
  - Consultation with a wide range of stakeholders on a range of options for forward direction, including requirements for coexistence, if feasible, and designated safety zones
  - Longer-term strategies such as mediation between local communities and sex workers
  - Multi-stakeholder forum at local levels, with formal links to city-wide strategic partnership, with primary focus on negotiation, prevention, harm reduction, support and strategy to help sex workers move on.
  - Piloting and evaluation of specific initiatives

- Address levels of hate crime, unemployment and poor housing for people with HIV, including improving understanding of HIV in schools.

All the supporting evidence and local examples of good practice are detailed in the main report.

6. Encourage the sensible drinking of alcohol

"Alcohol is a key factor in 50% of street crime."

"Several youth schemes have reported some success in reducing alcohol consumption and related crime by diverting youths into more constructive activities, such as drama, dance and DJ workshops."

Community

Working together with partners and the community is vital for local authorities seeking to encourage the sensible drinking of alcohol in their communities. Recommended initiatives include addressing licensed premises, housing and public transport.

Top tips for effective interventions

Joint working

- Continue with joint working on alcohol and crime, ensuring participation of the following key partners:
  - departments within local authorities, including planning, leisure, youth, trading standards, social services, environmental health, education and those concerned with community safety, crime and disorder and licensing.
  - businesses including pubs and clubs
  - police
  - primary care trusts
  - alcohol industry
  - strategic health authorities
  - both tiers of local government

Community approaches

- Develop sustainable solutions such as more:
  - parenting classes
  - family interventions
  - youth inclusion programmes
- Prioritise such schemes over the provision of more bars and clubs
- Develop community information campaigns on the health risks of alcohol misuse, for example, the social marketing ‘pssst’ campaign in Liverpool
- Encourage community access to support services, targeting vulnerable teenagers and families
- Work with local people to identify ‘hotspots’ and develop a plan of action

Licensed premises

- Encourage changes to the drinking culture through, for example, minimum pricing strategies, fewer promotions on cheap alcoholic drinks, promoting non-alcoholic drinks and the provision of comfortable seating, food and free water
- Provide trader training to help reduce intoxication of patrons
- Apply the ‘polluter pays’ principle whereby local authorities ask for a contribution towards the cost of any alcohol-related damage
- Limit the licensing of premises that encourage binge drinking
- Ensure retailers do not sell alcohol to under 18s.

Housing

- Provide supported housing for problem drinkers.

Public transport

- Co-ordinate public transport and licensed hours.

Workplace

Supervisors and employees who have completed worksite training on alcohol problems are more willing and able to take effective action toward alcoholic employees.

Top tips for effective interventions

Policy

- Implement a workplace alcohol policy covering drinking at the workplace, workplace discipline, alcohol education and recognition and help for those with alcohol-related problems.

Information

- Provide oral and written information on the damaging effects of alcohol and the availability of assistance to stop or reduce consumption
- Use 'themed months' to help raise alcohol awareness.

Support

- Offer access to a counselling and advice service, workplace based if available, including brief interventions for harmful drinking, or referral to an alcohol unit for dependent drinking.

Training

- Establish guidance and training for supervisors and selected employees, enabling them to identify alcohol problems early and refer employees for support.

All the supporting evidence and local examples of good practice are detailed in the main report.

7. Creating a smokefree environment

"Smoking is the biggest cause of premature deaths in the UK, with one person dying from a smoking-related disease every four minutes."

"Smoking is the leading cause of health inequalities in the UK and the main reason for disparities in death rates between the rich and poor."

Community

The July 2007 legislation establishing public places as smokefree does not apply to some institutions such as prisons and long-stay adult residential care homes. However, consideration should be given in these premises to ways in which smoking could be restricted in communal areas. Residents may be particularly affected by the effects of smoking; the smoking rate among prisoners, for example, is far higher than in the general population. Legislation covering prisons is expected to come into force in 2008.

In addition to the benefits to individuals' health, reduced levels of smoking can help protect the environment as cigarettes account for more than 40 per cent of street litter and cigarette filters take up to 12 years to degrade.

Top tips for effective interventions

Children

Enforcement:

- Implement effective no-smoking programmes in schools, youth groups and other venues for children and young people
- Work with vendors to reduce the incidence of under age sales.

Adults

Advice

- Enable staff to give advice to individual clients or citizens.

Support

- Support local businesses to become smokefree
- Support PCT Stop Smoking Services through community development work and joint working appointments.

Enforcement

- Establish a smokefree environment in public buildings and grounds.
- Work with police to deal with:
  - the smuggling and sale of cigarettes brought into the country
  - counterfeit cigarettes (which generally contain increased levels of toxins compared to normal cigarettes).

Workplace

The workplace has potential as a setting through which large groups of people can be reached to encourage smoking cessation. Employers have a role in supporting and encouraging employees who smoke to quit.

Top Tips for effective interventions

The NICE (National Institute for Clinical Excellence) guidelines recommend the following as the most effective and cost effective workplace approaches. NICE advises that employers can help their employees to give up smoking by:

- Making information on local stop smoking support widely available in your workplace
  - Contact the local stop smoking service and ask for help in providing information about the local support available. Local services can be found at www.gosmokefree.co.uk, or call the NHS Smoking Helpline on 0800 169 0169
  - Make information about the types of help readily available to all your staff, including when support is available, and where and how employees can access it
  - Ask staff if there is extra information and support you can offer in the workplace
- Offer support to help employees who want to give up smoking
  - Think about allowing employees to attend stop smoking services during working hours without loss of pay. NICE has produced tools to help you calculate the cost of this, and see the benefits for productivity if your employees give up smoking. See www.nice.org.uk/PHI005
  - Be responsive to individual needs and preferences. If there is sufficient demand, ask your local stop smoking service to offer help on your premises. This might include an on-site stop smoking group
  - Work with other local businesses to see if there is an opportunity to share smoking cessation support
- Work with your staff and their representatives to develop a stop smoking policy
  - Make the stop smoking policy part of an overall smokefree policy for your workplace
  - Think about whether staff will be allowed time off for smoking breaks during working hours
  - Think about whether any staff would like training to provide stop smoking advice.

All the supporting evidence and local examples of good practice are detailed in the main report.

1. Reducing health inequalities

Background

Inequality in health refers to an unacceptable gap in health status and access to health services or other influences on health. On average people are living healthier and longer lives, however, health and life expectancy are not shared equally across the population. For instance: recent data from the Health Profile for England confirms social class and regional inequalities in health. (DoH, 2006b) In Liverpool male life expectancy is 73.2 and for females it is 77.9 years. This is less than both the regional and national average and for women, the lowest life expectancy in England. There is a gap of 7.7 years between the poorest and the most affluent areas of Liverpool for life expectancy. (DoH, 2006b) Indeed, Britain is moving back towards levels of inequality in wealth and poverty, last seen more than 40 years ago. Even though there is less extreme poverty, the number of 'breadline poor'[1] households – where people live below the standard poverty line - has increased. There is also evidence of increasing polarisation, where rich and poor now live further apart. In some parts of the Liverpool constituencies of Riverside Liverpool 54.8% of all households are now 'breadline poor' (Dorling et al., July 2007). Relative poverty and social segregation fuel inequalities in health, whereas healthy societies have social inclusion and the smallest income differences between rich and poor (Wilkinson, 1997).

LAs and their associated primary care trusts (PCTs) that map on to them in the bottom fifth nationally for three or more deprivation indicators make up a Spearhead Group (Department of Health). While all areas have health inequalities, and action needs to be taken everywhere, the scale of the inequalities is greater in the Spearhead Group areas. Therefore, faster progress on improving health outcomes will be needed to reduce the inequalities gaps. All of the LAs on Merseyside and Halton and Warrington in Cheshire are part of the Spearhead Group, although Sefton is not a Spearhead PCT, but is in receipt of Neighbourhood Renewal (NR) funding. These LAs (with the exception of Warrington) are also in receipt of the NR Fund. This is granted to the 86 most deprived LAs as measured by the Index of Deprivation 2004. From 2007/2008 NRF will operate in the context of Local Area Agreements (LAA). Those Local Strategic Partnerships will need to continue to demonstrate through the LAA how they are narrowing the gap between the most deprived areas/groups and the rest. For these areas, LAAs must include mandatory outcomes with a neighbourhood renewal focus. (Communities and Local Government, 2002-2005) The NR programme is due to end in March 2008 which raises concerns about mainstreaming services and the ability to continue to target resources in these areas. (Atherton, 2007)

[1] In the Joseph Rowntree study 'breadline poor' is defined as living below a relative poverty line and excluded from participating in the norms of society. The definition is made up of a number of measures such as: not having central heating or sole use of amenities and overcrowding (more than one person per room).

The Health Secretary has announced an extra £8.9 million for 81 LAs to invest in schemes to tackle health inequalities. The £8.9M is provided for the second phase of the Communities for Health pilots which bring together local authorities, the NHS and community organisations to improve health in the most disadvantaged areas. LAs that will benefit within Merseyside and Cheshire include: Halton, Liverpool, St. Helens, Warrington and Wirral. Views are invited on working arrangements in the new Commissioning Framework of Health and Well-being that will bring local councils and the NHS closer together to deliver better care for their local communities. (DoH, March 2007)

To reduce unacceptable inequalities in health action must be taken on the wider determinants of health such as poverty, housing, employment and education. LAs working in effective partnership with the NHS, other public sector bodies and the private, voluntary and community sectors are seen, by the government, as crucial to tackling the health problems in their areas. For example: Directors of Public Health, working in partnership with Directors of Children's Services and Directors of Adult Social Services. Locally, Local Strategic Partnerships encouraged by the New Commitment to Neighbourhood Renewal, and Joint Strategic Needs Assessments (DoH, March 2007) are also central to tackling health inequalities by targeting the health needs of disadvantaged communities. Furthermore, LAs must consider the health impacts of everything they do, ideally through health impact assessments; otherwise their contribution to the communities' health will be compromised.

National policy, targets and commitments

Public Service Agreements (PSAs)

From the baseline year of 1998 (the average of 1997-99): By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.
(This commitment was reiterated in the *Choosing Health* White Paper).

Substantially reduce mortality rates by 2010 from the 1995-97 baseline.

Inequalities in Public Service Agreements across Government

In addition to focusing on overall improvements across government, PSA targets continue to address deprivation, particularly in key areas such as education and health through 'floor' targets or minimum standards. There is a strong correlation between these floor targets and the interests covered in the Programme for Action (DoH, 2003b). Local Area Agreements (LAAs) should be a significant means of addressing local inequalities issues (Atherton, 2007). Evidence of good practice and further guidance is available from the Communities and Local Government website. (DCLG, 2007b, February 2007)

Other targets have been set to reduce fuel poverty, improve energy efficiency, housing, and care for looked after children. There is also a focus on tackling unemployment and improving children's health.

Tackling the gap in inequalities in health:
Commissioning framework for health and well-being (DoH, March 2007) calls for strong local partnerships, and has highlighted that there are a number of strategic tools available to commissioners to ensure that services are targeted to meet local need. For instance: Health inequalities intervention tool http://tinyurl.com/ysx72a This is designed to support commissioners in Spearhead areas to identify the size of their local gap with England, and what diseases are driving it.
The Health Poverty Index enables commissioners to compare areas and groups in terms of their 'health poverty'. A group's 'health poverty' is a combination of its present state of health, the root causes and intervening factors. www.hpi.org.uk

Local Authorities and Primary Care Trusts also have a new duty to carry out Joint Strategic Needs Assessments (JSNAs) ("Local Government and Public Involvement in Health Bill. HL Bill 74 06-07," 2006-7) to describe the future health, care and well-being needs for the area of the responsible local authority and the strategic direction of service delivery to meet those needs. The JSNAs will inform the next stages of the commissioning cycle and underpin the Local Area Agreement. (DoH, March 2007)

Gender Equality Duty – the gender-equitable part of the Equality Act (2006) came into force on 6th April 2007. As a result, all public sector bodies and private sector, voluntary or charity organisations providing public services, must take gender into consideration when providing employment services and service provision.
http://www.opsi.gov.uk/si/em2006/uksiem_20062930_en.pdf

Top tips for effective interventions

Interventions to reduce inequalities in health through the prevention and reduction in smoking, unwanted teenage pregnancies, obesity, mental health problems and increasing physical activity are covered in other sections of this report. The evidence base on measures to tackle health inequalities is limited. Unless interventions improve the health status of those living in poor socio-economic circumstances at a faster rate than improvements in health of the better off, the gap will not be narrowed. (Hunter & Killoran, 2004)

Children

Reducing child poverty

This is a key issue as reducing child poverty will improve parental health and make future adults healthier. One of the main drivers of poverty is high levels of wage and wealth inequalities, with half of the 3.4 million children living in

poverty having a parent in paid work. Low-paid parents and couples can only avoid poverty if both are working. (Palmer, MacInnes, & Kenway).[2] To increase parental employment rates, there is a clear demand for help with entering work.

Recommendations:

- Every Children's Centre to have, as a minimum:
  - a 'warm' phone (that puts callers straight through to a Jobcentre Plus contact centre)
  - Relevant leaflets, on benefits, employment and training opportunities;
  - job notice boards
  - desk space – for reading and writing, applying for posts.
  - IT access
  - A designated employment adviser and a Job Point.

- Ask all parents on Welfare to Work programmes about their childcare needs and offer help with securing childcare by providing information or an appointment with the local Childcare Information Service. (Further recommendations to Job Centre Plus can be found in "Delivering on child poverty: what would it take?" by Lisa Harker)

Children's Centres – meeting the needs of groups at risk of being overlooked:

Recommendations:

- Identify under-represented groups within the area, for example through discussion with community groups and health professionals
- Bring together groups of people such as fathers, families with disabled children and smaller ethnic groups, to establish whether they have specific unmet needs
- Directly consult these groups on which services are the most valuable to them
- Engage parents and children in sensitive and subtle ways, such as through community cafes, informal social groups and volunteering. In this way, the centre can provide benefits beyond the services that they offer to children, and in some cases at relatively low additional cost. (See examples of good practice).

(National Audit Office, 2006)

Looked after children

Centrepoint have made recommendations based on their experience and consultation with young people after leaving care.

Young people need to be prepared for leaving care in ways that are:

[2] A household is classed as living in poverty if income is less than 60% of the British medium household income. In 2004/5 this was £100 for a single adult with no dependent children. £186 for a lone parent with two dependent children and £268 for a couple with two dependent children, after deducting council tax, income tax, and housing costs: (including rents, mortgage interest, buildings insurance and water charges).

- needs-driven
- person-centred and broad
- timely and ongoing
- purposeful and planned

This will be facilitated by:

- continual assessment, which involves young people
- having good personal advisers as required
- having and being actively engaged in pathway plans: for each young person which covers their needs for support and assistance as identified in their assessment and how these needs are to be met until they are 21
- treating housing-related support staff as active partners
- actively involving care-experienced young people in providing preparatory sessions.

Young people need access to safe and effectively supported accommodation. This will be facilitated by:

- ensuring there is a range and choice of accommodation which is needs-driven and personalised
- an understanding that 'leaving care' is a process not an event
- an understanding that all care leavers are different and therefore a differentiated response is needed
- protocols between housing and social services
- appropriate referral to accommodation
- paying attention to the physical layout of the building
- proper staff availability (24 hours) for 16 and 17 year olds
- chances to fail and try again
- delays in the benefit system being tackled
- continuity of preparation and support.

(Centrepoint, 2006)

From a sample of 1,244 young people in contact with leaving care teams, Rainer has found that one in six young people leaving care is being placed in unsuitable or unsafe accommodation. *Home Alone* assesses the scale of the problem and highlights the shocking conditions in which some care leavers are expected to set up their first home. It also identifies the gaps within local authority support, which can be as basic as simply not assessing the accommodation where vulnerable young people are being housed. (Rainer, April 2007).

Recommendations:

- LAs to include a specific section on housing for care leavers within their housing and homelessness strategies and their Children and Young People's Plan. Strategies to cover the range of accommodation from high-support to independent living. Strategies to be agreed jointly between Directors of Housing and of Children's services
- LAs to develop a list of approved properties and landlords and a system for rigorously inspecting properties before vulnerable young people are placed in them
- Young people should be able to veto housing that does not address their needs as set out in their Pathway Plan. (Rainer, April 2007)

Involving young advisors

Young Advisors are young people aged between 15 and 21, who show community leaders and decision makers how to engage young people in community life, regeneration and renewal. They are trained and employed consultants who guide local authorities, housing associations and other local partners about what it is like for a young person to live, work, learn and play in their neighbourhood.

Young Advisors have a fundamental role in engaging other young people and also ensuring that strategies relevant to young people are accessible to young people, particularly in terms of language and design.

Recommendations
These have been made following an evaluation of the four pilot schemes. (Neighbourhood Renewal Unit, 2006)

Practical Issues

- Develop suitable financial systems to facilitate easier payments to young people. In the pilots local and national systems were incompatible and inflexible thus increasing the workload for lead officers and causing delays in payments
- Reach an early agreement of suitable financial procedures for claiming back money from central government – a larger degree of flexibility. This could mean a change from retrospective claiming with project funding being assigned at strategic points within the project or a uniformed approach in terms of claim forms that will link easily to existing financial procedures
- Create a lead officer role in the planning and implementation of any Young Advisor programme. Evidence suggests that a minimum of 2 days a week of lead officer time be allocated to each scheme. This could mean buying out existing staff time or recruiting a dedicated lead officer post.

Training

- Involve Young Advisors in training new Young Advisors – possibly linking with accredited trainers to offer practical advice and support
- Ensure Lead officers receive good quality training so they fully understand the implications of their roles.

Partnerships

- Develop stronger links with LSPs to ensure that young people are engaged within this process
- Develop stronger links with LA youth services and voluntary youth organisations. Young Advisors have a vital role to play in the provision of services for young people. Positive relationships need to be established – this could be achieved through smaller project work initially on which to build a more sustainable integration.

Future Practice

- Clear criteria for Young Advisor involvement should be agreed to ensure they are not used in a tokenistic way. Young Advisors should be trained and supported to vet all requests for their input by meeting regularly as a group and inviting clients to attend to make their request, provide information and also demonstrate feedback mechanisms and action.

(Neighbourhood Renewal Unit, 2006)

Intensive early intervention for autistic toddlers

Individuals with autism and their families report social exclusion on a daily basis. Large numbers of children with autism are excluded from school or fail to fulfil their potential. In adulthood many individuals live lonely, anxious and unfulfilled lives. By leaving families to muddle through on their own, with often catastrophic results, society has to pour billions of pounds a year into the social consequences. There are hidden costs for families with high out of pocket expenses. (Research Autism, last accessed 27th April 07).

However, consideration should be given to introducing early intensive behavioural intervention (EIBI). A British study has found EIBI can lead to rapid improvements in young children that enables them to go to mainstream school. The cost of the intervention would be between £20-30K per year for LAs, but it can reduce the costs of lifetime care for a person with autism of approximately £2.9m. (Research Autism, April 2007; Ward L, April 26th 2007) [See examples of best practice]

Adults

One-Stop shops

Recommendation:

- Continued provision of multi-agency centres, such as welfare benefits advice in primary care settings, as part of a holistic approach to the care of people with chronic conditions in middle age or old age.

(Abbott & Hobby, 2002)

Anti Racist strategy

- Develop with partners an anti racist strategy that celebrates diversity and enables residents to report incidents that are swiftly acted upon. [See examples of good practice]

Reception and integration of new migrant communities

Research from the Institute for Public Policy Research (IPPR & CRE, 2007) looked at the reception and integration of new migrant communities, paying particular attention to the tensions arising from their arrival and settlement, key lessons from the response of public authorities, and how they use their responsibility under the race equality duty in this response.

The findings highlight some worrying trends such as the discrepancy between the misplaced burden of new immigrants reported by the media and actual impacts. Also, local authorities do not fully understand the relevance of race relations to the integration of new migrant communities. As new migrants are not commonly considered by public authorities as 'racial groups', race relations are generally confined to established white communities and established ethnic minority communities, but not new European immigrants. Therefore, the useful and thorough guidance issued by the Commission for Racial Equality on promoting good race relations is not consulted. Furthermore, public authorities are not well-informed about the scale and nature of new migration flows which limits their response to one which is largely reactive and driven by frontline pressures.

Three key characteristics underpinned all the evidence of good practice:

- Strategic partnerships between public authorities and other agencies;
- Effective communication with local communities; and
- Proactive measures to improve the local evidence base on new migrants in order to better inform integration policy.

Recommendations:

- Successful integration of new migrants needs to be part of a broader process of integration for all in society, focusing on interaction, participation and equality.

- *Promote good race relations*: fulfill obligations under the Race Relations Act, including assessing how policies affect race relations in order to maximise opportunities for interaction and participation.

- *Eliminate misperceptions:* Become more transparent in decision-making procedures, particularly in relation to housing and grants, in order to eliminate misperceptions of preferential treatment for some communities.

- Work proactively with local agencies to better inform local communities about the impacts of new migrants and work more closely with the local media to dispel myths and ensure more balanced coverage.

- *Improving local capacity:* Local authorities should work closely with employers, trades unions, and others to better plan for services; improve the evidence base at a local level; share best practice and resources; and establish who is best placed to support and facilitate integration.

(IPPR & CRE, 2007)

Promote equal citizenship for disabled people

In case study research conducted for the Department of Communities and Local Government by *the Institute of Applied Social Studies and the Institute of Local Government Studies, University of Birmingham,* there was some evidence of disability discrimination against employees and service users. Authorities found it more difficult to respond to the needs of people with mental health issues, learning disabilities or invisible impairments such as

chronic pain or diabetes. Generally, LAs were considered more reactive than proactive in making changes and there was scant evidence of co-ordinated change strategies being in place. Disabled people considered attitudes and approaches as important as practical responses. (DCLG, 2006)

Recommendations:

Senior managers and elected members in LAs to:

- Address discrimination that stems from both attitudes and structures
- Promote the involvement of people, across the spectrum of disability, in all areas of policy through an increased range of mechanisms
- Ensure disability equality strategies recognize the impact of negative attitudes for different groups of disabled people including those with complex needs
- Adopt a formal change strategy to implement the disability equality agenda that includes an understanding of the skills and resources necessary to achieve change combined with incentives for staff and members to achieve it.

All local authority staff to

- Ensure attitudes and behaviour give important messages to enhance the confidence of disabled customers
- Not assume that one disabled person is able to represent all disabled people
- Think about the type of relationship to be established, when working with disabled people and their organisations. For example, when is it useful to work together and when do you need to ensure independence to promote a constructive challenge? Ensure that these debates are reflected in contracts or partnership documents
- Work towards introducing a contract with the local community and voluntary sector and respect it where it does exist
- Be clear about the terms on which expertise is requested and ensure that adequate reward is made
- Recognise that achieving disability equality is ‘work in progress’.

Responding to the wider agenda

- LAs to adopt coherent change strategies which emphasise the importance of achieving well being for all their citizens: local area agreements provide a mechanism through which this could be addressed.

(DCLG, 2006)

Tackling age discrimination and inequality

The Joseph Rowntree Foundation task group on housing, money and care for older people (JRF, October 2004) proposed a fundamental shift in the way society addresses our ageing population to tackle age discrimination and inequality. It aims to support an approach which underpins the rights of all older people as citizens, values and supports the contribution which older people can make to society and gives active and more vulnerable older people greater choice and control over their lives and decision-making.

The recommendations relevant to LAs include:

- Developing a new vision and culture which celebrates older age and recognises the value of older people in society, both individually and as a whole. [See examples of good practice: *Manchester valuing Older People Positive Images of Ageing Campaign*]
- Improvements are needed to the provision of information, income maximisation and other advice and advocacy to enable older people to have greater choice and control in older age, especially at key points of transition in their lives
- Initiatives are required to meet the demands for the type of products and services that older people want, in order to retain independence, choice and control
- To promote a quality of life and well-being approach through:
  - Developing Quality of Life Strategies and partnerships with older people at a local authority level
  - Rethinking approaches to service delivery and
  - Developing a neighbourhood approach which enables older people to contribute in their local communities
- Housing and support options in both mainstream and specialist housing and across tenures, is required to support independence in older age
- To plan successfully for an ageing society, a stronger and more comprehensive strategy, resourcing and commissioning framework is required:
  - New holistic approaches turning the planning system from managing dependency to promoting active ageing
  - New local commissioning structures, with older people as partners; and
  - A whole-system financial framework to rethink resource use and priorities.

Improving men's health

There is overwhelming evidence to support the contention that men's health is much poorer than it need be. Many men die prematurely. Average male life expectancy at birth is just 75.6 years, five year's less than for women. In some parts of England and Wales, and among certain groups of men, it is as low as 71 years (Wilkins D & Baker P, 2004). Life expectancy among the least affluent women still exceeds that of the most affluent men (Granville, Last accessed 27th April 2007).

The Men's Health forum recommends:

To build healthy public policy:

- Ensure Local Strategic Partnerships and other multi-agency initiatives have a specific brief to tackle men's problems.
- Address men's health issues in partnership with local PCT(s) and the other agencies involved in delivering services. As providers of leisure, education, housing, environmental and social services, local authorities have a potentially enormous role to play in developing local health initiatives for men, especially those in disadvantaged groups.

(Wilkins D & Baker P, 2004)

Home and Environment

Neighbourhood renewal

Recommendations:

- Rapid health impact assessment can be used early in a regeneration scheme, contributing to plans for implementation.
- The prospective use of health impact assessment and Equality Impact Assessments (DCLG, 2007a) can be an important way to engage a range of stakeholders in making decisions about different interventions, taking account of the evidence, to assess both the negative and positive health consequences.
- Programmes that combine a range of approaches appear to offer the best prospects for changing health inequalities.
- Strengthening community involvement in decision making, governance and democratic renewal are ways of building social capital[3] to improve the health and well-being of socially disadvantaged communities and groups. For example, support to voluntary and community groups, and local people's participation in policy processes.

(Hunter & Killoran, 2004)

Housing and homelessness

The life expectancy of someone sleeping rough is estimated to be 42 years, half that of the average UK citizen. Children in temporary accommodation miss out on a quarter of their schooling. Around 8 per cent of all households accepted as homeless by councils are in priority need on grounds of mental illness. (Homeless Link, 2006)

The 2002 Homelessness Act obliges LAs to develop a strategy to prevent and deal with homelessness in partnership with local statutory and voluntary agencies. Partnerships with health service providers enable such strategies to deliver targeted interventions to this group. Good strategies will start by drawing together a full picture of the levels and nature of homelessness in their area. (Homeless Link, 2006)

Many LAs are developing effective emergency preventative approaches, often with the third sector, that can stop someone becoming homeless or give them breathing space for the move to a new home to be planned.

Recommendations:

- Use a range of interventions that are proven to be effective in preventing homelessness, including:
  - County court assistance schemes
  - family mediation services
  - rent deposit services
  - Sanctuary schemes for people suffering domestic violence, enabling victims to choose whether to remain in their home with professionally

[3] defined as the advantage created by a person's location in a structure of relationships.

installed security measure. Guidance on setting up and running effective sanctuary schemes has been produced (LGA & DCLG, 2006)

- Enter partnerships with private landlords and voluntary organisations to offer tenants greater security and support. [See example of good practice for homelessness prevention]
- Incentivise private landlords to offer longer-term tenancies and more affordable rents by offering management solutions.
- Use Empty Homes powers to encourage better use of available stock
- Create incentives to reduce under-occupation of social housing

(Homeless Link, 2006)

Racial Equality housing code of practice

Britain's ethnic minority population has changed, with the arrival of new migrants, including refugees. Integration and community cohesion have become increasingly important considerations for housing organisations and agencies. Also, while there have been improvements for some ethnic minority groups, significant differences still persist overall in the type and quality of housing available to people from ethnic minorities, who are more likely to live in inferior housing, and to have fewer opportunities to improve their circumstances than people from other groups. (Commission for Racial Equality, 2006a)

Recommended

- Follow the Statutory Code of Practice on Racial Equality in Housing, which sets out what constitutes good practice in the field of housing. It explains the provisions of the Race Relations Act 1976 that are relevant to the provision of housing in England, Scotland and Wales. It aims to:
  - Set standards for achieving racial equality;
  - Provide practical guidance that will help organisations and individuals involved in all areas of housing to avoid unlawful racial discrimination and harassment, promote equal opportunities for all, and encourage good race relations.

(Commission for Racial Equality, 2006b)

Workplace

Promoting the rights of vulnerable groups and supporting them in the workforce and working with Jobcentre Plus on recruitment could significantly impact on reducing inequalities in health.

Top tips for effective interventions

- Support staff who are single earners to help them progress in work through career advice and skills development. (Harker, 2006)
- Promote the rights of disabled employees by identifying in job descriptions the roles and responsibilities of all officers in relation to access and monitoring through employee performance frameworks. (DCLG, 2006)
- Develop support for staff who have basic skills. For more information and advice on addressing literacy and numeracy issues in the workplace and

government support for training call a skills broker on 08000 15 55 45 or visit www.traintogain.gov.uk

- Utilise Jobcentre Plus who provides a free recruitment service and specialist help and advice on training, rates of pay, equal opportunities and employing people with disabilities or from overseas. http://www.jobcentreplus.gov.uk/JCP/Employers/index.html

Box 1
Examples of evidence for the effectiveness of interventions to reduce inequalities in health applicable to local authorities

Children's Centres – meeting the needs of the most excluded groups
The most disadvantaged families have the greatest need for the integrated services provided by children's centres. However, a recent report has found that still more can be done to reach and support some of the most excluded groups that are non-users. (National Audit Office, 2006)

Looked after children
A substantial proportion of young people leaving care experience poor outcomes in the key aspects of life: including education, employment and housing. They are over-represented in indicators of social exclusion such as homelessness, unemployment and the criminal justice system. Typically they have to take on adult responsibilities on leaving care between 6-8 years earlier than children brought up in a parental home. Centrepoint has recommended practical action to improve the accommodation and related support for care leavers. Their propositions derive from their experience, and the views of young people and those who work directly with them. (Centrepoint, 2006)

Involving young advisors
Young Advisors within 4 pilot areas have become involved with a range of strategies. This has involved consultation, input and youth proofing. One element of this work has been to engage other young people in strategy development. Many of the Stakeholders report that Young Advisor input to date has been very positive and valued. Much of this work has yet to be completed but Young Advisors have a fundamental role in engaging other young people and also ensuring that strategies relevant to young people are accessible to young people, particularly in terms of language and design. (Neighbourhood Renewal Unit, 2006)

Neighbourhood renewal
Research shows that regeneration can make a positive contribution to improving health and reducing health inequalities. But there is potential for negative health impacts and a worsening of health inequalities. An assessment of the health consequences of schemes must be an integral part of their planning and design. (Hunter & Killoran, 2004)

One Stop Shops
Evidence suggests that welfare benefits advice service users find it easier to access such services in a setting which is familiar, unstigmatising and nearer to home and it also improves their health (on two aspects: vitality and mental health) as well as their income. (Abbott & Hobby, 2002)

Poor housing and homelessness
From a comprehensive review of research, Shelter concludes that more than a million children in Britain are living in poor housing. Indeed, on every aspect of life – mental, physical, emotional, social and economic – living in poor housing can hand children a devastating legacy. Homeless children are three to four times more likely to have mental health problems than other children. Evidence suggests that nearly half of young offenders have experienced homelessness as a child, and the roots of offending behaviour may well be traceable to problems that emerge when children grow up in such conditions. (Shelter, 2006)

Examples of good practice

Heal 8 – a virtual healthy living centre
Health 8 has won a 2005 reducing health inequalities achievement of the Year award, funded for 5 years from the Big Lottery. Heal 8 addresses five key policy areas on acute health needs in the deprived district of Liverpool 8: Food and nutrition; fitness and physical well-being, mental well-being, environmental health, and community capacity building. Liverpool City Council is the lead partner.
Guiding principles of Heal 8 include creating opportunities for:

- Liverpool 8 communities to be fully engaged in project design and delivery;
- individuals to improve their health through increased activity and lifestyle changes;

Among other things, Heal 8 is working to address social exclusion by enhancing access to appropriate services, facilities and employment opportunities for black and minority ethnic groups and people with disabilities. Details of some projects are featured under other sections of this report.
Further details: Karl Smith, Heal 8 Project Manager, Liverpool PCT, Karl.smith@liverpoolpct.nhs.uk

Knowsley Against Racism is a campaign to challenge all forms of racial hatred and make Knowsley a safer place in which all people can live, work and spend their leisure time regardless of their background. The council and its partners have launched this campaign as part of a strategy to *stamp out racism* in Knowsley.

The campaign was launched at King George V playing fields on 23 October 2005 through a programme of lively and family focused activities that celebrated diversity, highlighted different cultures, and gave out a strong anti-racism message. It aims to work with the local community to ensure all residents feel welcome, accepted and safe, irrespective of their colour, race or

religion. Knowsley Council and its partners are committed to tackling racism in the borough, changing public attitudes and encouraging people to report racist abuse or behaviour. The council and its partners promise to act swiftly in response to proactively challenge racist behaviour and inform residents of any developments. Residents are also encouraged to show their support by signing pledge cards and displaying window stickers. A Multi Agency Racial Harassment Forum in Knowsley has been established to address racial harassment in the borough. The community of Knowsley is represented on this forum through the Community Empowerment Network. (Knowsley Council, 2nd November 2005, last accessed 17/4/07)

Partnership working between the NHS and LA

A partnership joining together Knowsley Council and Knowsley Primary Care Trust to tackle health inequalities known as "the Health and Well-being Partnership" is using their Local Area Agreements as a tool to enable the partnership to deliver on its key priority: "narrowing the gap between the most disadvantaged areas and groups in Knowsley. As a result of this, the Partnership has developed a framework for a highly mainstreamed approach to delivery of both neighbourhood renewal outcomes and of agreed standards of service across the Borough.
Further information from: Heather Vaughan, Knowsley Partnership Communications Officer Tel: 0151 443 3054.

Homelessness prevention

Newcastle City Council has put in place a partnership with local housing providers and voluntary sector services, which provides an early warning when a vulnerable person is getting into trouble with their tenancy. This triggers input from agencies that can help the person get back on track and keep their home.
http://www.endhomelessness.org.uk/vision2action/action/prevention

Sanctuary scheme

Home Shelter is an award winning partnership between Islington Council, the Police, Domestic Violence Matters, Homes for Islington and Kier Islington. It helps those escaping domestic violence to feel and to be safer and prevents them from becoming even more vulnerable by becoming homeless. Fireproof letterboxes, solid core doors, second phone lines and reinforced safe rooms plus information and support on taking legal action are given. The measures are cost-effective costing about £30,000 for 19 women, but re-housing in temporary, sometimes cramped, accommodation would have cost £200,000. The measures can keep violent partners out long enough for the police to arrive. http://tinyurl.com/22asdl

Children's centres: Engaging parents sensitively and providing benefits beyond immediate services.

The Sure Start North West Nottingham children's centre encourages users to volunteer for work at the centre. One mother started attending yoga classes and the toy library at the centre and subsequently volunteered to run the centre's weight watchers class. The centre paid for and provided childcare to enable her to run the class. She received training in a wide range of areas

including first aid, basic food hygiene and volunteer training. She gained qualifications from the volunteering and is now employed as a community food worker across a number of children's centres in the area. She has ambitions to start her own healthy eating café. (National Audit Office, 2006)

Lift your lifestyle
'Lift Your Lifestyle' is a joint programme between Sefton PCT and Sefton Council, which aims to encourage employees aged 50 and over to be health aware and make healthy lifestyle choices. Employees can attend a short 15 minute appointment, in which they will be offered health advice and information about leisure activities in Sefton. In addition, they will be offered confidential screening including blood pressure, random cholesterol and carbon monoxide testing for smokers. For more information, contact Gareth Lewis, gareth.lewis@seftonpct.nhs.uk

Sefton compact education & training sub-group
Education and training leads and public health leads have developed a partnership arrangement within the Sefton Compact (Sefton PCT, Sefton LA and Sefton CVS) to provide leadership and expertise to inform the development of the Health Trainer programme across Sefton. The approach agreed by Compact partners has been to develop the health trainer programme within the existing workforce. This sub-group has also developed a shared training programme to meet joint public health targets. For further information contact Una Gordon Una.Gordon@seftonpct.nhs.uk

Manchester City Council Valuing Older People Positive Images of Ageing Campaign
This involved a high-profile media campaign that promoted active and healthy images of ageing and older people. It also challenged older people to adopt healthier, active lifestyles.

To challenge negative stereotypes, a city-wide poster campaign on street furniture, coupled with other media coverage, was used to promote the production of the 2006 calendar *Growing Older with Attitude in Manchester.*

In September 2005, the Full of Life Festival was held to celebrate the creativity of Manchester's older residents. It included a photographic montage – *What Older People Value* – in the City Art Gallery, and other satellite exhibitions and drama productions across the city, all produced by older Mancunians.

An extremely positive response was received to a formal evaluation of the festival and anecdotal evidence suggests that there has been an increase in the number of older people accessing local groups and activities. The imaging work and library of images now owned by the initiative have attracted national attention. Other LAs have asked to purchase the images in order to share the good practice. The project has also encouraged new approaches to working with and engaging older people in the City of Manchester. (DoH, 2007b)

Intensive early intervention for autistic toddlers provides rapid improvements

A study into the impact of Early Intensive Behavioural Intervention (EIBI) was conducted by a team led by Professor Bob Remington from the School of Psychology at the University of Southampton and Professor Richard Hastings from the School of Psychology at Bangor University. Results show that a group of children who received two years of EIBI had higher IQs, more advanced language, and better daily living skills than similar children receiving standard educational provision. IQ increased for two thirds of the children receiving the early intervention and 'very substantially' for more than a quarter of them. For example, one child moved from an IQ of 30 up to 70; another from an IQ of 72 to 115.

Specially trained staff and parents taught children with autism a wide range of skills in their own homes for 25 hours a week. Teaching was individualised to take full advantage of each child's abilities and focus on areas of need; each lesson was carefully broken down into easy steps and children received constant praise and other rewards for their successes.

In North Wales, the EIBI techniques are now being applied with children with autism in a unit attached to a mainstream school. The project at Westwood School in Buckley was recently evaluated as an "outstanding" educational provision by Estyn (Inspectorate for Education and Training in Wales). (University of Wales, Last accessed 27th April 2007)

2. Tackling obesity: Creating opportunities for healthy eating

Background

Diet-related cardiovascular disease and cancer are the leading killers in the UK, accounting for over 60% of deaths in 2004 (Allender, Peto, Scarborough, Boxer, & Rayner, 2006). Along with physical inactivity, diet is one of the two main factors behind the current upward trend in obesity (Wanless, 2004). More than 1 in 5 adults are obese. Obesity reduces life expectancy by an average of 9 years (CMO, 2003). The prevalence of obesity in England has tripled since the 1980s. This has lead to a growing number of people with diabetes, cardiovascular disease, high blood pressure, strain injury, joint problems and hormone related cancers (NWFH, 2006; WHO, 2005).

There are more obese people amongst the least well-off. In 2001, it was reported that in social class I, 14% of men and women were obese, compared to 28% of women and 19% of men in social class 5 (DoH, 2005d).

In the North West, 14% of schoolchildren were reported to be obese in 2005/06. The two North West PCTs with the highest percentage of obese children were both in Cheshire and Merseyside (West Cheshire 17.87% and Halton & St.Helens 17.43%). Knowsley and Liverpool were also higher than the North West average (NWPHO, February 2007).

The National Heart Forum (National Heart Forum, 2004) highlighted the poor dietary trends in the population:

- Over 80% of adults in Great Britain are exceeding the maximum recommended intake levels for saturated fat (11% of energy intake);
- Over 50% are exceeding the maximum recommended intakes for total fat (35% of energy intake);
- Adults are eating almost double the maximum recommended amount of salt (6g per day);
- Adults are eating half the oily fish recommended (1.5g per week);
- Adults are eating half the 5 portions per day of fruit and vegetables recommended.

Children from disadvantaged households eat on average half as much fruit and vegetables as children from high income group households (DoH, 2004d).

There are encouraging signs of improvement, with the most recent Health Trends survey for 2005 showing that over the past year, more people are eating the recommended five portions of fruit and vegetables (The Information Centre, December 2006).

The impact of a healthy diet on health has been well documented (Box 2). In addition to health benefits, there are numerous social economic and

environmental benefits in increasing local food growing, including community cohesion and local employment (WHO, 2001).

The public sector in England spends £2 billion on food and catering services. Local authorities are part of the Public Sector Food Procurement Initiative (PSFPI), which is working towards embedding sustainability in procurement, with healthier food as a goal (DEFRA, 2006).

Box 2
Impacts of a healthy diet

- Over 50% of cardiovascular disease (including coronary heart disease and stroke) could be prevented through better diets (WHO, 2002);
- 30%-40% of all cancer cases preventable by appropriate diets, physical activity & appropriate body weight (NWFH, 2006);
- eating '5 –a-day' could reduce cancer rates by 20% (NICE, December 2006; NWFH, 2006) improved diet could prevent up to ½ of all breast cancer cases (NWFH, January 2007);
- 3 out of 4 cases of stomach and colorectal cancer could be prevented through better diet (HDA, 2005a; NICE, 2006a; NWFH, 2006).

It is estimated that the economic burden of food related disease in the UK costs the NHS between £4 billion and £6 billion a year (DEFRA, 2006). Additionally there are *economic costs* in terms of loss of productivity, sick pay and *personal costs* from sickness, loss of opportunities and reduced quality of life. Obesity is estimated to account for over 18 million sick days and 40,000 lost years of working life each year (NWFH, January 2007). Absenteeism for overweight employees is 10% higher than average (JMU, 1999).

There is evidence that it is easier to prevent obesity than to treat or reverse it (NWFH, January 2007). The various interventions that could be made by local authorities to help to achieve this will be discussed under '*top tips for effective interventions'* below.

National policy
'Choosing a Better Diet' (DoH, 2005b) presents a range of actions and commitments to improve food, nutrition, and public health, across a number of settings. There is a section on what can be done in local communities, and in the workplace.

Targets and commitments
Public Service Agreement on tackling obesity :

- ❖ Halt the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.

'Delivering Choosing Health' commitments (DoH, 2005d):

- ❖ Raise awareness of the health risks of obesity and the steps people can take through diet and physical activity to prevent obesity (p.62).

- ❖ Introduce a system to use as a standard basis for signposting foods, building on the nutrient criteria for the 5 a day logo (p.61).
- ❖ Simplify messages on what a portion means for children and adults, e.g. using 'a handful' (p.62).
- ❖ Funding of community food initiatives in PCTs. The focus will be on deprived communities, and will build on the lessons learned from the evaluation of lottery-funded initiatives (p.72).
- ❖ Development of guidance on good practice in food procurement (p. 73).
- ❖ Develop nutritional standards for all foods provided by public bodies – building on the work in schools. Increase access to a range of healthier foods and take account of the different formats of food provision – restaurant, fast food, vending etc. (p.73).

Local agreements

- ❖ The Wirral Local Area Agreement 2007/08 includes baseline figures and targets for numbers of people attending healthy cookery courses (Wirral Borough Council, 2007).

Top tips for effective interventions

The ability to maintain a healthy weight is influenced by the environment in which people live, including access to an affordable, healthy diet (NICE, 2006b). Nutrition initiatives in schools have been widely reported elsewhere, with extensive guidance (DfES, September 2004), so they are mentioned only briefly here. (see also http://www.wiredforhealth.gov.uk/cat.php?catid=842).

There are two documents that specifically outline what action can be taken by local authorities to encourage healthy eating:

- the NICE obesity guidance, which includes a quick reference guide for local authorities (NICE, 2006b, December 2006);
- and the North West Food and Health Action Plan p.16 (NWFH, January 2007).

Other documents and guidelines include:

- two WHO documents, outlining what local authorities can do to promote initiatives to produce healthy local food (WHO, 2001) and to promote healthy weight (WHO, 2006b);
- an obesity toolkit, developed to provide local authorities and other local planners with a starting point for developing a local strategy to tackle overweight and obesity (National Heart Forum, Updated March 2007);
- 'Food Vision', a government initiative, which provides a resource for local authorities as well as community members to promote safe, sustainable and nutritious food to improve local community health and well-being (Foodvision, 2007).

The following points are a summary of the interventions available for creating opportunities for healthy eating:

- *Joint action*.
  Local Strategic Partnerships (LSPs) are well placed to ensure that a co-ordinated approach is taken to improving nutrition and health within

a community, involving working with the strategic health authority, PCTs, industry and the private and voluntary sectors (DoH, Spring 2004). The local authority departments involved in food initiatives will include planning, environmental health, regeneration, transport, leisure, youth and community work, and housing.

- *Improve access to healthy food:*
  Access to food is one of the four most important opportunities for reducing social exclusion (DoH, Spring 2004). Effective interventions would include the following:
  - Encourage food co-ops, local markets farmers markets, and food delivery schemes (DoH, 2005b; NICE, 2006b; ODPM, March 2005; WHO, 2001). Such schemes are also good for community cohesion, and personal well-being, which are benefits that are difficult to quantify, but which are real benefits to the people involved (Towers, Nicholson, & Judd, 2005). Joint working between local authorities, PCTs, neighbourhood renewal, and Local Strategic Partnerships, with the provision of professional support is key to the sustainability of the schemes (Towers et al., 2005). Planning and regeneration departments need to consider encouraging the placement of supermarkets in low-income areas, accessible without cars (Cohen, Perales, & Steadman, 2005).
  - Encourage the development of local shops (NICE, 2006b; WHO, 2001) Improve access by public transport to food retailers, and consider subsidised transport in some areas (DoH, 2004d). Accessibility planning is an important consideration for local authorities in their Local Transport Plans, involving close working between transport and land-use planning departments (DoH, 2004d).
  - Regenerate allotments and community gardens (DoH, 2004d, 2005b; NICE, 2006b). Local authority land that is under-utilised or vacant can be leased to growers (WHO, 2001).
  - Provide financial, technical and legal incentives to encourage the above schemes that bring local producers in closer contact with their consumers (WHO, 2001).
  - Develop breastfeeding policies, to create breastfeeding friendly environments (NWFH, January 2007).
- *Ensure local procurement:*
  LAs have a responsibility to promote sustainability and protect the environment. Where possible, there should be local procurement of food and use of seasonal produce to reduce food miles. The Chief Medical Officer recommended that the proportion of high-quality local suppliers of food through the public sector should be increased substantially (CMO, 2005). This would also benefit the local economy, increasing local jobs. In the same report, it was also recommended that public sector food buyers be given training and guidance on the impact of food and diet upon health and on the principles of sustainable purchasing.

- *Provide information and education campaigns:*

Box 3
Examples of evidence for the effectiveness of nutrition interventions in the community

Food co-ops: In a study of food co-operatives, 63% of respondents reported changing their eating behaviour by eating more fruit and vegetables and 71% reported eating more healthily. A number of spin-off activities have developed, such as cook and taste sessions (Towers et al, 2005).

Supermarkets in underserved areas: In Leeds, the opening of a supermarket in a deprived poor-retail-access community led to an increase in fruit and vegetable consumption of 0.23 portions per day. Cost was a concern amongst 28% of those who did not switch to using the new store, suggesting that although physical access improved, economic access was still a problem (National Heart Forum, Updated March 2007). A survey of over 10,000 households in the USA documented that fruit and vegetable intake by African-Americans increased by 32% for each additional supermarket in the neighbourhood (Cohen et al, 2005).

    - Encourage local shops and caterers to promote healthy food and drink choices via signs, posters and pricing (NICE, December 2006)
    - Continue with the '5 a day' initiative.
    - Encourage 'community cook' or 'cook & taste' sessions in community centres and schools (NICE, 2006b)
    - Ensure healthy food advertising in LA facilities.
    - Address people's concerns about mixed messages in the media about weight and diet (NICE, December 2006)
    - Endorse weight loss programmes and clubs that meet best-practice standards (NICE, December 2006).
- *Set an example in LA facilities:*
    - Set up healthy eating cafes in community centres. There is little evidence available on the effectiveness of such interventions, but one study made the following recommendations for increasing healthy choice sales in community cafes: the need for a strong lead to provide co-ordination and support; café staff should be actively involved, trained and supported; promotion to be encouraged and best practice shared between cafes; healthy options to be competitively priced and to include special offer incentives (NICE, 2006b).
    - Provide healthy snacks in all LA facilities (such as leisure & community centres)
    - Ensure healthy eating in residential homes and day centres (see examples of good practice – Surrey).
    - Provide healthy meals on wheels: The CMO also suggested that minimum standards for meals on wheels be followed. These should already be in place for those local authorities who are members of the National Association of Care Caterers (CMO,

2005). (Case study: see http://www.foodvision.gov.uk/pages/healthy-meals-on-wheels)

- *Ensure community involvement*
    - Community involvement is essential in identifying what limitations and possible solutions exist when addressing the community's food needs, and in ensuring that sustainable action results (WHO, 2001).

LA Workplace interventions

Workplaces are an ideal setting to promote healthy eating as a lot of people spend most of their day at work and have at least one meal there. Local government employs over two million people and so is one of the largest employers in the UK. Many local authorities provide places where staff can purchase food and therefore offer direct opportunities to provide safe, sustainable and healthy food. Even workplaces without canteens can get involved by addressing the catering they provide for meetings, conferences and events (NWFH, August 2006). Workplaces can also encourage employees to eat more healthily by providing good kitchen facilities or healthier snacks (Foodvision, 2007).

The NICE guidance (NICE, 2006b), the HDA (HDA, 2004b) and NWFH (NWFH, 2005, August 2006) give advice on how to effectively implement workplace initiatives. This includes ensuring enthusiastic support and involvement from management, and using motivators such as incentives, competitions and events to launch the intervention. A comprehensive set of healthier catering guidelines have been produced for the North West, aiming to ensure that healthy options are available to staff and visitors (NWFH, 2005, August 2006). The NWFH (August 2006) recommend the following:

- Set up a healthier workplace food policy. This should take the 'whole day' approach, covering canteen food provision, food trolley services, catering for meetings and events, drinks provision and vending. It would involve setting up a working group, which would agree products and sourcing, and ensure good communication between staff, caterers and commissioners. Wirral PCT is developing a food policy, and the long-term goal is that this could be adapted by the local authority to develop their own food policy (Baines, 2007).

The NICE draft guidance on obesity (NICE, 2006b) includes the following evidence-based workplace recommendations, which should all be included in the workplace food policy:

- all food provision for staff and visitors to actively and continuously promote healthier choices, including staff restaurants and vending machines;
- health checks for staff to encourage people to monitor their weight, diet, and provide ongoing support to enable healthy lifestyle changes;
- workplaces to actively promote a healthy diet, through:
    - incentive schemes (e.g. lower priced healthy food and drinks), to be sustained and be part of a wider programme to support staff to manage weight and improve diet;

- tailored educational and promotional programmes to improve food provision to be introduced, including heavy promotion and advertisement at point of purchase.

(all the above from p.92-4, (NICE, 2006b).

Box 4 gives some examples of the evidence for the above workplace interventions.

Box 4
Examples of evidence for the effectiveness of nutrition interventions in the workplace

- Worksite behaviour modification programmes that include health screening with counselling/education can result in:
  - short-term weight loss;
  - an increased consumption of fruit and vegetables from 0.09 to 0.5 portions per day;
- There is a body of evidence to show that the provision of healthier food choices can encourage consumption of a healthier diet;
- In one study, when prices of low-fat snacks in 55 vending machines were reduced by 10%, 25% and 50%, the total number of items sold increased by 9%, 39% and 93% respectively.

(NICE, 2006b)

- 3 out of 4 good quality studies show positive effects of healthy eating interventions in the workplace, with decreases in blood cholesterol of between 2.5 and 10% (HDA, 2004b)
- Point of purchase promotions, such as signs alerting consumers to healthy options, can increase the selection of these items to up to 2-12% of market share (JMU, 1999).
- Workplace interventions, including provision of information and more healthy food options, resulted in a siginificant positive change in fruit intake, use of lower fat milks, and consumption of sweet puddings and fried foods (Holdsworth, Raymond, & Haslam, 2004).

Local authorities have a responsibility not only within their own organisations, but also to encourage a co-ordinated approach amongst all major employers in their area to promote nutrition and health, using Local Strategic Partnerships.

Examples of good practice

The ***Knowsley Veggie Van*** is a project developed by Health in Knowsley (Health inK). Health inK was set up as a result of the success of a New Opportunities Fund healthy living centre bid, bringing £929,511 to the Borough of Knowsley. Community mobile fruit and vegetable vans provide a service for people living in areas with limited access to shops selling fresh fruit and vegetables. The van buys fruit and vegetables from a wholesale market and

sells them on the street and at other community venues. See: http://www.within-reach.org.uk/toolkit/case_studies/Case_Study_Knowsley_Veggie_Van.doc.pdf and Mobile Fruit and Vegetable Vans - NW Food & Health Task Force

Four food co-ops were established by 'Heal 8', in partnership with the community, during 2004-5. Heal 8 is a virtual healthy living centre in Liverpool 8, with Big Lottery funding. The co-ops now run independently, but can call on Heal 8 for assistance if needed. During 2005, almost 2,000 customers plus their families benefited from using the food co-ops. Heal 8 also run a scheme engaging residents in ***growing their own fruit & vegetables***. Heal 8 bought 200 grow bags for local residents who expressed an interest in growing their own vegetables on a Heal 8 sponsored community allotment. Stretch targets aim to increase this by 30 residents per year. Heal 8 were Municipal Yearbook winners of the 'Reducing Health Inequalities Achievement of the Year' award, 2005. Contact: Karl Smith, Heal 8 Project Manager, Liverpool PCT, Karl.smith@liverpoolpct.nhs.uk
(http://www.municipalyearbook.co.uk/index.asp?pageid=465)

Heart of Mersey is facilitating a new Greater Merseyside Food Policy Forum with representatives from various agencies on Merseyside. The aim of the forum is to support the sharing of good practice and collective initiatives to improve food provision and procurement practices on Merseyside. The Greater Merseyside Food Charter Award is a Heart of Mersey and Liverpool John Moores University initiative, involving partnership working with various agencies including the local authorities across Merseyside. It is open to all food service outlets that are committed to making changes that are mutually beneficial in providing access to nutritious, affordable and safe food for the people of Merseyside. Those awarded the Charter receive a variety of benefits including free promotional material and the possibility of free publicity. Contact: modi.mwatsama@heartofmersey.org.uk.

Fruit on Desks is a north west workplace initiative. http://www.foodvision.gov.uk/document/view/100. It has been successfully implemented in various local authority offices on the Wirral, where the scheme bears the name 'Fruit on Reception' (Baines, 2007), and elsewhere in Cheshire and Merseyside.

The ***Public Sector Sustainable Food Procurement Initiative***, run by the Department for Environment, Food and Rural Affairs, has compiled a list of case studies, including the following (DEFRA, 2006):

- *Sustainable Food Procurement Initiative - South West Public Procurement Group***.** A strategic group including the South West Public Health Observatory, the District and County Councils, Sustain and the Countrywide Agency. The group co-ordinates the strategy, research and funding needed to increase the procurement of South West local and regional food and drink into the South West public sector. http://www.defra.gov.uk/farm/policy/sustain/procurement/casestudies/swpp-group.htm

- *Public Sector Sustainable Food Procurement Initiative* - Produced in Kent Ltd, with Kent County Council, EU and South East England Development Agency (SEEDA). 'Produced in Kent' promotes the county's produce, locally, nationally and internationally. It now operates at arm's length from Kent County Council (KCC) as a limited company but remains a wholly owned subsidiary of KCC and will receive funding for a further two years of about £400k per annum. PIK is not for profit: The company will aim to make a surplus, which will be reinvested into promoting Kent produce and food and drink services. 'Produced in Kent' will:
  - Help to develop the rural economy.
  - Stimulate local demand for local produce.
  - Promote local fresh seasonal produce will also raise awareness of the benefits to the local communities, schools and hospitals.
  - Environmental benefits: if the countryside is providing a boost to the economy then it will be more likely to be protected from development.
    http://www.defra.gov.uk/farm/policy/sustain/procurement/casestudies/producedinkent.htm

In ***Surrey***, the Young at Heart Award scheme encourages establishments to provide a quality catering service for older people in residential homes and day care centres. The scheme involves partnership working between the four Borough Environmental Health Departments and the Public Health Department. http://www.foodvision.gov.uk/pages/young-at-heart-award

3. Tackling obesity: Creating opportunities for physical activity

Background

The prevalence of obesity in England has tripled since the 1980s, with almost a quarter of people now obese. Obesity reduces life expectancy by an average of 9 years (DoH, 2005d). There are more obese people amongst the least well-off. In 2001, it was reported that in social class I, 14% of men and women were obese, compared to 28% of women and 19% of men in social class 5 (DoH, 2005d). The current upward trend in obesity is attributable to two main factors: poor diet and lack of physical activity (Wanless, 2004). The term 'physical activity' includes the full range of human movement, from competitive sport and exercise, to active hobbies, walking, cycling or activities of daily living (CMO, 2004).

The health impacts of physical activity are wide-ranging (Box 5). Even moderate intensity activity, such as brisk walking, can be effective. Along with a healthy diet, it can help to reduce weight and maintain weight loss. There are also mental health benefits from physical activity, which can help to reduce anxiety and depression. In the elderly, the risk of falls can be reduced, with activity helping to improve joint flexibility, balance and co-ordination (CMO, 2004; HBC, 2006)

Increased physical activity can also benefit society and the economy. Active living, such as sport and leisure pursuits, offers the chance to develop new skills and meet new people, and may help to reduce levels of crime and anti-social behaviour (WHO, 2006a). Wanless pointed out the economic consequences of physical inactivity, with an annual cost estimated at £8.2 billion, including costs such as lost productivity and sickness absence as well as costs to the NHS (Wanless, 2004). This doesn't include the contribution of physical inactivity to overweight and obesity, which in itself has been estimated to cost at least £6.6 billion annually (NICE, September

Box 5
Example of the health impacts of physical activity

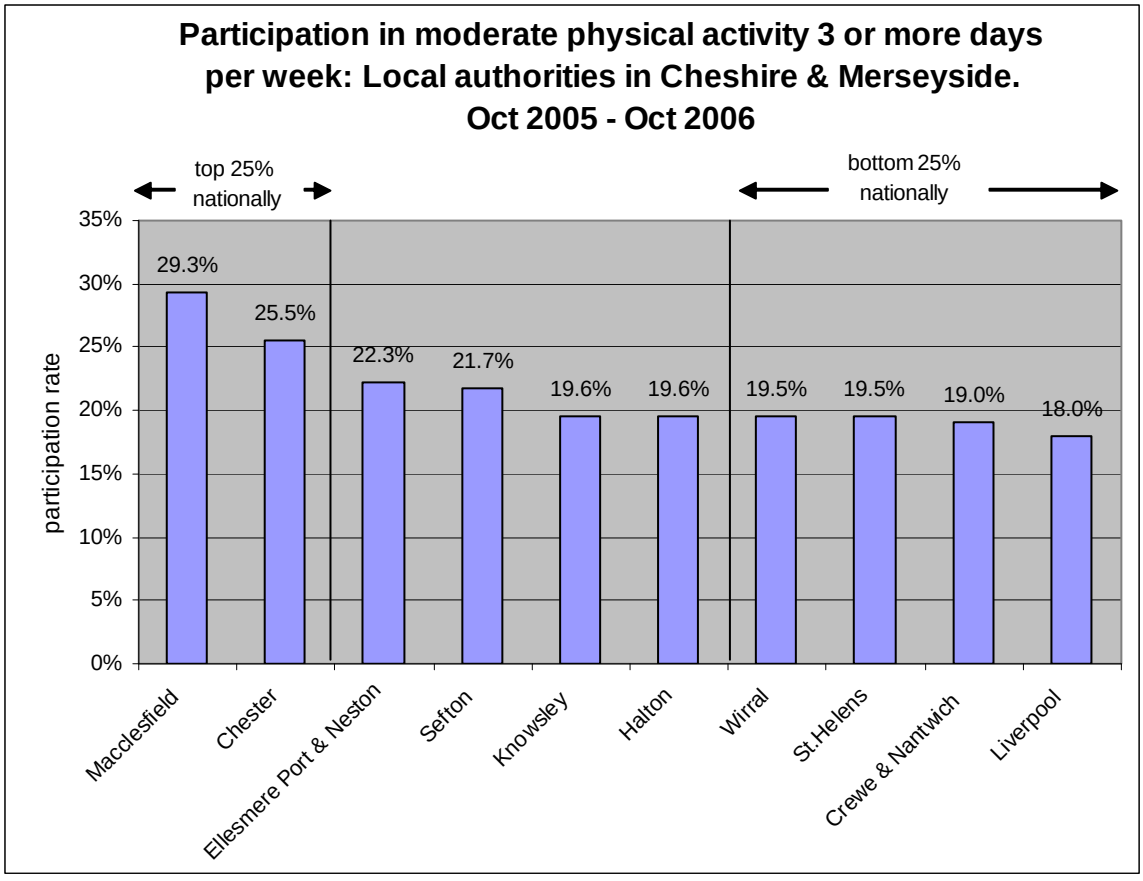
- People who have a physically active lifestyle reduce their risk of major diseases such as coronary heart disease, stroke and type 2 diabetes by up to 50% (CMO, 2004)
- Over a 5 year period, people who went from being unfit to fit had a reduction of 44% in the relative risk of death compared with people who remained unfit.
- Protective effects from cardiovascular-related death can be seen with as little as 1 hour of walking per week. (Warburton, Nicol, & Bredin, 2006)
- A walk in the park can reduce the risk of diabetes by 50%, heart attack by 50%, colon cancer by 30% and fracture of the femur by up to 40% (CABE, 2004).

2006). It has been estimated that a 10% increase in physical activity would result in a direct health saving of £85 million each year. If sickness absences and earnings lost as a result of premature mortality are added, the savings rise to £500 million per year (NICE, May 2006).

The prevalence of physical inactivity is higher than that of all other modifiable risk factors for cardiovascular disease and a wide variety of other chronic diseases (Warburton et al., 2006). In England, about two thirds of men and three quarters of women report less than 30 minutes of moderate intensity activity per day on at least 5 days a week – levels which substantially increase their risk of contracting a broad range of chronic diseases (CMO, 2004). Men in the lowest social classes are more physically active than those in higher social classes, but people in higher social classes take part in more leisure-time activity (CMO, 2004).

Figure 1 shows results for Cheshire and Merseyside of a Sport England survey on levels of participation in regular moderate physical activity. Levels of activity were highest in Macclesfield (29.6%), and lowest in Liverpool (18%).

Figure 1



National average rate is 21%. Participation rate is the % of adults participating in at least 30 mins moderate intensity physical activity on 3 or more days per week (N.B. which is less than the public heath recommendation).
Source: results from Ipsos MORI 'Active people survey' for Sport England, 2006.
http://www.sportengland.org/061206_active_people_northwest_factsheet_embargo_7_dec.pd

The proportion of primary school children walking to school fell from 67% in 1985-86, to 53% in 1997-99 (CABE, 2004). Regular travel on foot or by bicycle has declined by 26% over the last 25 years (CMO, 2004). However, to return to 1975 levels of walking would require people to walk only just over a mile more each week (DfT, 2004). The various interventions that could be made by local authorities to help to increase physical activity will be discussed under '*top tips for effective interventions'* below.

National policy

'Choosing Activity' (DoH, 2005c) presents a range of actions and commitments to improve physical activity and public health, across a number of settings (http://www.sportdevelopment.org.uk/Choosingactivityphysicala.pdf)

Targets and commitments

Public Service Agreement on tackling obesity (DoH, 2005c):

- Halt the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.

Supporting cross-government Public Service Agreements:

- By 2008, increase the take-up of cultural and sporting opportunities by adults and young people aged 16 and above from priority groups by increasing the number who participate in active sports at least 12 times a year by 3%; and increasing the number who engage in at least 30 minutes of moderate intensity level sport at least three times a week, by 3% (DoH, 2005c).
- Further enhance access to culture and sport for children and give them the opportunity to develop their talents to the full and enjoy the full benefits of participation (DoH, 2005c).
- To lead the delivery of cleaner, safer, greener public spaces and improvement of the quality of the built environment in deprived areas and across the country, with measurable improvement by 2008 (DoH, 2005c).

'Delivering Choosing Health' commitments relevant to local authorities (DoH, 2005d):

- Raise awareness of the health risks of obesity and the steps people can take through diet and physical activity to prevent obesity (p.62);
- Support the development of school travel plans by funding 250 local-authority-based school travel advisors (p.67);
- Develop 'School Sport and Club Links' to encourage lifelong participation in sport via out of school hours learning (p.68);
- Continue to increase the numbers of maintained schools in a school sports partnership, to 100% coverage by September 2006 (p.68);
- Support local authorities, schools and parents in administering the National Standard for cycle training for children (p.68);

- Develop initiatives to promote physical activity (e.g. with a promotion fund, and physical activity coordinators), with guidance for local authorities on what works (p.69);
- Continue to improve parks and public places (p.69);
- Local authorities will continue to work with the transport charity Sustrans, to develop cycle lanes and tracks (p.69);
- Build on the Sustainable Travel Towns pilots to develop guidance for local authorities in shifting travel away from cars (p.70);
- Ensure that any sale of school playing fields is an absolute last resort, and that any sales proceeds are used to improve outdoor sports facilities (p.70);
- Continue to support free swimming and other sports initiatives (p.70).

Department for Transport

- The National Cycling Strategy (DfT, 1996) established the target of quadrupling the number of cycling trips between 1996 and 2012. To date, there has been no success in raising cycling levels significantly above the 1996 baseline (DfT, 2004).
- The Department for Transport will produce a standard on pedestrian and cycle access to government buildings – both for visitors and staff. A target date will be set by which high quality access for pedestrians and cyclists, whether visitors or staff, and secure storage for cycles will be delivered at all buildings (DoH, 2005c).

Local agreements

- The North West Plan for Sport and Physical Activity 2004-2008 aims to increase participation from 33% of the north west population active in 2003 to 50% active in 2020 (1% annual increase) (Sport England, 2004). It also aims to widen access and reduce inequality in participation amongst priority groups.
- The Merseyside Local Transport Plan (LTP) has been produced by the partnership of Merseytravel (the Passenger Transport Authority), Knowsley, Liverpool, Sefton, St Helens and Wirral councils. Included in this is the Transport Supplementary Planning document, which will commit the councils to sustainable developments in planning for walking and cycling, and reducing pollution from car use (LTP, 2006).
- The Merseyside local authorities have all committed themselves to the LTP (a statutory document) and to the Merseyside Cycling Strategy, which includes the target of increasing cycling by 10%.
- The Wirral Local Area Agreement 2007/08 includes baseline figures and targets for numbers of people aged 60+ participating in swimming and other leisure activity (Wirral Borough Council, 2007).

Top tips for effective interventions

The built, natural and social environments in which people live have an important influence on participation in physical activity. The World Health Organisation (WHO) has recently published a document, based on the best available evidence, making suggestions for policy and practice in local government. It outlines the crucial role that local government has to play in creating environments that promote opportunities for physical activity (WHO, 2006b). Two other useful documents are the NICE[4] summary of policy interventions with potential influence on physical activity (NICE July 2006), and the NICE obesity guidance, which includes a quick reference guide for local authorities (NICE, December 2006).

Joint planning

There is a need for joint working with strategic health authorities and primary care trusts to promote physical activity. Planners and designers have a part to play in encouraging the health sector to see the built environment as a means of meeting their targets on physical activity and obesity. Joint working with industry and the private and voluntary sectors is also required (NICE, December 2006). The Carter Report (Carter, March 2005) proposed a single system for sport and physical activity. It includes recommendations for how local authorities and the private sector can work together, encouraging private sector investment in sport, for example through simpler local planning guidelines, and recognising the benefits of sponsorship and joint funding. There are also joint funding opportunities with bodies such as Sport England. The new Sport and Physical Activity Alliances, one in each local authority area, will bring together all the relevant agencies to set out how participation and access targets will be strengthened.

Within local authorities, interventions to increase physical activity should involve action from senior managers and budget holders in the areas of urban planning, regeneration, environmental health, the natural environment, transport, leisure services, education, children and young people's services, engineering services and building design – not just those with an explicit public health role (NICE, December 2006, June 2006). As promotion of physical activity is often split between several departments, this can lead to a lack of cohesive action. The introduction of area-based managers and local management teams can help to provide a sense of direction and vision (ODPM, July 2003).

NICE also recommends working with the local community to identify environmental barriers to being physically active, using tools such as audits and health impact assessments (NICE, 2006b). It is important to involve existing cycling and walking groups in planning processes, so that planning

[4] The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. The Department of Health commissions NICE to develop guidance.

decisions are made from the perspective of local users. For this purpose, cycling and walking forums (such as the Liverpool Cycle Forum) should be encouraged. In Merseyside, the Merseyside Cycling Campaign is an important voice (Ireland, 10th Feb. 2007).

Promotion of walking and cycling for transportation, as well as for leisure

To encourage walking and cycling, the DfT report that the evidence base for what works suggests that the most effective approach is to combine improvements to the environment and facilities for walkers and cyclists with carefully targeted information about travel choices, health benefits and recreational opportunities (DfT, 2004). There is a need to encourage more physical activity as part of a daily lifestyle.

Safety:

NICE suggested that local authorities develop community programmes to address people's concerns about the dangers of walking and cycling (NICE, June 2006). There is some evidence that improvements in pedestrian safety will lead to increased levels of walking (Cohen et al., 2005). Traffic management measures such as speed cameras, more safe places to cross and 20mph zones will help to ease safety fears of walkers and cyclists (DfT, 2004; NICE, December 2006, July 2006). Action should be taken to tackle obstructions by e.g. illegally parked vehicles and driving in cycle lanes. Measures to reduce traffic volume, such as congestion charging, can have significant impacts. In London, the congestion charge has led to year on year reductions in accidents involving cyclists (a 4% reduction from 2003 to 2004), despite corresponding significant increases in the numbers of cycle journeys taking place (Transport for London, June 2006).

The Cyclists Touring Club have launched a facility to advise local authorities about dangerous potholes. The Slower Speeds initiative provides important information about the benefits to physical activity of reduced vehicle speeds in urban areas (Ireland, 10th Feb. 2007).

Priority for pedestrians and cyclists:

Under existing planning policies, local authorities are required to create places and spaces which are attractive, with the needs of people in mind (DfT, 2004). To encourage people to walk and cycle around their neighbourhoods, rather than use their cars, then the network of streets and connecting spaces must be planned, designed and managed accordingly (Arendt, 2007; CABE, 2006b). Streets and public spaces should be designed to create enjoyment rather than be seen as through routes, as a traffic corridor (ODPM, July 2003). Improvements that can be made include upgrading of footpaths, relaying of poor pavements, regular sweeping and washing of streets, improved street lighting and shop fronts, ensuring facilities are accessible by foot or bicycle (e.g. more local shops) and tree planting (NICE, July 2006; WHO, 2006a). If pavements were maintained better, people might use their cars less. In a recent survey, 30% of car users said they would use their car less if pavements were better maintained, and 37% would do so if there were

safer walking routes (DfT, 2003). Home Zones are to be encouraged. These are residential areas designed with streets to be places for people, instead of just thoroughfares for motor traffic (DfT, 2004). See 'Examples of good practice: Home Zones' below).

The new planning policy statement 6 (PPS6) will advise that town centres are planned to give priority to pedestrians and cyclists and that the pedestrian environment is improved (DfT, 2004). Local Transport Plans will include full consideration of walking and cycling, and will set out plans for appropriate improvements, such as pedestrianisation and traffic management schemes. NICE recommend that the needs of pedestrians and cyclists are given priority when maintaining or developing roads, for example by widening pavements and introducing cycle lanes to re-allocate road space to pedestrians and cyclists. They present evidence from three studies to suggest that closing or reducing the capacity of roads can lead to long-term increases in levels of walking (NICE, July 2007).

The building of cycle lanes and tracks in partnership with Sustrans should continue. Between 2000 and 2005, 8,000 miles of paths and tracks were completed (DoH, 2005c). There is evidence that the development of new cycle and walking paths appears to encourage use of the paths. This use is optimised by local promotional campaigns. In one study, cycle count usage increased significantly in the short-term (3.5 months) after the launch of a trail (NICE, September 2006).

Public open spaces:
Access to good quality, well-maintained public spaces can help to improve physical and mental health by encouraging walking, playing sport, or simply enjoying a green and natural environment (CABE, 2004). A recent report by CABE Space outlines the range of models available for funding the management of public parks and urban green space. These include joint funding arrangements with the health service and other bodies, and use of income-generating opportunities such as cafes and sponsorship (CABE, 2006a) (See 'Examples of good practice: Sefton Park' below).

Full NICE guidance on improving the environmental factors that promote physical activity will be available in 2008. Draft guidance was published in July 2007 http://guidance.nice.org.uk/download.aspx?o=439338

Walking and cycling schemes and facilities:
The Department for Transport have produced an action plan to set out measures to increase walking and cycling. The companion guide contains 50 examples of successful schemes (DfT, 2004). Local authorities have an important role in encouraging cycling schemes. Up until now, grants for small projects have been available from the Cycling Projects Fund (see examples of good practice – Halton Borough Council, below). The DfT have decided to pass the responsibility for funding and delivering these schemes to local authorities (DfT, 2004). Local authorities' schemes should include support for the provision of cycle racks and lockers (DfT, 1996).

NICE reported no definite evidence from four primary studies on community-based walking programmes and four randomised controlled trials on pedometers, on the effectiveness of these schemes at increasing physical activity in the short or longer-term (NICE, 2006a). No evidence was found for cycling programmes, although these schemes were found to be popular and well received by participants. NICE concluded that there was insufficient evidence to recommend the use of pedometers and organised walking and cycling schemes to promote physical activity, other than as part of research studies where their effectiveness can be evaluated (NICE, 2006a).

However, it is important not to use a lack of evidence as an excuse for inaction (Wanless, 2004). A report from the Local Government Association suggested that, due to there being very few studies, local authorities should be prepared to act on and promote activity that has a 'soft' evidence base. At the same time, they should support research programmes aiming to produce hard evidence (Butcher, 2001). (CABE, 2006b) pointed out that proving the effect of these interventions is difficult, but the impact of the results can be far-reaching. The emphasis should be on long-term outcomes.

Transport interventions:
Improvements to public transport will promote physical activity, as there is always a walking or cycling stage in a bus or train trip. Improvements would include more, and more reliable, bus services; priority for buses; providing concessionary fares and transport vouchers for certain groups; ensuring safer and more secure streets, with e.g. better street lighting, CCTV, and neighbourhood warden schemes (NICE, July 2006). To date, there have been very few studies in this area, so it has not been possible to demonstrate the effectiveness of travel interventions in promoting active travel (NICE, July 2006).

There is evidence that road-user charging schemes can lead to short term increases in levels of walking, and long-term increases in cycling (NICE, July 2007). In London, the introduction of the congestion charge has led to significant year on year increases in cycle journeys (see Box 6).

Travel plans:
All schools should have a travel plan in place by 2010 (DfT, 2004). The DfT is providing £10million to Sustrans to build traffic-free links from the cycle path network to more than 300 schools, allowing pupils to walk or cycle more easily (DoH, 2005c). Local authorities will be able to pilot new approaches to home/school travel under the School Transport Bill (DoH, 2005c). Long distances, dangerous traffic, pollution and crime have been identified as barriers to children walking and cycling to school. School travel plans cover a range of measures to overcome these barriers. The 'travelling to school' initiative will fund school travel advisors and provide small grants to pay for items such as secure cycle parking and lockers (ODPM, March 2005). It would be advisable for local authorities to make their post of school travel advisor permanent; otherwise the benefits of encouraging active travel to school will be at risk (Dewar, 2007). NICE have summarised the evidence that

shows the introduction of safe routes to school schemes can lead to short-term increases in levels of walking and cycling (NICE, July 2007).

In Merseyside, school travel plans are delivered by local authorities and Merseytravel, through the TravelWise initiative. There are 32% of schools with adopted travel plans, and a further 26% are working towards a plan (Dewar, 2007). The Travel wise website has further information on developing school travel plans (http://www.letstravelwise.org/).

Stair use:
Small changes to the environment can encourage people to make active choices, for example between using the lift or stairs (WHO, 2006b). Making stairs more attractive, with clear signposting and attractive décor, can have a short-term effect on stair use for up to 3 months, with one study reporting an effect at 6 months after baseline (+29%) (NICE, September 2006). One review reported by NICE suggested that point of decision prompts increased stair use by 54%. New buildings should be designed to ensure ease of access to stairs.

Other benefits:
In addition to encouraging physical activity, improvements to the environment and creating opportunities for walking and cycling will improve mental health and well-being; promote sport, culture and education; help to reduce crime and the fear of crime; improve employment and commercial investment; reduce pollution; increase pedestrian safety; reduce accidents and their associated health costs, increase a sense of community and reduce traffic (CABE, 2004, 2006a).

Cost-effectiveness evidence:
Providing opportunities for walking and cycling are particularly cost-effective, as people do not require supervision or costly facilities such as gyms (Sustrans, June 2007). NICE was able to calculate that improvements to the walking and cycling infrastructure, and to stair signage, were cost effective. The avoidance of long-term chronic disease and short-term improvements in well-being lead to incremental cost-effectiveness ratios (ICERs) of approximately £90 - £9,400. A cost-benefit analysis of the cycling infrastructure gave a standardised cost-benefit ratio of 1:11, which from a transport perspective, is very cost-effective (NICE, July 2007). This compares very favourably to typical road schemes, where the cost benefit ratios are usually less than 3:1 (Sustrans, June 2007).

The sustainable transport charity Sustrans used the Department for Transport's *'Guidance on the Appraisal of Walking and Cycling Schemes*' to look at the economic benefits of a number of schemes (DfT, March 2007). They report on three walking and cycling routes which have been calculated as having a benefit to cost ratio of 20:1 (Sustrans, June 2007). One of these was in Bootle, Merseyside (see 'examples of good practice' below). As much as half of the net present value of the routes would be savings to the health services. Congestion reduction also leads to savings. Environmental benefits

such as reduced pollution were not included, otherwise, the benefit to cost ratio would have been even more favourable.

Promotion of sport and recreation

A shift in emphasis is required, away from competitive and elite sports, to health enhancing physical activity for all (WHO, 2006a). This would include the promotion of 'alternative' leisure and sports activities, such as urban dance, skateboarding and rollerblading, which would especially help to keep teenagers and young adults active.

Multi-sectoral partnerships between local and national government, businesses, charitable organisations and the health sector can lead to important changes in the funding of sports organisations and services and the construction of sports sites, as demonstrated in Finland and Holland (WHO, 2006a).

The development of planning policies for the increased use of sports and recreational facilities is required. Access for all should be encouraged, for example with transport and access for disabled people and women-only swimming sessions (ODPM, March 2005). The free swimming initiatives currently targeted at young people could be extended, and also offered to older people and those on benefits (DoH, 2005c). Work with schools will open up more of them out of hours to provide additional sports opportunities. With the help of school sport partnerships, more school sport is taking place. The long-term aim is that by 2010, all children will be able to spend four hours each week on sport (DoH, 2005c).

New facilities should be provided, and existing ones protected (DoH, 2005c). It is important to stop the sale of school and local authority playing fields and green spaces. The regime governing the sale of school fields has recently been strengthened (DfES, August 2004) (see 'targets and commitments' above).

The provision of ranger and park-keeping schemes will help to improve safety and encourage use of parks and open spaces (ODPM, March 2005; WHO, 2006b). Upgrading play areas for children (swings etc.) and providing facilities for young people (basket ball and tennis courts, and all-weather football pitches) will encourage activity amongst these age groups.

Green gyms are exercise groups aiming to promote health, fitness and well being through physical work, whilst improving the local environment, learning new skills and meeting new people. The schemes are particularly effective at encouraging physical activity amongst older age groups, or people not inclined to take part in traditional sporting activities. There is a network of around 65 green gyms, which are run in partnership with local authorities and health trusts (http://www2.btcv.org.uk/display/greengym_start).

Exercise and activity referral schemes

Exercise referral schemes involve individuals being directed to a service for assessment, often a local authority leisure centre. A tailored physical activity programme is developed, including monitoring and follow-up. It is estimated that there are 600 exercise referral schemes in England (NICE, 2006a).
The DH reported on reviews that have found that these schemes can result in sustainable improvements in physical activity and indicators of health. However, they also point out that there is a lack of evidence on their cost effectiveness (DoH, 2001b). A significant part of the cost of the schemes may have been evaluation costs – the cost of research undertaken by one PCT was £30,000. NICE suggests that attempts should be made to join national research projects, which would be less expensive. However, NICE do recommend that walking and cycling and other forms of physical activity should continue to be promoted as a means of incorporating regular physical activity into people's daily lives (NICE, May 2006).

Local Exercise Action Pilots (LEAP) have tested different ways of helping less active people do more exercise. A recent evaluation of LEAP showed that an exercise referral scheme resulted in around two thirds of those who were previously sedentary or lightly active achieving or exceeding recommended levels of physical activity (GNN, December 2006). A Department of Health evaluation of LEAP concluded that, overall, exercise referral schemes are an effective intervention in bringing about physical activity change in people who were previously not active enough (DoH, 2006d).

The leisure sector is in a good position to supplement this approach with self-referral (HDA, 2005a). The Health Development Agency (HDA) suggests that targeted recruitment in areas of need could be carried out by community physical activity development officers.

Some GPs and other health professionals refer patients to organised bike rides in the community (Tierney & Cavill, 2006). 'Health on wheels' is a guide produced by the North West Public Health Team to encourage this activity by outlining the benefits, and giving practical advice on establishing referral schemes. Cycling referral involves GPs working with a local authority cycling officer. The schemes increase the use of cycle paths, parks, and other amenities, stimulating the demand for cycling.

The positive effects of exercise and activity referral include improved heart health, improved mental well-being, increased self-esteem and social interaction/ community cohesion (and see Box 5). These factors should be considered when deciding whether to support exercise referral schemes. This is true for all the interventions aimed at achieving more active communities. In addition to public health gains, there are wider social benefits, such as crime reduction, the creation of social networks, social inclusion and urban regeneration (DoH, 2005c).

Box 6 gives examples of some of the evidence that exists for the above interventions.

LA Workplace interventions

There are various measures that local authorities can take to provide opportunities for employees to be more physically active. The NICE guidance on obesity (NICE, 2006b) includes the following evidence-based workplace recommendations:

- Establish an active workplace travel plan, incorporating the following points, and with policies to encourage walking and cycling to and from work and between work sites, and to restrict workplace parking.
- Actively promote physical activity in workplaces, as follows:
    - change the physical environment: encouraging stair use (good quality environment, re-decoration, signposting walking routes); providing showers; cycle parking; information on local facilities and walking maps etc.;
    - ensure incentive schemes are sustained and become part of a wider programme to support staff to manage weight and increase activity levels. Such schemes would involve travel expenses, subsidised gym membership and the payment of adequate cycle mileage rates. The permitted Inland Revenue cycle mileage rate for tax relief is 20p for employees cycling on business (CTC, last accessed 7/9/07).
    - use tailored educational and promotional programmes to encourage physical activity to be introduced.
- Implement tailored physical activity programmes in workplaces, including recreational opportunities such as:
    - support out-of-hours social activities;
    - use leisure facilities/groups;
    - encourage the establishment of groups such as Bicycle User Groups (BUGS). BUGS are usually set up at work places to support staff who cycle at and/or to and from work. Information about setting up BUGS is available form the Cyclists Touring Club (CTC, last accessed 7/9/07);
    - introduce walking and cycling opportunities during break time (e.g. lunchtime walks);
- Carry out health checks for staff to address physical activity, and provide ongoing support.

(NICE, 2006b)

Box 6
Examples of evidence for the effectiveness of physical activity interventions in the community

Recent draft NICE guidances presents evidence for the effectiveness of various environmental interventions in increasing walking and cycling, including: traffic calming measures; closing or reducing the capacity of roads; the introduction of a cycle infrastructure; safe routes to schools; development of cycle/walking trails (NICE, July 2007).

The benefit to cost ratio of 3 walking/cycling schemes supported by Sustrans was 20:1 (Sustrans 2007) (see 'Bootle' in examples of good practice).

Evidence indicates a pattern of positive relationships between walking and environmental attributes such as convenience of pavements and trails; accessibility of destinations (shops, park, beach); street lighting and perceptions about traffic and busy roads (NICE, July 2006).

In Denmark, a six-fold increase in high quality public spaces in Odense led to a variety of social, economic and environmental benefits, including a 65% rise in cycle use (CABE Space, 2006).

A new traffic free cycle and walking path alongside a main road in East Sussex has seen an increase in use from 17,000 trips in 2004 to 63,000 in 2005 (CABE 2006).

Upgrading and increasing the connectivity of a cycle route network led to a 3% increase after 3 years in the share of trips made by bicycle (NICE, July 2006).

Cycle useage amongst nearby residents increased significantly in the short term (3.5 months) after the promotional launch of a new cycle trail (NICE September 2006).

There are 50 examples of successful walking and cycling schemes listed in the DfT website: http://www.dft.gov.uk/stellent/groups/dft_susttravel/documents/page/dft_susttravel_033860.pdf

A review suggested that point of decision prompts increased stair use by 54% (NICE September 2006).

Green gyms: One study found that up to 1/3 more calories were burnt during some activities by participants than if they'd been taking part in a step aerobics class. (Reynolds 1999).

Exercise referral schemes: A recent evaluation of LEAP showed that an exercise referral scheme resulted in almost 70% of those who were sedentary or lightly active to achieve or exceed recommended levels of physical activity (Carnegie Research Institute, March 2007).

Congestion charging in London: During the first year of the charge in 2003, there was a 28% increase in cycle journeys. The rise continued, with 14% more cycle journeys in 2005 compared to 2004 (Transport for London, June 2006).

A recent WHO report makes similar recommendations, based on 'solid facts', adding that employers and businesses that provide opportunities for physical

activity for their employees and families should be publicly recognised (WHO, 2006b). Local governments can also play a part by ensuring safe cycle and pedestrian routes to work, and workplace access to public transport (WHO, 2006b)

Box 7 gives examples of some of the evidence of the effectiveness of physical activity interventions for the workplace.

The NICE guidance (NICE, 2006b) gives advice on how to effectively implement workplace initiatives. This includes ensuring enthusiastic support and involvement from management, and using motivators such as incentives, competitions and events to launch the intervention.

Cairns et al reported that 24% of local authorities had a travel plan in place, and 45% were developing one (Cairns et al., 2004). The Travel wise website has further information on developing workplace travel plans (http://www.letstravelwise.org/).

Additional health benefits: In addition to increasing walking and cycling, travel plans have various other health benefits, including:

- improved social inclusion (through increased access to work);
- improved social interaction (e.g. through cycle user groups, and car share groups);
- reduced staff turnover (through improved travel options);
- improvement in local job availability (e.g. through increased revenue for local bus companies).

Travel plans also give workplaces positive public relations (PR), lead to reduced parking costs, and free-up space previously used for car parking (Cairns et al., 2004).

In a British study of 20 organisations, Cairns et al (Cairns et al., 2004) report the median annual running cost of a travel plan as £47 per full-time equivalent employee – which they point out is notably cheaper than the £300-500 quoted as the annual cost of running a car park space. Travel plan costs ranged from £2 (which included a 33% discount on train fares) to £431 (involving 10 dedicated bus services) per full-time equivalent employee.

NICE has been asked by the Department of Health to produce intervention guidance on workplace health promotion with reference to physical activity and what works in motivating and changing employee health behaviour. The guidance will provide recommendations for good practice that are based on the best available evidence of effectiveness, including cost effectiveness (http://tinyurl.co.uk/cjvk).

Box 7
Examples of evidence for the effectiveness of physical activity interventions in the workplace

- *Active travel policies*: The intervention group in a UK study included an acute hospital trust with a workforce of over 4,000. They received a *'Walk in to Work Out'* pack, containing written interactive materials, local information about distances and routes, and safety information. The intervention group was almost twice as likely to increase walking to work as the control group at 6 months (Mutrie et al., 2002; NICE, 2006b)
- There is strong evidence for a positive effect of workplace physical activity programmes. In one study, participants had significantly increased their reported participation in regular exercise by 11.9% (NICE, 2006b).
- A subsidy for employees who did not drive to work showed a positive shift of 1% of commuting journeys after 1-3 years, compared with no significant change at the control workplace (NICE, July 2006).
- A cycling strategy was introduced by GlaxoSmithKline, where employees were guaranteed a parking space only if they arrived by bike. Secure bike parking, with showers and lockers, saw numbers of cyclists rise from 50 to 400, representing about 13% of all staff on site (CABE, 2006b)

See Cairns et al, 2004, for additional evidence on costs and benefits of workplace travel plans.

Examples of good practice

In Bootle, Merseyside, the local authority matched funding of £131,000 provided by the sustainable transport charity Sustrans to carry out improvements to a walking/cycling route close to a number of schools. Improvements included resurfacing, some new construction, road marking, signing and lighting. The benefit to cost ratio was extremely favourable, at 29.3 (Sustrans 2007).

Cost benefit of walking/cycle scheme in Bootle, Merseyside	
Present value of benefits	£12,601,051
Present value of costs	£430,294
Net present value	£12,170,757
Benefit to cost ratio	29.3

Source: Sustrans 2007

In Liverpool, the local authority and PCT has worked closely with the Local Transport Plan Support Unit to assess the accessibility of new health centres, prior to deciding on their location. Access to sustainable transport is considered as a priority. Contact: john.smith@merseytravel.gov.uk

Sefton's Active Workforce programme aims to provide employees of Sefton Council and Sefton PCT with increased physical activity opportunities by removing barriers to participation such as time, cost and venue availability. Supported by Sport England, Active Workforce has enabled participants to use Sefton's leisure centres for free for the entire twelve-month period of the pilot programme. It involved rolling out a programme of cycling and walking to support workplaces as well as providing a wide range of taster physical activity opportunities around the working day such as yoga, golf and salsa. In addition the programme offers weight management support, stop smoking referral and back care support. Feedback gathered by phone and self-assessment sheets indicated that 70 % of participants are undertaking more activity outside of the traditional exercise setting as a result of the Active Workforce programme.
Contact: Sefton Health Improvement Support Service (SHISS) on 0151 479 6550, or linda.evans@seftonpct.nhs.uk

TravelWise Merseyside promotes walking, cycling and public transport. It works with Active Cities in Liverpool and with a local community interest company, Cycling Solutions, to promote cycling amongst teenagers and families. It also works with PCTs to produce healthy walking/calorie maps and schools and businesses to develop Travel Plans. Contact: sarah.dewar@merseytravel.gov.uk' www.LetsTravelWise.org

PAMS in ***St.Helens*** is a volunteer project aiming to encourage people of all ages to be trained as Physical Activity Mentors, to motivate and become positive role models to their local communities. Contact suelightup@sthelens.gov.uk, or Debbie.bishop@sthelens.gov.uk.

Knowsley Council and Knowsley PCT have established a healthy working group, as a sub-group of the Improving Working Lives Model Employer steering group. Initiatives include a 'Green Transport Plan', linked with a 'Healthy Workplace Strategy' where staff activities such as walking, cycling and use of public transport are encouraged. Interest free loans will be made available to staff to purchase bicycles and safety and walking equipment. The development of safer walking and cycling routes across the borough will be encouraged. Contact: Fiona O'Reilly, Assistant Director of HR, Knowsley PCT, Fiona.O'Reilly@knowsley.nhs.uk

Women only sessions in local sports facilities in the Heal 8* area of Liverpool led to an increase in women's use of sports facilities. Working in partnership with Liverpool City Council's Leisure Services, women-only sessions have been established in two of the main sports centres serving residents within the Liverpool 8 area. In particular these sessions have proved very popular for women who are Muslim and women from ethnic minority communities. (*Heal 8 is a virtual healthy living centre in Liverpool 8, established with Big Lottery funding. Heal 8 were Municipal Yearbook winners of the 'Reducing Health Inequalities Achievement of the Year' award, 2005). Contact: Karl Smith, Heal 8 Project Manager, Liverpool PCT, Karl.smith@liverpoolpct.nhs.uk
(http://www.municipalyearbook.co.uk/index.asp?pageid=465)

In Sefton, joint working between the Council and the health sector has developed over some years. Current initiatives include:

- Freewheeling; in January 2003, funding was obtained by Sefton Council from the Department for Transport to provide free bikes for hire at 10 sites in the borough. Two of the sites are hospitals (Aintree and Southport), where staff are allowed to keep the bikes for more than one day as an incentive to try commuting by bike. The scheme has been very successful, with all bikes in use all the time.
- Health on Wheels is a project run with Aintree and Southport Hospital, in partnership with the GP referral scheme in Sefton. Since 2003, the project has provided a bike-based programme for cardiac rehabilitation patients.

(Sefton MBC, 2004)

Contact: brian.nener@technical.sefton.gov.uk and for Aintree hospital: terry.owen@aintree.nhs.uk'

Home Zones are residential areas with streets designed to be places for people, not just traffic http://tinyurl.com/2l5et5. In Cheshire and Merseyside, there are Home Zones in the following areas:

- Wirral – Dundonald and Methuen Streets
- Warrington – Whitecross
- St.Helens – Bidston Ave.
- Liverpool – Grafton St., supported by 'Slowdown' (http://www.village.u-net.com/slowdown/)
- Chester – Egerton St. (http://www.cheshire.gov.uk/roads/HomeZone/)

Halton Borough Council used a grant from the Cycling Projects Fund to enable 4 schools to take part in the Halton cycle challenge, where trained British Cycling coaches delivered training to pupils over a 6 week period. 79 children took part in total, and 41 completed the full training course and entered the GO Ride time trials. In addition 6 children experienced a track riding session at the Manchester Velodrome. Feedback from some pupils rated the courses "10 out of 10" and said it had helped improve their confidence on a bike. It is also reported that there has been a general increase in cycling levels since the training took place. One school continues to use the Go Ride equipment for after school cycling sessions.
Contact: paula.parle@halton.gov.uk

Halton Borough Council obtained funding from Sport England to produce leaflets encouraging walking in Widnes and Runcorn. Leaflets include those for the general public, and one promoting walking to work for council staff. They commissioned 'urbanwalks.co.uk' to design and print the maps. This is part of a wider initiative to promote sport and activity, which includes guided walks, exercise sessions for teenagers, older people and other groups, a sports club for those with a disability, and a GP exercise referral scheme.
See: http://www2.halton.gov.uk/pdfs/tourismandleisure/urbanwalks
Contact: paula.parle@halton.gov.uk

Active travel: '*How to produce active travel directions for your visitors and staff*' is a useful, practical guide, recently developed by the Government Office for the North West, in partnership with Sustrans Active Travel (a sustainable transport charity).
http://www.nwph.net/phys/Publications/AT%20Directions.pdf

Liverpool SAZ (Sport Action Zone) was part of the SAZ initiative launched in 2000 to help combat low levels of participation in sport in deprived areas. Local people were encouraged to help themselves by identifying what was needed, and then worked with local partners to play a part in the planning and delivery process. Significant increases in participation in sport and physical activity were recorded, generally rising from 60% to 65%. Amongst the over 50s, there was a 12% increase (from 36% to 48%). There was an impressive 10% increase among socially deprived groups, from 43% to 53%. (see http://www.sportengland.org/sportengland_saz_final_report.pdf). One of the projects was Admiral Park, which was transformed from a 'grot spot' to a sports facility for local schools and the local community. Partners in the project included Liverpool SAZ, Dingle Granby Toxteth Education Action Zone, local schools and Liverpool City Council (WHO, 2006b).

The ***Ellesmere Port & Neston*** multi sports club for people with learning disabilities was established in January 2001. The club evolved due to a very successful partnership between Health Promotion, Cheshire & Wirral Partnership NHS Trust and Ellesmere Port & Neston Borough Council. The Community Development Officer has the responsibility of booking the leisure centre and organizing suitable coaches for the sessions. Funding to pay for the coaches comes from weekly pay at the door scheme and various sports funding via the sports development team. Some of the sessions (swimming and low impact aerobics) are now sustainable, with the leisure centre taking ownership. The multi sports club has grown and developed and recently joined the Special Olympics Great Britain group. Contact: michele.bering@cwpnt.nhs.uk or sandra.johnson@cwpnt.nhs.uk

Litherland Sports Park is the only NW short listed entry in the National Lottery Sports Awards category. The Sports Park started as a project to improve school sports facilities and find a home for an athletics track. It evolved into a community venue for the provision of health care, the promotion of healthier lifestyles and the development of economic and social regeneration. It provides cardiac and pulmonary rehabilitation, a home for 16 sports clubs and a venue for 12 schools. It has been described as "a unique example of leisure and health integration in action".
http://www.lotterygoodcauses.org.uk/awards/project/73

4. Improving mental health and well-being

Background

People's mental health is affected by the communities in which they live, the quality of their housing, neighbourhood, their school or work environment; how safe they feel, how connected they believe they are to others and how supported; access to leisure and cultural pursuits. Furthermore, local democracy and control over decisions that affect residents is a determinant of mental health and well-being. Certain people are more vulnerable to mental ill health: suffers of severe abuse, black and minority ethnic groups, asylum seekers, rough sleepers, prisoners, those with physical illnesses, the unemployed and socially isolated.

Women's experience of partner violence is a significant factor for subsequent mental health problems, creating a cycle of extreme distress and deprivation (DoH, 2003a). Children who live with domestic violence may suffer from a range of effects including mental health difficulties in adult life (NIMHE, 2005) (UNICEF, 2006) Around 8 per cent of all households accepted as homeless by councils are in priority need on grounds of mental illness. Research has consistently shown that between 30 and 50 per cent of rough sleepers have mental health needs.(Homeless Link, 2006) Emotional and social competence has been shown to be more influential than cognitive abilities for personal, career and scholastic success. (Weare & Gray, 2003) Poor mental health significantly increases the risk of poor physical health (Mentality, 2003) and is associated with poor self management of chronic illness and a range of health damaging behaviours, including smoking, drug and alcohol abuse, unwanted pregnancy and poor diet.

Mental health problems currently affect more than 25% of the UK population each year, costing the economy an estimated £93 billion (Mental Health Foundation, 2005). Mental illness accounts for as much suffering as all physical illnesses put together and the bulk of these mental illnesses are depression and anxiety (Layard, 2006). The rate of suicide varies according to geographical area and social class, with the highest rates of suicide occurring among people in social class V, illustrating a relationship between social inequality and suicide risk. The prevalence of depression in children is estimated to be between 2-6%.(Costello, Angold, & Burns, 1996) Prevalence tends to increase with age, with a sharp rise at around the onset of puberty (Home Office, 2000).

Stress-related conditions are now the commonest reported causes of work-related sickness absence (DWP, DoH, & HSE, 2005). The Health and Safety Executive has issued a series of six stress management standards that define a desirable set of conditions to work towards. They address job demand, job control, support, relationships, role clarity and organisational change. (HSE, 2005)

National policy, Targets and commitments

Department of Health Public Service Agreements (PSAs) and Saving Lives Our healthier nation (Department of Health, 1999):
Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%.

Commitments have also been shown to expand help for mental illness and carers; reduce access to the main methods of suicide; improve the well-being of children; homeless youngsters; to help victims of domestic violence and prevent further abuse; to promote mental health and eliminate discrimination; (DoH, 2002, 2004e, 2006a, 2007c, July 2007) (HM Government, 2004) (Office of the Deputy Prime Minister, 2004). The Government has asked NICE (National Institute for Clinical Excellence) to develop guidance on promoting the mental well-being of children in primary education using a whole school approach and targeted activities. http://www.nice.org.uk/page.aspx?o=440949

Top Tips for effective interventions

Children

Young carers
To improve the support given to young carers and their families by following the Barnado's report (Barnardo's, 2006) recommendations:

- All schools to have a strategy for supporting young carers.
- Social services departments, health services and schools to work together.
- LAs to:
  - Review their strategies for meeting the needs of young carers and their families
  - Ensure a multi-agency approach that includes adult and children's services and health authorities.
  - Make provision for publicity materials to be produced that advertise local support services and set about distributing these to schools, doctors' surgeries and hospitals.

Further help for schools/school children
- Take advantage of the Samaritans DEAL (Developing Emotional Awareness and Learning) Programme for schools. (The Samaritans, 2006) The DEAL pack resources help students understand 'emotional health' as it relates to them, their friends, family and peers. [See also examples of good practice: Happiness lessons]

A voice in policy making and services
Develop mechanisms and processes to enable children and young people to have a voice in policy making and services affecting their lives and futures. [See examples of good practice and young advisors under section: *"Reducing Health inequalities"*]

Homeless Children
Shelter recommends:

- Ensuring key agencies, including PCTs, local education authorities, Sure Start children's centres and Connexions branches, have an officer with designated responsibility to provide support for homeless children. Their roles should have a particular emphasis on prevention work around health and education.

- The development of closer working relationships between key children's services and housing services would facilitate better information sharing and prevent gaps in service provision from arising.

(Shelter, 2006) [See also examples of good practice]

Adults

Carers
Around 6 million adults in Britain provide unpaid care. They include over 1.5 million carers who devote at least 20 hours a week to their caring activities. Mental health problems are more likely to be associated with caring, than physical ill-health in the form of high levels of psychological distress, including anxiety, depression, loss of confidence and self-esteem. (Hirst, 2004) Female carers are more likely than males to be assessed as having high levels of neurotic symptoms (Females 21%: Males 12%). Indeed, female carers have been found to be 23% more likely to have neurotic symptoms than women in general. There is a strong association between people's assessment of their health status and the level of neurotic symptoms they report. Almost a third (30%) of carers rates their health as only fair or poor. Of this group 37% have high neurotic scores, compared with 7% of those carers who rate their health as being excellent or very good. (ONS, 2002)

There are several costs associated with a carer's ill-health: direct costs in treating the carer's ill-health; costs incurred if the carer is less able to care – these are substantial given that all carers' support in 2004 was estimated to be worth £57 billion a year. (Carers UK, December 2004) The causes of carers' poor physical and mental ill-health are due to a lack of information and support, worry about finances and the general stresses and strains of caring full-time and isolation. (Carers UK, December 2004).

Recommendations:
To promote better health of carers:

- Carers' assessments to address their health issues and wider concerns that impact on carers' health, such as flexibility of service delivery.
- Ensure carers are aware of their entitlements by conducting regular information campaigns, through as many means and formats as possible including ethnic minority languages, large print etc.
- Ensure measures are put in place to help working age carers remain in the workforce for as long as possible since paid employment reduces many negative factors affecting carers' health.

Recognition of carers as an at- risk group:

- Public health and social inclusion strategies need to identify carers as an at-risk group in terms of health.
- Support needs to be provided at high-risk times i.e. at the beginning of caring, any major change in the caring situation and following bereavement.
- Sufficient planning for predictable problems and emergencies should be regularly included in all carer's assessments and assessments of disabled or older people.

Provision of practical support:

- Ensure as much flexibility in services for disabled people and carers as possible in order to minimise negative health impacts. For example, direct payments, vouchers, not having to travel long distances, etc.

(Carers UK, December 2004)

Effective local democracy

Local democracy and control over decisions that affect us is a determinant of mental health and well-being. A practical way of doing this is to involve people in health impact assessments and also mental health impact assessments of projects, policies, and programmes.

Information services

Providing free access to written and multimedia information on mental health within libraries is an effective mechanism to reach individuals that do not take up other health interventions. Furthermore it supports informed choice on mental health and promotes self-care and management. (See Active Reading under examples of good practice).

Encouraging prisoners to write story CDs to their children can improve links with families and develop skills that will facilitate future employment. (See Bedtime Stories under examples of good practice).

Strong and safer communities

The audit commission recommends that local government:

- Makes better use of frontline workers in gathering information on antisocial behaviour and crime and community intelligence, empowering them to take swift action;
- Enable frontline workers to perform an effective two-way communication role between the council and local people with an emphasis on keeping residents well informed of action taken
- Ensure data on anti-social behaviour is reliable, up to date, easily accessible to other partners and conforms to the National Standard for Incident Recording.
- Use enhanced scrutiny powers to support improved performance in crime and disorder reduction partnerships.

(The Audit Commission, 2006)

- Reduce fear of crime and enhance social cohesion by involving residents in democratic decision-making.

Community arts opportunities

- Develop community arts opportunities which promote the life satisfaction of all residents. Research suggests that participation in arts projects can have long-term outcomes that are beneficial to individual mental well-being and social cohesion. (Jermyn, 2001) (See examples of good practice: Heal 8]

- Provide art on prescription as an alternative or in addition to medication. For Sefton patients suffering mental health problems this has proved a successful creative alternative. (See examples of good practice in Sefton)

- Provide a range of books and multi-media resources on mental health to borrow free-of-charge from Libraries, which have been validated by mental health professionals. (See examples of good practice: Active Reading)

Promoting responsible gambling

Local Authorities have a responsibility under the Gambling Act 2005 to grant licences for premises used for gambling. When licensing premises they should take into consideration the physical and mental health of people attending.

- Ensure that gambling operators and service providers supply information on gambling addiction, treatment and services to patrons. (BMA, 2007)

Domestic Violence

The Local Government Association have produced a good practice guide for LAs to tackle domestic violence (LGA, 2006) that recommends:

- Agreeing a corporate response that meets the needs of the community that includes:
  - Setting budgets;
  - Training relevant staff, both front-line and decision makers;
  - Providing publicity, to raise awareness;
  - Increase access to local services;

Home Office guidance (Home Office, 2000) on multi-agency working recommends that every authority publishes a clear policy on domestic violence, which is understood and complied with by its entire staff. The policy to include:

- Details of the good practice which is expected from council staff;
- Promote good practice in individual departments of the authority;
- Provide a framework of co-ordinated and measurable responses to domestic violence by all key departments, including social services, education, housing and youth and leisure services;
- Include a clear emphasis on effective monitoring and evaluation and ensure that staff receive appropriate training.

Support to asylum seekers and refugees

Asylum-seekers and refugees require a wide range of support. Unfortunately, many support services are voluntary projects which survive on short-term

funding and have difficulty in meeting all needs. In some cases there is patchy provision, lack of integration or competition between providers. Women refugees, unaccompanied children, disabled people, and people with mental health problems have particular support needs that are often unmet. (Perry, 2005)

Asylum-seekers have to contend with considerable uncertainty in their dealings with officialdom and they are usually unaware of their entitlement to the various forms of welfare assistance. Stable accommodation promotes good mental health and reduces the demand upon other health and social services. Unfortunately, asylum seekers are liable to frequent changes in accommodation and even homelessness. (Royal College of Psychiatrists, 2003) Settled accommodation provides an address from which to apply for benefits, training, or a job, and establishes entitlement to a school place. Housing related support workers act as key links with health, education, training, and other services. (Perry, 2005)

Recommendations from the Royal College of Psychiatrists:

- The provision of appropriate, stable accommodation for refugees and asylum seekers to be seen as a priority. Local Government agencies will need to provide for this within their budgetary plan.
- Health and social services to take the lead to ensure that users' voices are heard in local planning for services and research pertaining to refugees with mental health problems. (Royal College of Psychiatrists, 2003)

Good practice guide from the Joseph Rowntree Foundation:

- Accommodation: Developing innovative solutions include putting liaison measures in place to minimise the risk of homelessness, making constructive use of private sector accommodation, and self-build (or renovation) projects involving refugees.
- Support services: Local Authorities and government departments look to 'mainstream' support services and funding to allow them to be more widely and more permanently available.
- Community integration: Mechanisms are needed to link 'personal integration' with measures to promote wider 'community cohesion'. For example by involving both long-term residents and newcomers in drawing together and implementing a 'community support plan'.
- Stronger partnership working between housing organisations and refugee community organisations (RCOs) could lead to more culturally-sensitive services, related more closely to people's needs. Refugee housing strategies are essential in areas which have significant refugee populations, if the disparate public and voluntary services that together support refugees in different ways are to be co-ordinated and gaps in services filled.

Home and Environment

Green Spaces:

One suggested way to obtain both physical and mental health improvements is through 'green exercise' – taking part in physical activities 'whilst at the

same time being directly exposed to nature'.(CABE, 2004) [See section on providing opportunities for physical activity]
In their report on promoting green spaces for the promotion of both physical and mental health, the Urban Green Spaces taskforce made the following recommendations for LAs:

- Ensure that local strategies for green spaces are integrated with other strategies for improving local quality of life.
- Involve and support communities in green space service planning and delivery. To be underpinned by local community strategies, best value review and performance indicators, and improved information about local parks and green spaces for users.
- Promote and support partnership work for improving local green spaces. To be reflected in other local strategies which impact on green spaces, Best Value reviews and performance indicators. To provide appropriate training for members and officers.
- LAs and Local Strategic Partnerships (LSPs) to provide information and advice on available funding streams and opportunities for supporting local partnerships involving local residents, voluntary and business groups for improving urban green spaces.

Social Spaces:
Public spaces also have a social value – They are social arenas, and have potential for enabling social contact between different ethnic groups and enhancing individual well-being. (Dines & Cattell, 2006) Independent cafes and shops create a sense of diversity, as well as the social ties that cement cohesion (Minton, 2006). The possibilities for casual social encounters are a key element in people's commitment to their area, while memories of familiar places create a sense of belonging or safety.

Unfortunately, the economic focus of regeneration can undermine the social value of public spaces, including their role in creating people's sense of attachment to a place and their contribution to community cohesion. (Dines & Cattell, 2006) The private ownership and management of the public realm, with the creation of over-controlled, sterile, bland environments protected by private security firms (Minton, 2006) results in the marginalisation of public activity outside of consumption. This private-public space destroys place attachment and reduces local democracy. It lacks connection to the reality and diversity of the local environment and displaces social problems into neighbouring districts. This process enhances the hot spot (areas of affluence, high property prices/rents) and cold spot areas of exclusion. Furthermore, the creation of atomised and polarised communities is damaging to trust, social cohesion and consequently increases fear of crime. (Minton, 2006)
LAs are recommended to take a more holistic approach to sustainable communities rather than transfer power to private investors. "Regeneration which involves the re-use of old buildings for new unexpected and innovative purposes does tap into the power by retaining people's memories, and indeed love for a place." (Minton, 2006)

An area's social and therapeutic properties to be recognised and accessible to all when regeneration is being planned and a health impact assessment (which incorporates a mental well-being impact assessment) conducted. The mental well-being impact assessment toolkit can be accessed from: http://tinyurl.com/3cyzbn
These health impact assessments would involve the participation of local communities and stakeholders in identifying and enhancing the positive and negative health impacts at each stage of development.

Homeless women – develop gender sensitive services
Recommendations from Crisis:

- Homelessness assessments, decisions and practices to ensure those homeless women's wider situations such as their children, their mental and physical health needs, and their vulnerabilities arising from accumulated traumatic experiences, are adequately taken into account.
- Provide gender-sensitive services and increase availability of women only services.
- Addressing current gaps in service provision to prevent and resolve homelessness:
- Provide a more integrated approach joining-up services which homeless women would benefit from including sexual and domestic violence, substance misuse and mental health services.
- Consider developing homelessness-related initiatives in public buildings e.g. libraries, and enable homelessness agencies to deliver their services within 'non-homelessness' spaces and services. (Crisis, 2006)

Suicide prevention at hotspots
Guidance on action to be taken at suicide hotspots (NIMHE, 2006) provides a summary of available measures that can be adopted to prevent suicides and a practical guide to an inter-agency collaborative approach. Examples of best practice are also provided. A hotspot is a specific, usually public site which is frequently used as a location for suicide and which provides either means or opportunity for suicide.

Box 8 **Examples of evidence for the effectiveness of mental health and well-being interventions applicable to LAs**
Young carers: The Barnardo's and YouGov survey (Barnardo's, 2006) of teachers and young carers indicates that children (under 18) caring for family members with mental or physical health issues are not receiving vital support. Consequently the young carers' mental health and well-being can suffer even after caring has ceased. The official estimate is of 175,000 young carers in the UK, spending on average, 17 hours a week for 4 years before they receive external support with some coping for up to ten years without support. The survey recognised a 'culture of secrecy' within the family and by young carers themselves. Furthermore, many young carers are failing to be identified by schools, social services, or young carer support projects. They suffer from isolation and ignorance of support services whilst parents do not get the assessments and help from LAs to which they are entitled. (See

under evidence based interventions)

Development of emotional and social well-being: There is sufficient supporting evidence for the role of explicit programmes to justify their use in schools. In view of this:
• Schools develop and adopt programmes designed to promote emotional and social competence and well-being that include the taught curriculum, and which teach emotional and social competences in a comprehensive, organised, explicit and developmental way. (Weare & Gray, 2003)
• That schools take advantage of the Samaritans DEAL programme for schools, as part of a 'whole school' approach to emotional health and well-being. Over a thousand students from 10 schools have taken part in testing the programme. (The Samaritans, 2006) The programme is described as "sustainable" and will help to improve the emotional health of children well into the future and enable them to identify positive coping strategies. Feedback from both school staff and students on DEAL has been positive and students taking part in the programme showed an improvement in their understanding and attitude towards emotional health. It has been shown to improve teacher confidence, which helps to create a more emotionally healthy school environment.

Poor housing and homelessness in childhood: A comprehensive review of research examining the impact of bad housing on children's futures has been undertaken by Shelter.(Shelter, 2006) They conclude that more than a million children in Britain are living in poor housing. Indeed, on every aspect of life – mental, physical, emotional, social and economic – living in poor housing can hand children a devastating legacy. Homeless children are three to four times more likely to have mental health problems than other children. Evidence suggests that nearly half of young offenders have experienced homelessness as a child, and the roots of offending behaviour may well be traceable to problems that emerge when children grow up in such conditions. (See under evidence based interventions)

Participation in community arts projects: A review of research suggests that participation can have positive impacts for individual mental well-being and social benefits. For example: increased self-confidence, self esteem, reduced isolation or anxiety, emotional literacy[5] acquisition of skills and development of community identity, greater connectedness to others and encourages collective effort. (Jermyn, 2001)

Strong and safer communities: The Audit Commission (The Audit Commission, 2006) have carried out a review that confirms that it is residents' daily experience of anti-social behaviour in their immediate neighbourhood, or their perception of what is happening locally that shapes their view of how safe their community is. Dirty streets cluttered by abandoned cars and anti-social behaviour such as noisy neighbours fuels their fear of crime. Thus addressing crime and anti-social behaviour must be linked to other improvements in the environment to enhance the quality of life for people. Information on crime and antisocial behaviour is aggregated at the local authority level, but high-quality data is required for areas smaller than a ward, to paint a faithful picture of life in individual neighbourhoods.

[5] Emotional literacy, whereby people use art to express needs frustrations or feelings that would otherwise remain unarticulated.

Precise and detailed data are particularly important in relation to anti-social behaviour where real-time intelligence can best single out what response is needed. Frontline workers such as neighbourhood wardens, police community support officers and housing officers are in daily contact with local people. (See under evidence based interventions)

The environment and mental health: When housing and the surrounding external environment on one typical new-town estate were upgraded in consultation with residents, 'substantial improvements' were recorded in the mental health of those residents. (Halpern, 1995)
There is increasing evidence that 'nature' in the urban environment is good for both physical and mental health. Natural views – elements such as trees and lakes promote a drop in blood pressure and are shown to reduce feelings of stress. (Hartig, Evans, Jamner, Davis, & Garling, 2003; Urban Green Spaces Taskforce, 2002)
Recent research suggests that an emphasis on the economic and commercial benefits of public space regeneration should not be to the detriment of other considerations. In particular, existing and potential social and therapeutic properties of public open space be more widely recognised, nurtured and developed. (Dines & Cattell, 2006)

Homeless women – gender sensitive services: Research amongst 160 single homeless women across England reports that many are not receiving the assistance they require with accessing accommodation, reflecting the fact that their wider situations, needs and vulnerabilities are not always adequately taken into account. The report calls for improvements and changes to local authority homelessness assessments, decisions and practices, and addressing the ways in which current services are not sensitised to the needs of women. Gaps in current provision and the important role of 'non-homelessness' spaces are also highlighted. (Crisis, 2006)

Suicide prevention at suicide hotspots: Signs promoting help seeking and advertising appropriate sources of help have been found to prevent suicide attempts at hotspots (Kind & Frost, 2005). (See examples of good practice – Suicide prevention)

A positive working environment and appropriate support at work has a significant impact on stress related sickness absence and long term outcomes for employees experiencing mental distress. (Sainsbury Centre for Mental Health, 2000 Stansfield, Head, & Marmot, 2000a). For example: through employees feeling valued, trusted and supported at work, receiving social support from supervisors in the form of two-way communication, providing sufficient and consistent information, frequently offering help and support and a willingness to listen to problems. (Stansfield, Head, & Marmot, 2000b)
Organisational changes have been found to have a greater impact than individually focused interventions (Williams, Michie, & Pattani, 1998) and these may have more lasting effects (Konpier & Krishensen, 2001). Facilitating staff in the identification and solving of work-based psychosocial factors has beneficial results for staff well-being (Bourbonnais, Brisoon, Vinet, Vezina, & Lower, 2006)

Workplace

Organisational changes have greater impact on decreasing adverse psychosocial work factors than individually focused interventions and may have more lasting effects. Helping staff to identify and solve work based psychosocial factors has beneficial results for staff well-being.

Organisational changes associated with a positive impact on the mental health:

- Increase social support by making available clear, consistent information and enhancing social support from managers.
- Offer assistance, advice and support to staff experiencing mental health problems at work, and to those returning to work following a mental health problem:
  - Building a working culture in which mental health issues are not taboo
  - Support options which are confidential and non-stigmatising.
- Redress effort/reward imbalance by involving staff in identifying what kinds of benefits or recognition they would value, if an additional financial reward is not an option. Rewards can take the form of: psychological, (esteem, respect, job status) training or promotion.
- Improving two way communications and staff involvement.
- Developing a culture in which staff are valued: Consulting and listening to staff can make them feel more secure and valued, notably at times of organisational change.
- Assessing job demands (e.g. including pace, intensity of work, conflict between competing tasks and support from colleagues and superiors), increasing job control and decision making latitude (e.g. ability to decide which work is tackled, with whom and how work is done, when to take a break, flexibility in working time).
- Developing an effective response to bullying and harassment:
  - Complaints and a workplace culture that challenges bullying behaviour.
  - Enhancing team working.
  - Promote a positive approach to employing people with mental health problems.

(Friedli, 2003)

Domestic Violence: Work-based policies need to be robust enough to give employees suffering domestic violence the support they need. Develop a human resource policy to include:

- A statement of commitment to provide support, advice and information;
- An overview of the legal basis for the policy;
- What the organisation will provide for those experiencing abuse;
- How the organisation will respond to perpetrators;
- How policy will be implemented and monitored; and
- What training will be made available to line managers.

(DoH, 2005e)

Additionally, the Department of Health have issued six guiding principles to promote positive mental health in the work environment and to ensure that customers are treated with courtesy, respect and sensitivity. These cover:

raising staff awareness of issues; supporting staff with mental health problems and improving customer/client skills. (DoH, 2006a)

- Employers to follow the six principles to reduce stigma:
  - Making employees aware of steps they can take to preserve and maintain their own and others mental well-being;
  - Promote a culture of respect and dignity for everyone, ensuring that staff are trained to recognise and be sensitive to mental distress or disability in others, whether they are workplace colleagues or customers;
  - Encourage awareness of mental health issues, so that employees are aware of the danger signs and understand the importance of seeking help early
  - Demonstrate that no one is refused employment on the grounds of mental illness or disability;
  - Make reasonable adjustments to the work environment for people with mental health problems so that they can continue working;
  - Demonstrate that they take positive steps to ensure that people with mental health problems are not disadvantaged, in relation to the availability of their goods and services.
  - Adopt strategies to ensure that working age carers are helped to remain within the workforce.

Examples of good practice

Enabling the young to have a voice in policy making and services

Across Cheshire and Merseyside, local authorities and the newly emerging Children's Trusts have placed increasing emphasis on the development of mechanisms and processes to enable children and young people to have a voice in policy making and services affecting their lives and futures.

The Centre for the Study of the Child, the Family and the Law, University of Liverpool has an established track record in the promotion of children and young people's participation through its evaluation, and other work, across a range of programmes and initiatives, for example: the Liverpool, Knowsley and Sefton Children's Funds; Knowsley Sure Start; Liverpool's Children and Young People's Participation Standards; Liverpool's Bureau for Children and Young People. Latterly, the Centre has been working to support such initiatives as: young people's involvement in the Cheshire and Merseyside Child Health Development Programme; children and young people's involvement in Liverpool's Capital of Culture 2008.

As part of a national initiative the Centre has worked with The Children's society and Investing in Children to support young people in developing the 'Don't Just Tick the Box Group'. This Group has arisen out of a concern that the rhetoric of participation is not always matched by outcomes which make a difference to the lives of children and young people. For further details please contact: Professor Christina M. Lyon, The Centre for the Study of the Child,

the Family and the Law. Liverpool Law School, University of Liverpool, Liverpool L69 7ZS. Email: CLyon32178@aol.com

Therapeutic use of the arts:

Heal 8: Liverpool City Council. The award winning Heal 8 has two projects to support mental health in Liverpool 8. The Research programme compiled a database of holistic approaches to mental health and all the agencies providing support and funding for these services in Liverpool. This information has been used to inform the Heal 8 mental health work programme for year 2. The Art Clinic Project uses arts and multimedia to engage people in exploring their experiences and understanding of mental health. It helps residents to understand the relationship between their daily lives and the toll that "life stress" can take on their mental health and to develop strategies to manage stress and improve their mental health. Further information: Karl Smith, Heal 8 Project Manager, Liverpool PCT, Karl.smith@liverpoolpct.nhs.uk

Creative alternatives - Sefton's innovative arts on prescription service
Creative Alternatives is a new remedy for stress, anxiety and depression which can be accessed for free in Sefton.

There is plenty of research to show that the arts can help improve well-being. For this reason Sefton Council and Sefton Primary Care Trust (PCT) are now offering creative activities as an alternative or addition to medication for people who experience mild to moderate depression, anxiety or stress.

The free arts and leisure schedule may include workshops in painting, sculpture, photography, drama, dance, music, creative writing or crafts and may also include free gallery, theatre and museum visits. In addition, participants also receive *Explorations at Home*, a home activity pack which features lots of activities including: creative writing, drawing and photography. The activities are explained step-by-step and all required materials are included. For further information contact: Pat Nicholl, Health Promotion Specialist, Mental Well-being, at Sefton PCT Pat.Nicholl@seftonpct.nhs.uk

Active reading
Active Reading provides self-help information on mental health. It supports informed choice on mental health and promotes self-care and management. Active Reading provides an additional source of help for individuals being treated in Primary Care, or whilst awaiting treatment from psychological services. It is an 'open access' provision that is free from any charges. Additionally, it is an effective mechanism to reach individuals that do not take up other health interventions. The programme also broadens usage of the public library services in Sefton.

Active Reading is a joint initiative by Sefton Council's Library Service and Sefton Primary Care Trust (PCT), which complements the Active Sefton Referral Programme on physical activity that is already well established within

Sefton's GP practices. Active Reading provides a range of books and multi-media resources on mental health to borrow from Sefton Libraries, which have been validated by mental health professionals. The issues covered by the resources include depression, stress, anxiety, eating disorders, phobias, etc. Active Reading is available to everyone in Sefton, including children and young people. The stock collection is available in all 13 branch libraries, the mobile library and via the home visit service. For further information contact: Pat Nicholl, Health Promotion Specialist, Mental Well-being at Sefton PCT Pat.Nicholl@seftonpct.nhs.uk

Happiness lessons: Boys and girls between 14 and 15 have been having a 40-minute timetabled lesson "the skills of well-being" every fortnight for two years at Wellington College, Berkshire. The lessons will give them an understanding of what factors help a life to thrive and flourish, as well as teaching them some practical skills for everyday use. The curriculum has been devised by Dr Nick Baylis of the University of Cambridge (www.Cambridge Well-being.org), a leading world specialist in the science of well-being. Already several schools in the state sector are looking at starting happiness lessons in September 2007. If effective, the lessons could combat a huge rise in depression, self-harm and anti-social behaviour among young people.

Specialist hostels and 24 hour support for homeless youngsters
To prevent homeless youngsters being accommodated in bed and breakfast accommodation, Bournemouth council has worked with organisations such as the YMCA and Bournemouth Churches Housing Association to open a range of cheaper and more tailored schemes. In hostels young people can receive 24-hour support; and in lower supported housing projects, residents receive shorter visits from staff, learn life skills and sign up for education and training. The council has also set up a young people's panel, led by children's services, with housing, social services and accommodation providers to quickly find suitable services for each homeless person. Another key service is its return home liaison scheme that helps them to work through problems that might have prompted them to leave home. The council is trying to adopt an early intervention and prevention approach where they can provide a housing solution before a crisis arises. Further options include supported lodgings, where teenagers can stay in the homes of trained hosts, and Nightstop, an emergency, one-night version of the scheme. (Stothart, 22 November 2006)

***Domestic Violence*:** Cheshire County Council
Services for children are carried out by the Cheshire Domestic Abuse Partnership which has:

- Placed part-time children's support workers in each refuge in the county
- Provided two outreach posts;
- Developed therapeutic group work for children and their mothers; and
- Developed outcome based monitoring systems within their data project;
- The LEA has also set up a small team to promote the attendance and achievement of young people experiencing domestic abuse at home or in their own relationships

Early findings are very positive, showing the importance of addressing the safety and well-being of the abused parent alongside the needs of the child. Prevention is also essential, with work to challenge attitudes to violence having reached over 50 per cent of schools. The Cheshire Children and Young People's Strategic Partnership is now looking at how early intervention preventive work can be commissioned to improve outcomes in the new structures for children's services. Contact: Sue Bridge, Performance and Projects Manager. E-mail: sue.bridge@cheshire.gov.uk

Safeguarding links with families

Bedtime stories: Bristol City Council Library Service has enabled prison inmates to produce story CDs for their children, from a story they have written. The project also aims to raise prisoners' awareness of the benefits of reading to children and to enable them to help their own children enjoy books. This has safeguarded important links with their families. They have also acquired literacy and IT skills which will help them find employment on release. The project was funded by the South West Museums, Libraries and Archives Council with £3,700 for the materials required. Further information: Alison Duffy, Prison Librarian, Bristol City Council Library Service. 0117 9808 269.

Developing Support Services for asylum seekers and refugees: Housing departments in Sheffield, Glasgow and Leicester have been lead actors in bringing together a wide range of agencies in each city to co-ordinate and identify gaps in service provision and to develop integration strategies. (Perry, 2005)

5. Promoting sexual health

Background

Definition:
"Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 1975)[6]

Increase in sexual risk-taking:
Research suggests that sexual risk-taking behaviour is increasing across the population. More people in the North West than ever before are living with HIV or AIDS. The North West also has the highest number of newly diagnosed cases outside London. (UK Collaborative Group for HIV & STI Surveillance, 2006) Furthermore, in comparison with other regions across the country, the North West as a whole shows higher rates of new diagnoses of chlamydia and syphilis. Sexual transmitted infections (STIs) and HIV infections are increasing in Cheshire and Merseyside, and in some areas the rise is dramatic (Thurston & Alexander, 2006). However, the dramatic rise is to some extent the reflection of an increase in detection as a result of the extremely successful Chlamydia (and gonorrhoea) screening programmes that have been introduced. (Ryrie, 27th April 2007)

Almost all STIs are becoming more common. In 2005 there were high rates of genital chlamydia, genital herpes, and genital warts due to human papilloma viruses (HPV), especially in young adults. There was a further substantial increase in syphilis incidence, while the decline in gonorrhoea incidence, first seen in 2002, continued. Re-infection and re-attendance are thought to be common in GUM clinics (Ward, Rowe, Pattison, Taylor, & Radcliffe, 2005). The number of human immunodeficiency virus (HIV) infections newly diagnosed in 2000 was the highest since reporting began (DoH, 2001c). An estimated 31% of people with HIV in the UK remain undiagnosed. Sexually transmitted infections (STIs), including HIV, remain one of the biggest infectious disease threats facing the UK (Health Protection Agency, 2004). Nearly a quarter of all pregnancies in England and Wales end in abortion (DoH, 2004b). The UK has the highest rate of teenage pregnancies in Western Europe (United Nations Children's Fund (UNICEF), 2001).

[6] This working definition was presented on the WHO website as a contribution to on-going discussions about sexual health, but **does not represent an official WHO position, and should not be used or quoted as a WHO definition**.

Risk of poor sexual health:
Poor sexual health can lead to a range of health problems including pelvic inflammatory disease, infertility, ectopic pregnancy, cervical cancer, unintended pregnancies, abortions, neonatal disorders and death (NICE, 2006c). The annual direct costs of treating STIs in the UK, excluding long term effects, are considered to be in excess of £700 million. Alcohol alters a person's ability to think clearly. For instance, after drinking alcohol, one in seven 16-to-24-year-olds have had unprotected sex, while one in five have had sex that they regretted. One in 10 has been unable to remember if they had sex the night before. (Rondini, Last accessed: 16/04/07). (See section on: *Encourage the sensible drinking of alcohol*, in this report). Focusing preventative strategies on the young is likely to yield the most benefit since there is the potential to establish healthy patterns of behaviour (Thurston & Alexander, 2006).

Inequalities in sexual ill-health:
Sexual illness disproportionately affects those experiencing poverty and social exclusion. The highest burden is borne by men who have sex with men, some black and minority ethnic groups and young people. Individuals and groups who find it most difficult to access services include asylum seekers and refugees, sex workers and their clients, people in custodial settings, those who are homeless and young people in – or leaving – care. (Medical Foundation for Aids and Sexual Health, 2005). The most deprived areas suffer the greatest sexual and reproductive health problems. (Centre for Public Health, NWPHO, & HPA, 2006).

Social costs:
Social costs can also be high with affected individuals and their partners often experiencing emotional distress, stigma and discrimination. For many people living with HIV in the UK, poverty is a harsh reality. Many of these people have faced barriers such as discrimination in the workplace, social stigma, hate crime, difficulties accessing benefits and inappropriate accommodation. (Crusaids & National Aids Trust, 2006) Research has found for some looked after children their earliest memory was of sexual abuse and instead of love and security, home represented danger. Indeed, in this study, eighty-seven percent of young people leaving care had suffered sexual or physical abuse, which had started before they were ten. Early abuse leaves these young people often immature and emotionally ill-equipped for independence. (Sergeant H, 2006)

For some young people, becoming a parent is a positive choice. However, teenage pregnancy is often associated with poor health and social outcomes for both the mother and child. Young mothers are more likely to suffer postnatal depression and less likely to complete their education. Children born to teenage parents are less likely to be breastfed, and more likely to live in poverty and to become teenage parents themselves (Botting B, Rosato M, & Wood R, 1998). These outcomes are more adverse in the case of looked after children who become parents because this group are more likely than others to be unemployed, have more mental health problems, be expected to be independent, and to have little social or economic support. Young people in

care are recognised as being one of the principal groups to experience social exclusion, and social exclusion has been identified as a "key determinant of teenage pregnancy". (DoH, 2001a)

National Policy, Targets and Commitments

The Social Exclusion Unit's report on teenage pregnancy (Social Exclusion Unit, 1999) forms the National Teenage Pregnancy Strategy, stating that teenage pregnancy is often both a major cause and consequence of social exclusion. It has the following targets:

- To reduce the under-18 conception rate by 50% by 2010. (This is a joint Department of Health and Department for Education and Skills Public Service Agreement.)
- To increase the participation of teenage parents in education, training or work.

It indicated that a ***Sure Start Plus pilot programme***, that supports pregnant teenagers and teenage parents under 18, should be located in areas with: high rates of teenage pregnancy; an existing Sure Start local programme and a Health Action Zone (HAZ).

The National Healthy School Standard is part of the Healthy Schools programme, led by the Department for Education and Science and the Department of Health launched in October 1999. It provides a model of partnership working between the health service and schools, with the aim of promoting a coherent and holistic message about the importance of a healthy lifestyle. The standard covers four key themes: Personal, Social and Health Education (PSHE); healthy eating; physical activity: emotional health and well being (including bullying). By 2009, the Government wants every school to be working towards achieving national Healthy School status.

The Sex and Relationship Education Guidance (DfEE, July 2000) offers support for schools on how to deliver effective sex and relationship education (SRE). The guide states that SRE should be firmly rooted within the PSHE and citizenship. All schools should have an up-to-date SRE policy developed in consultation with parents and the wider community.

The National Strategy (DoH, 2001a) argues that health education and health promotion are the foundation for improving sexual health. The aims of the strategy include:

- Reducing the transmission of HIV and STIs: a 25% reduction in the number of newly acquired HIV and gonorrhoea infections by 2007.
- Reducing the prevalence of undiagnosed HIV and STIs: GUM clinics to offer HIV testing to all attenders on first screening for STIs and to offer hepatitis B vaccine to those from high-risk groups, including sex workers, injecting drug misusers and gay men.
- Reducing the rates of unintended pregnancy.
- Reducing the stigma associated with HIV and STIs.

Commitments in the 2004 government Public Service Agreement (PSA) (HM Treasury, 2004); National Standards, Local Action (DoH, 2004f) and Choosing Health (DoH, 2004c):

- Reducing the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health.
- Expanded service access.
- A decrease in the rates of new diagnoses of gonorrhoea.
- An increase in the percentage of people aged 15-24 accepting chlamydia screening by 2007.

Commitments in ***Choosing Health*** (DoH, 2004c):

- Investment to support service modernisation.
- Accelerated implementation of the National Chlamydia Screening Programme (NCSP). Women who attend contraception services will be the main focus, and the introduction and evaluation of chlamydia screening in retail pharmacies starting in London.

Supporting People is an initiative administered through the Office of the Deputy Prime Minister (ODPM), to provide housing-related support services to vulnerable people (including those with HIV) to enable them to live independently in accommodation that is decent, appropriate and affordable. (ODPM, 2004)

A ***Co-ordinated prostitution strategy*** (Home Office, 2006) takes a zero tolerance approach to street prostitution focusing on five key areas: prevention, tackling demand, developing routes out of prostitution, ensuring justice and tackling off-street prostitution. Proposals in the strategy include the introduction of new Intervention Orders to be attached to ASBOs and revision of the law on street offences to 'provide a penalty specifically tailored to the needs of men and women in prostitution' The strategy does not support the creation of managed areas.

Teenage parents next steps Guidance for Local Authorities and Primary Care Trusts (DoH & DfSF, 2007) To complement guidance sent last year to local areas on accelerating reductions in under-18 conceptions, the Department for Children, Schools and Families has launched a refreshed strategy designed to improve outcomes for teenage parents and their children. The strategy provides guidance for local authorities and primary care trusts on the integrated services that the government wants each local area to provide. It also gives details about the support that will be provided nationally to assist local delivery.

Top tips for effective interventions

Children and young people:

[See also to reach vulnerable groups]

Looked after children
Two years after leaving care 35% will be either a mother or pregnant. A successful system of care would halve the number of prostitutes. "Handle with care" calls for long-term stable, secure and loving care for these children in care and on leaving care. (Sergeant H, 2006)

Reducing Unwanted Teenage Pregnancy
LAs to get better value from existing resources by learning from successful areas that have reduced their teenage pregnancy rate:

- Active engagement of all the key mainstream delivery partners who have a role in reducing teenage pregnancies including education, social services and youth support services;
- A senior champion driving the local strategy.
- Giving a high priority to PSHE in schools, with support from LA to develop comprehensive programmes of sex and relationships education (SRE) in all schools;
- Targeted interventions with young people at greatest risk of teenage pregnancy, in particular with Looked After Children;
- The availability (and consistent take-up) of SRE training for professionals in partner organisations working with the most vulnerable young people;
- A well resourced Youth Service, providing things to do and places to go for young people, with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse.
- Ensure best practice continues to be identified and shared
- All stakeholders understand the actions required – from senior managers to front line professionals
- A senior official from each stakeholder is accountable for delivery.
- The provision of young people focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them. [See also examples of good practice]

(Department for Education and Skills, 2006a, 2006b)

Involving young people in teenage pregnancy and sexual health work
Consider the participation of young people in teenage pregnancy work as set out in the guides by the Teenage Pregnancy Unit and the National Children's Bureau. Involving young people in decision-making can develop credible, creative approaches to awareness raising and service provision [see box 10] (Lewis E, 2006; Teenage Pregnancy Unit, 2001).

School-based SRE
The Health Development Agency (HDA, 2004a), has found that effective sex and HIV education programmes:

- Focus on reducing sexual behaviours that lead to unintended pregnancy, or HIV or other STIs;
- Base programmes on theories which explain what influences people's sexual choices and behaviour.
- Contain clear messages about using contraception;
- Include activities to help with resisting social pressures;

- Give examples of, and practice with, communication, negotiation and refusal skills;
- Use participatory teaching methods;
- Ensure goals, teaching methods and materials are:
  - appropriate to the teaching group;
  - of adequate and substantial duration;
  - led by those who believe in the programme and receive training
  - participatory
- Signpost young people to sexual health advice and specialist services.

School based health advice service

- Local Authorities to consider introducing school-based health advice services, including sexual health as a main component.
- LAs, through their Extended Schools Remodelling Adviser, consult and work with Primary Care Trust (PCT) colleagues before deciding on the range of health advice services provided by the PCT.
- A LA teenage pregnancy co-ordinator to advise on local teenage pregnancy rates and identify schools that serve wards where teenage pregnancy rates are highest. They can also provide comments on schools' emerging plans, drawing on their knowledge of young people's views about accessing services.

(Department of Education and Skills, 2007)

Youth Offending Service:

Provide training for staff in youth offending services so they can offer support to fathers, as well as mothers, and provide sexual health advice to young offenders. [See Box 9 and examples of good practice]. (Ubido J, 2001)

Adults

To reach vulnerable groups:

Making STI information, and potentially also testing, available through a range of locations including pharmacies, workplaces, and youth and community settings. This would help to reach vulnerable groups such as young people, black and ethnic minorities, sex workers and men, who might otherwise find it difficult to access these services (FPA, January 2006). [See also examples of good practice: *"So to Speak" and "Brook and Abacus"*

Living and working in areas of street sex work:

From research by the Joseph Rowntree Foundation (see Box 9) the following are suggested policy responses to street sex work in local neighbourhoods:

- Develop strategic, city-wide, multi-agency practical responses. For example targeted action against drug suppliers, balanced with harm reduction, support to help sex workers move on
- Designated contact for residents to raise immediate concerns
- Communication strategy at strategic partnership level, including raising awareness among communities

- Consultation with a wide range of stakeholders on a range of options for forward direction, including requirements for coexistence, if feasible, and designated safety zones
- Longer-term strategies such as mediation between local communities and sex workers
- Multi-stakeholder forum at local levels, with formal links to city-wide strategic partnership, with primary focus on negotiation, prevention, harm reduction, support and strategy to help sex workers move on. For instance, alternatives to increased enforcement, such as court diversion schemes, which steer sex workers towards support services after arrest, are used as an alternative to receiving a fine or other penalty such as ASBOs.
- Piloting and evaluation of specific initiatives

(Joseph Rowntree Foundation, 2006)

Addressing the needs of people with HIV

A recent report calls for action to tackle the root causes of poverty including addressing levels of hate crime, unemployment and poor housing. (Crusaids & National Aids Trust, 2006)

- Improving understanding of HIV in schools,
- Prioritise their housing needs,
- Develop specific strategies to provide improved integrated services.
- Care needs assessments and eligibility criteria to include reference to people living with HIV, and their dependants.
- Social care services to ensure care needs of children acting as carers are properly addressed.
- Disability equality schemes to include measures to address HIV-related hate crime, record incidents and implement appropriate remedies and redress.
- Ensuring discriminatory or inaccurate perceptions about HIV are addressed through development of disability and HIV awareness training for staff and act as champions to encourage the adoption of a similar policy by private sector organisations.
- Consistent implementation of the new dispersal process for people living with HIV, who are asylum seekers and refugees, and in particular improved communication with Home Office caseworkers, must be urgently achieved.

Box 9:
Examples of evidence for the effectiveness of sexual health interventions applicable to Local Authorities

Reducing teenage pregnancies: Intensive reviews of statistically similar areas with contrasting rates of progress have identified the factors in successful areas including: targeted interventions with young people at greatest risk, a high priority given to PSHE in schools, a well resourced youth service, a senior champion driving the local strategy, active engagement of key delivery partners and availability (and consistent take-up) of SRE training for professionals working with vulnerable young people. (Department for Education and Skills, 2006a, 2006b)

Experience has shown that involving young people in teenage pregnancy work can have positive outcomes by:

- Developing credible approaches to awareness raising and service provision;
- Ensuring that support services for pregnant teenagers and teenage parents are accessible to those who need them most;
- Communicating effectively with those groups most at risk. (Teenage Pregnancy Unit, 2001)

There is good evidence that school-based SRE, particularly when linked to contraceptive services, can have an impact on young people's knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates. (DfEE, July 2000)

School-based sexual health advice: has been found to provide a closer point of need; ensure young people can easily access services they may not be able (or want) to access in traditional clinical settings; allows them to make informed choices, reduce the likelihood that they put themselves at risk of STIs/unplanned pregnancies and provide opportunities to disclose concerns about abusive or coercive relationships. This support helps young people to overcome anxieties that might affect their ability to concentrate on lessons. It provides a swift referral route for pupils facing difficult and sensitive issues. Young people value talking to a professional not associated directly with school. There is a strong demand for sexual health advice in particular. The service is non-stigmatising and other health concerns can be addressed such as smoking cessation, drug and alcohol problems, obesity, eating disorders and depression.

Youth offending services: In Liverpool gaps for advice on sexual health advice and fatherhood for male offenders was noted. It was suggested that a health worker become a statutory member of the youth offending team. As staff build up good relationships with young offenders, if they were given specific training, this would provide an ideal opportunity for young males to receive sexual health guidance and advice on other issues that could affect their health. (Ubido J, 2001)

Living and working in areas of street sex work: A study looking at five residential areas used by female street workers considered whether residential streets could serve as shared spaces where residents and sex workers could coexist. Many residents and sex workers in their study supported the concept of designated spaces for working. They concluded that an integrated, multi-stakeholder response to street sex work is

essential. Involving sex workers in local governance can help to ensure consideration of their needs when addressing community conflicts and managing the street scene. Whereas attempts by police and LAs to tackle problems through enforcement such as Anti-Social Behaviour Orders against sex workers had caused difficulties. Sex workers were sometimes prevented from accessing vital services, or were forced to operate in unsafe areas, thus displacing the issue and increasing their vulnerability. Regeneration initiatives which moved street sex workers had similar negative outcomes. (Joseph Rowntree Foundation, 2006)

Housing needs of people living with HIV: A needs assessment highlighted the importance of privacy in accommodation (including own toilet and kitchen facilities). Confidentiality and empathy were paramount in the provision of housing support. (Brent Local Authority, 2005)

Examples of good practice

Promoting sexual health in young people:

So To Speak is Liverpool and Sefton's Young Person's Sexual Health Education Outreach Team, funded through the Liverpool and Sefton Teenage Pregnancy strategies. The project's aim is to equip at risk groups of young people with the information required to make informed choices about their sexual health; to promote a greater understanding of the broader issues that impact upon sexual health; and to support agencies that work with young people to appreciate their role in tackling those issues and thereby enabling good sexual health. The team also delivers staff training and support to agencies that work with vulnerable young people including youth workers, social workers, teachers, members of the Youth Offending Team and foster carers.
For further information Contact: Carmel Farley, Manager, So To Speak, Sexual Health Outreach Team for Young People in Liverpool and Sefton 0151 227 1487 Carmel.farley@sotospeak.nwest.nhs.uk or Tim Blackstone Sexual Health Community Development Co-ordinator tim.blackstone@sotospeak.nwest.nhs.uk

Brook and Abacus
Liverpool provides strong services through two discrete, highly visible, and young people friendly sexual health/contraceptive advice services in the city centre – Brook and Abacus. These services are highly accessible and trusted by young people. The services are supported by the strong outreach work provided by *So To Speak*. Liverpool Brook has been providing contraceptive services for young people for over 30 years. It has been located in the city centre for the last 20 years and, following relocation to larger more visible premises in 2002, has been offering a 'drop in' service, which is open every weekday from 10am to 6pm and on Saturdays from 10am till 2pm. The service is commissioned by Liverpool PCTs, and provides all the main methods of contraception, emergency contraception, pregnancy testing, referral for abortion, chlamydia screening and sexual health advice. The centre also provides a twice weekly full STI testing service run in partnership

with the Royal Liverpool University Hospital GUM department and 2 Chlamydia Treatment Sessions. The provision of young people focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them was cited as the factor having the biggest impact on conception rate reductions in high performing areas. Liverpool's teenage pregnancy rate has fallen by 24.7% between1998 to 2004. (Department for Education and Skills, 2006a)

Teenage pregnancy: Tower Hamlets has seen a progressive decline in teenage conception rates well ahead of the decline nationally, as part of a broader strategy to improve sexual health that has targeted areas with high teenage pregnancy rates to ensure and maintain an accelerated decline. Neighbourhood Renewal Funds have funded training in sexual health for representatives from all social service teams working with children and training for foster carers. Also, development of information leaflets on sexual health for children in care and sexual health relationship guidance for people working in non-educational settings. Tower Hamlets is recruiting five trainers to provide sex and relationship education in secondary schools and providing youth workers with additional training to deal with sexual health. Support is also being provided for pregnant teenagers and teenage parents through the Under-18 Pregnancy and Parenting Service (formerly called Sure Start Plus). (Sexual Health Program Group, 2006)

6. Encourage the sensible drinking of alcohol

Background

Alcohol misuse is associated with various health and social harms, such as accidents and illnesses such as coronary heart disease, stroke, certain types of cancer, cirrhosis of the liver, suicide and self-harm (ODPM, March 2005). The ODPM reported that there is also an association between alcohol misuse and crime, where alcohol is a factor in 50% of street crime, 33% of burglaries and 30% of sexual offences. Around a third of domestic violence offences are linked to alcohol misuse. There is an association between youth crime and alcohol use (ODPM, March 2005). Box 10 lists some of the impacts of alcohol use.

Box 10
Impacts of alcohol misuse

Alcohol misuse is associated with:

- 50% of street crime
- 33% of burglaries
- 30% of sexual offences
- 33% of domestic violence offences (ODPM, March 2005)
- causing some 60 different diseases/ conditions, including injuries and mental and behavioural disorders, (Anderson & Baumberg, 2006)
- between 15,000 and 22,000 deaths each year (DoH, 2004a)
- 150,000 hospital admissions (HDA, 2005c)
- up to 35% of A&E attendances and ambulance costs (rising to 70% between midnight & 5am at weekends) (DoH, 2004a, 2005a, 2005d)
- 49% of attendances at A&E after an assault, in Merseyside (TIIG, 2005)
- £2.4 billion annually lost to the economy due to premature death (DoH, 2004a)
- 17 million days of absences from work each year (DoH, 2004a)
- annual losses in productivity of £6.4 billion (DoH, 2004a)

Between 15,000 and 22,000 deaths each year are associated with alcohol misuse (DoH, 2004a). In the North West, alcohol related male deaths rose from 12.8 to 19.2 per thousand, between 1995-2002. Female deaths rose from 7.7 to 10.7 per thousand over the same period (Brown, McVeigh, Beynon, & Bellis, 2006).
In Cheshire and Merseyside in 2004/5, male hospital admission rates for conditions attributable to alcohol were strongly associated with deprivation. More deprived local authorities had higher rates (R^2 = 0.79, males) (Morleo et al., 2006). A recent BBC investigation showed that there has been a 20% rise in hospital admissions related to excessive drinking by young people (BBC, 2006). Liverpool has the most alcohol-related hospital admissions in England (Liverpool First, April 2007).

In the North West, an average of 42% of men and 27% of women report drinking over the recommended daily limits. The England averages were 37% and 22% respectively (Brown et al., 2006). The UK is one of the top bingeing nations in western Europe, binge-drinking 28 times per year on average, or about once every 13 days (Anderson & Baumberg, 2006). In the North West between 2000-2002, 23% of adults were estimated to be binge drinkers. In Cheshire and Merseyside, this ranged from 28% in Liverpool and 25% in Knowsley, to 21% in Macclesfield (Morleo et al., 2006). The introduction of the 24-hour licensing laws in 2003 have had a small impact. Together with the Alcohol Misuse Enforcement Campaigns, they have been associated with a 15% decrease in assault presentations at A&E on the Wirral (Bellis, Anderson, & Hughes, November 2006). However, the London Ambulance Service reported that there is no evidence so far that the change in licensing laws has led to a move to a more café-style drinking culture (Woodward, 29th January 2007).

Under age drinking is a problem in the North West. A survey of 15 and 16 year olds in the North West showed that, of those who drink at least once every 6 months, 24% are frequent drinkers, and 38% usually binge when drinking. Of those that drink, 40% reported buying their own alcohol (Bellis et al., September 2006). In October 2005, 51% of licensed premises, and 50% of supermarkets were found to be selling alcohol to under 18 year olds (LGA, 9th February 2006).

The drinks market does make an important contribution to the UK economy, generating around 1 million jobs, and £7 billion per year in excise duties (HDA, 2005c). However, the financial burden of alcohol misuse is around £1.7 billion annually to the NHS and over £10 billion to society as a whole. The loss to the economy of premature death from alcohol misuse is around £2.4 billion each year. Up to 17 million days absent from work are alcohol-related (DoH, 2004a). Alcohol misuse among employees costs up to £6.4billion in lost productivity, through increased absenteeism, unemployment and premature death (HDA, 2004b). Alcohol misuse is also a clear health and safety issue.

National policy

The government's Alcohol Harm Reduction Strategy was published in 2004 (Cabinet Office, March 2004). It is the first coordinated strategy on alcohol misuse in England. Its recommendations include the provision of more support and advice for employers, and improvements in the early identification and treatment of alcohol problems. The strategy requires co-ordinated action to be taken by government departments, NHS, police, local authorities and the drinks industry at both local and national levels (ODPM, March 2005).

The 'Choosing Health' white paper made a number of commitments to tackle alcohol misuse and treatment. Much of the work will be based on the National Treatment Agency for Substance Misuse (NTA) Models of Care guidance, (NTA, 2006).

Targets and commitments

Public Service Agreement supporting target (DoH, 2005d):

- Reduce crime by 15% and further in high-crime areas, by 2007-08.

'Delivering Choosing Health' commitments (DoH, 2005d):

- Develop a programme of improvement for alcohol treatment services, based on the Models of Care framework for alcohol treatment. Support with additional funding through the Pooled Treatment Budget for Substance Misuse (p.82 – joint work between PCTs, acute trusts, LAs and the voluntary sector).

The government also recommends that all employers have a workplace alcohol policy to provide guidance to managers and staff on alcohol-related problems in the workplace (DoH, 2004a).

Liverpool has a Local Area Agreement (LAA) target for alcohol (Liverpool First, April 2007):

- To reduce alcohol related hospital admissions that result in a 24 hour stay by 5% over the next 3 years.

There are other, related targets, which will be more achievable if alcohol issues are addressed. These are listed in Annex B of the Department of Health report on Alcohol Misuse Interventions (DoH, 2005a). They include targets on suicide, domestic violence and road accidents, where for each, alcohol is an important factor.

Top tips for effective interventions

Alcohol is a public health problem that needs to be addressed within a social model of health promotion, rather than focussing on treatment. It is not possible to order the range of interventions into a hierarchy, with one being considered more effective than another. The evidence points to multi-component approaches, where attempts are made to make progress with each intervention, within available resources.

Joint working

The encouragement of the sensible drinking of alcohol requires joint action, with local authorities working with the strategic health authority, primary care trusts, the police, the alcohol industry and businesses including pubs, clubs and other venues. Several local authority departments will be involved, including planning, leisure, youth, trading standards, social services, education and those concerned with community safety, crime and disorder and licensing (LGA, 1st March 2005). In 2-tier areas, licensing and community safety are the responsibility of District councils. County councils are responsible for services such as trading standards, social services and education. Both tiers of local government need to work together to ensure an effective campaign for responsible drinking (LGA, 1st March 2005).

Community approaches

Sustainable solutions: The government's proposals on alcohol are outlined in the document 'Drinking Responsibly' (DCMS, January 2005). However, it is felt that they focus largely on enforcement issues, with not enough attention paid to a broader preventive approach (LGA, 1st March 2005). The Local Government Association has suggested that local councils should continue to argue for extra funding to support sustainable solutions to anti-social behaviour, such as

- more parenting classes,
- more family interventions, and
- more youth inclusion programmes, all of which will deliver real benefits

(LGA, 7th April 2005).

Research shows that drinking amongst youths is strongly related to the amount of spending money they have available. Therefore, effective advice and information for parents would include the suggestion that if spending money available to children was reduced, or monitored more effectively, then this could have the effect of reducing their alcohol consumption (Bellis et al., September 2006).

There have been two national youth schemes, which have reported some success in reducing alcohol consumption and related crime, by diverting youths into more constructive activities. Over 100 'Summer Splash' schemes targeted those aged 13-17 from deprived estates, engaging them in constructive activities in the summer months. Activities included arts and crafts, drama, football, and DJ workshops. Schemes were administered by the Youth Justice Board, but in some cases, management was handed over to local authorities (Loxley, Curtin, & Brown, 2002). 'Positive Futures' involved 24 projects providing sporting opportunities combined with outreach work, including a wide range of partners, some with the local authority as the lead agency (Sport England, 2002). Bellis et al suggest that local authorities would be advised to prioritise providing legitimate youth activities, over the provision of more bars and clubs (Bellis et al., September 2006).

The ODPM reported that there is evidence for the potential effectiveness of community approaches to tackling alcohol misuse (ODPM, March 2005). These approaches would include:

- The development of community information campaigns on the health risks of alcohol misuse that are culturally and linguistically appropriate. In Liverpool, the multi-agency 'Pssst' campaign, using social marketing methods, has recently been launched (see 'examples of good practice' below).
- Youth services working in partnership with young people to develop programmes to inform them about alcohol misuse.
- Ensuring that appropriate local services are easily accessible, with support targetted at vulnerable teenagers and families affected by alcohol misuse (DoH, 10 October 2006).
- An assessment of particular problems in the local area. There may be certain groups, people or neighbourhoods at particular risk of alcohol related ill-health, crime or disorder. Collection of all available local data,

combined with information from key local people, can be used to build up a picture of 'hotspots' or areas of need (ODPM, March 2005).

- All relevant partners, including community representatives, health care workers and providers, and local authority representatives, to then draw up a plan of action (ODPM, March 2005).
- Crime and disorder planning groups to ensure that local people are represented in discussions about alcohol related crime. Local people to lead the way in discussions about developing solutions (ODPM, March 2005).

Licensed premises

- Creating an environment more conducive to moderate drinking can be achieved by reduced 'happy hour' or '2 for 1' promotions, less 'vertical drinking', with an emphasis on comfortable seating, providing food, free water, and non-alcoholic drinks promotions. Such measures will encourage people to take breaks whilst drinking and slow consumption (Bellis et al., November 2006; CEC, November 2006; Hughes, Tocque, Humphrey, & Bellis, September 2004).
- The provision of trader training to help to change the drinking culture and reduce levels of intoxication in patrons. This would include training glass collectors and other staff to recognise the signs of drunkenness (LGA, 1st March 2005), giving advice on preventing under-age sales, and encouraging moderate drinking, as in the previous point.
- Giving local authorities the power to impose minimum pricing and to ban promotions where necessary (LGA, 1st March 2005). It is important that councils are supported by government departments – the LGA reported that one council was stopped by the DTI from trying to achieve a voluntary code on drink prices (LGA, November, 2004).
- Research suggests that increasing the price of alcohol, especially in off-licence premises, will help to reduce alcohol consumption and its related harm in children (Bellis et al., September 2006).
- Application of the 'polluter pays' principle', where local authorities have the power to require a contribution towards the cost of dealing with any trouble in the Alcohol Disorder Zones (ODPM, March 2005).
- Limiting the licensing of premises that encourage binge drinking amongst teenagers.
- Alcohol retailers to stop selling to people under 18. Regular test purchasing to identify premises selling alcohol to minors can have an important effect on reducing underage sales (Bellis et al., September 2006). Penalties such as fines and closures need to be seen to be imposed. Other measures would include the increased use of the 'Challenge 21' scheme by retailers, asking for proof of age for those looking under 21. Information campaigns to discourage the illegal 'purchase by proxy' of alcohol by adults for children should become more widespread (Bellis et al., September 2006). A combination of new legislation, better co-ordination of activities, targeting and enforcement is showing signs of success (see Box 11).

Housing

- Local authorities and registered social landlords working with local people to provide opportunities for problem drinkers to access housing, support and health services. Services such as 'foyer schemes' that provide supported housing (ODPM, March 2005) can be an effective way of meeting the needs of socially excluded groups such as street drinkers, especially those who are homeless.

Public transport

- The co-ordination of public transport and licensed hours to help to avoid disorder (CEC, November 2006).

Box 11
Examples of evidence for the effectiveness of alcohol-related interventions in the community

A one-month campaign by trading standards officers and police resulted in a decrease in underage sales of alcohol, from 51% to 29% on licence; 36% to 19% off-licence; and 50% to 17% in supermarkets. This contributed to an 11% decrease in violent crime (LGA, 9th February 2006).

According to the ODPM there is considerable academic literature about the potential effectiveness of community approaches to tackling alcohol misuse (ODPM, March 2005)

Workplace interventions

All employers should have a workplace alcohol policy to provide guidance to managers and staff on alcohol-related problems in the workplace (DoH, 2004a; HDA, 2004b). The policy would cover:

- drinking at the workplace;
- workplace discipline;
- recognition and help for those with alcohol-related problems;
- alcohol education. (HDA, 2002)

The full range of support for alcohol problems should be available:

- Provide oral and written information for employees on the damaging effects of alcohol and on the possibilities of assistance to stop or reduce consumption. Themed months on alcohol issues would help to raise alcohol awareness.

- Offer access to a counselling and advice service (workplace-based if available), ranging from brief interventions (for harmful drinking) or referral to an alcohol unit (for dependent drinking).

- Establish guidance and training for supervisors and selected employees, so they are able to identify alcohol problems early and refer employees for support.

Interventions based on the model of employee assistance programmes (EAP) are effective, i.e. where employees have access to a work-based counselling and advice service, covering a wide range of issues (HDA, 2004b).

Based mainly on a paper by Roman and Blum, (Roman & Blum, 1996) the HDA (2004) concluded that there is strong evidence that worksite interventions (especially with components of EAP) are effective in rehabilitating employees with alcohol problems. General prevention and counselling or treatment are cost efficient in reducing harm for the individual and the broader community (HDA, 2004b).

There is more information on the evidence for models of treatment and their cost effectiveness available from the National Treatment Agency for Substance Misuse (NTA, 2006).

Box 12 gives examples of the effectiveness of alcohol-related interventions relating to employees.

Box 12
Examples of evidence for the effectiveness of alcohol-related interventions applicable to employees

- In a review of worksite interventions, one study compared 54 companies with access to general work-based counselling and advice (EAP) to 124 without. In the companies with EAP, there were significantly more referrals to a problem drinker centre, per 1,000 employees (Roman & Blum, 1996).
- Worksite training oriented to alcohol problems affects the attitudes of supervisors and employees for reasonable periods after the completion of training. Merely completing instruments had a strong effect on trainees in the desired direction of becoming more willing to take effective action toward alcoholic employees (Roman & Blum, 1996).
- Heavy drinkers receiving brief interventions* are twice as likely to moderate their drinking 6 to 12 months after an intervention, when compared with drinkers with no intervention (review-level evidence, (HDA, 2005c))
- Brief interventions* (especially those with follow-up sessions) can reduce net weekly drinking by 13% to 34%, resulting in 2.9 to 8.7 fewer mean drinks per week, and a significant effect on recommended or safe alcohol use. Interventions showing statistically significant improvements included at least 2 of 3 key elements: feedback; advice; goal setting (review-level evidence, (HDA, 2005c)).
- For one person to reduce their drinking to low risk levels, then 8 need to receive brief interventions*. This compares favourably to smoking cessation, where 20 people need to receive brief interventions (DoH, 2005d; NICE, 2002; Wanless, 2004).

**brief interventions are defined here as advice or counselling lasting between 5 to 15 minutes, and varying from 1 to 4 sessions (HDA, 2005c)*

Examples of good practice

Psst is a revolutionary new alcohol awareness campaign in Liverpool, using a social marketing approach. Key partners within Liverpool have for many years launched public awareness campaigns aimed at tackling the various aspects of alcohol consumption. However, as the issue has continued to increase in prevalence there has been concern that the public are being bombarded with a huge variety of competing alcohol related messages due to the volume of campaigns launched by partners at the same time. In September 2005, the Chief Executive of Liverpool City Council requested that Community Safety arrange a Liverpool Partnership Group half day seminar at the Town Hall to increase understanding of alcohol related harm in the City, agree key action, and develop a social marketing campaign to raise awareness. In December 2005, Citysafe partners ran a pre-Christmas Alcohol Misuse Awareness Campaign entitled ‘Respect Alcohol, Respect Yourself’. In future Citysafe -

Liverpool's Crime and Disorder Reduction Partnership will work with all the strategic partners: Liverpool City Council, Liverpool Primary Care Trusts, Merseyside Police and Merseyside Fire and Rescue Service to devise an overarching alcohol brand to unify all alcohol related campaign work. From the concerted efforts of all partners, the '*Pssst! Be Alcohol Aware'* identity is now established and will be used long term to address the three primary areas of: health, law enforcement/crime reduction and community safety (http://www.pssst.org.uk/).

Halton Borough Council has teamed up with Halton and St.Helens PCT in launching a training scheme for Halton's alcohol retailers to help them to play their part in tackling under-age drinking and crime (A. Short, Widnes Weekly News, p.4, 8/3/07).

TIIG: Co-ordinated through the Centre for Public Health at Liverpool John Moores University, the Trauma and Injury Intelligence Group (TIIG) data base is collating data regarding trauma (e.g. intentional and unintentional injuries) referrals to A&E departments across Merseyside. For example, data are collected on alcohol-related violence referrals to A&E departments. These data are being shared with Merseyside Police to identify hotspots of violent crime that will enable the police, local authorities, trading standards and the licensing bodies to tackle such behaviour.
(contact: z.a.anderson@ljmu.ac.uk)

7. Creating a smokefree environment

Background

All workplaces and enclosed public places must be smokefree after 1st July 2007 (http://www.dh.gov.uk/en/News/DH_065562)

Enforcement will be carried out by local councils, predominantly by Environmental Health Officers. The Department of Health and the Local Government Association have agreed a total funding package of £29.5 million for 2007/8 (the first year of smokefree legislation) for first-tier local authorities.

The **Smokefree England campaign** was set up to advise the country's 3.7 million businesses, including nearly 200,000 pubs, bars, restaurants and other leisure outlets on preparing for the introduction of the legislation. General information about the legislation, about enforcements and exemptions, and support available for implementing the policy, including brochures and factsheets, can be found on the Smokefree England website at www.smokefreeaction.org.uk

Effects of smoking

Smoking causes a wide range of diseases, including 90% of lung cancer and 30% of ischemic heart disease. (WHO, 2005) It is the leading cause of health inequalities in the UK and the main reason for disparities in death rates between the rich and poor (NICE, January 2007).

A new study published in The Lancet has reviewed the current drug classification system in the UK. It's no surprise that tobacco is high up the list and was considered the ninth most dangerous drug amongst 20; higher than cannabis, solvents and ecstasy (Nutt D, 2007)

Although the current prevalence of smoking within Great Britain has fallen from 40% in 1978 to 25% in 2004 (ONS, 2005), these figures hide a steep social class gradient that has worsened over the past 20 years. The latest General Household Survey reported a smoking prevalence of 31% among routine and manual workers compared with 18% among managerial and professional workers (ONS, 2005). One study in Great Britain found smoking levels in excess of 75% for lone parents living in rented accommodation and on state benefits (Dorsett & Marsh, 1998)

Help the environment

In addition to health benefits, giving up smoking can help protect the environment. In the UK, 120 tons of cigarette related litter is discarded on our streets every day. Cigarettes account for over 40 per cent of street litter, and cigarette filters can take up to 12 years to degrade. They are harmful to birds and wildlife. If you litter with cigarette butts you can face a £75.00 fixed penalty fine. http://www.roycastle.org/kats/facts_env1.htm

Surveys

- More than three out of four people in England already choose not to smoke
- Nearly three quarters of those who do smoke say that they want to give up
- 91% of **employers** agreed that people at work have the right not to breathe in other workers' smoke
  http://www.herefordshire.gov.uk/environment/28560.asp

National policy

The government's smokefree legislation, that came into place on 1st July 2007, means that all workplaces and enclosed public places, including private members clubs, will be smokefree. (www.dh.gov.uk).

- The **European Commission** has consulted relevant stakeholders from across Europe, examining the health and economic burdens associated with passive smoking, and public support for smoking bans. For more information see:http://europa.eu/rapid/pressReleasesAction.do?reference=IP/07/109&format=HTML&aged=0&language=EN&guiLanguage=en
  Three further sets of regulations will be published in 2007, detailing; exemptions and vehicles; penalties and discounted amounts; and offences in vehicles and the format for fixed penalty notices. (www.smokefreeengland.co.uk).

The current regulations state that;

- Organisations must have a smokefree policy in place. Current policy may need to be altered so that it clearly states where and when smoking is permitted according to the new legislative guidelines

- Enclosed or Substantially Enclosed Premises must be smokefree - premises are considered to be enclosed if they have a ceiling or roof. If they have a ceiling or roof, but there are openings in the wall which are less than half the total area of walls, then they are defined as substantially enclosed.

- Smokefree premises will have to display a 'prominently visible' no - smoking sign at each public entrance to the premises. The sign will have to be at least A5 in size, display the 'international 'no smoking' symbol (a burning cigarette in red circle with red bar across it), and carry the words 'No smoking. It is against the law to smoke in these premises'
  (http://www.smokefreeengland.co.uk/thefacts/the-regulations.html)

The government will not at this stage use its powers to designate additional places such as sports stadia, bus and railway stations smokefree (although the Football League has introduced a 'smokefree' policy of its own – see below.

Penalties
Smoking in a smokefree place could lead to a fine of up to £200, and failing to prevent smoking in a smokefree place to a fine of up to £2500.
http://www.smokefreeengland.co.uk/thefacts/the-regulations.html

External smoking areas
If staff smoke during break times, they must not smoke in an enclosed or substantially enclosed area. Employers must decide whether or not to permit smoking elsewhere on their premises e.g. in open car parks or grounds.

Outside areas are not covered by the legislation. However, employers may want to consider making it a policy that smoking is not permitted within a certain distance from outside entrances, so that staff and visitors do not have to walk through a cloud of smoke to get into the building. There is no legal requirement for employers to provide designated external smoking areas, e.g. smoking shelters, and health-focused employers may prefer not to spend money creating places for smokers to congregate.

Outside smoking shelter or areas, must not be "enclosed" or "substantially enclosed" under the definitions that will be set out in smokefree regulations. The TUC has published guidance on negotiating smoke free workplaces - visit www.smokefreeaction.org.uk/

Future legislation

Further legislation is expected in the near future - legislation relating to mental health trusts will come into force in July 2008., as set out in a Department of Health letter on 1st Feb, 2007

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_064794

Organisations who will be covered by future legislation include:

- Any place occupied as a residential premises or as living accommodation, including bedrooms in a hotel, bed and breakfast or hostel
- Halls of residence (bedrooms only)
- Adult hospices
- Long-stay adult residential care homes
- Bedrooms in psychiatric hospitals and units
- Prisons or other places of detention

Funding and support from the Department of Health
The Department of Health is distributing £29.5 million, to support first-tier local authorities to undertake new work associated with the introduction of smokefree legislation. In recognition that many local authorities have already commenced preparations and spent resources, the Department will distribute £5 million of the funding package immediately, with the remainder to be distributed in the next financial year. Grants will be paid under Section 31 of the Local Government Act 2003 as a specific formula grant, with no conditions attached.

The Government proposes that first-tier local authorities, together with Port Health Authorities, will have enforcement authority duties under smokefree legislation.
In addition, the Department of Health is supporting implementation of smokefree legislation, including:

- The provision of guidance directly to all businesses in England
- The provision of no-smoking signs free of charge
- A comprehensive Smokefree England website: www.smokefreeengland.co.uk
- A freephone Smokefree Information line
- The approach to enforcement will be non-confrontational, focused on raising awareness and understanding to ensure compliance, and enforcement officers are expected to work closely with businesses to build compliance through education, advice and support before the legislation comes into force (DoH, 2006c)

(http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/DH_064384)

Public Service Agreement on smoking
The Public Service Agreement on smoking aims to reduce adult smoking rates, from 26% in 2002, to 21% or less by 2010. It aims to reduce prevalence among routine manual groups, from 31% in 2002 to 26% or less in 2010 (DoH, 2006e)

Smokefree stadia
The Football League has announced the introduction of a 'smokefree' policy, to take effect from the beginning of the 2007/08 season. The new policy anticipates and exceeds legislation in this area. Smoking will not be permitted throughout stadium confines from July 2007 onwards.

The new policy follows a survey of 43,000 fans in the Football League Supporters Survey 2006, which showed that 80% of fans were in favour of introducing some sort of 'smokefree' policy at matches, with half of fans wanting an outright ban. There is more information on the website, www.football-league.premuimtv.co.uk

Association of Public Health Observatories
The Department of Public Health has commissioned the Association of Public Health Observatories to produce a tool for commissioners in Spearhead areas that enables them to identify the size of their local gap in life expectancy compared with England as a whole. The Tool focuses on stopping smoking as a key measure, and a prototype is available at http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx
Commissioning Framework for health and well-being P89
(DoH, 2007a)
[See also health inequalities section]

Legal age to buy cigarettes will be increased from 16 to 18
The legal age for the purchase of tobacco will be raised from 16 to 18 from October 1st 2007 in England Wales. It is expected that the change in law will also come into effect in Scotland from the same date. Pressure groups such as ASH (Action on smoking and health) welcomed the announcement, but also called for the Government to introduce a licensing system for the sale of tobacco. Currently retailers are not required to hold a licence, and the penalties for breaking the law on the sale of tobacco to minors are not sufficiently well enforced.

Top tips for effective interventions

Local Authority Staff
Local authority staff can play an important role in promoting health:

- They can provide examples of what can be done to achieve a healthy environment, and give advice to individual clients and citizens
  Monitoring role: Local Authority staff play an important role in cutting down on cigarettes being brought into the country, and on sales of counterfeit cigarettes, which generally contain increased levels of toxins compared to non-counterfeit cigarettes. Local Authorities have a role to work with HM Revenue and Customs on surveillance operations in relation to this. LA staff also have a role to play in enforcing bans on dropping cigarette-related litter.

Client based
Although some institutions, such as prisons, and long-stay adult residential care homes, are not covered by the legislation that will come into force in July 2007, consideration should still be given in these types of premises as to how smoking could be restricted in communal areas. These groups may be particularly affected by the effects of smoking – smoking rates amongst prisoners are far higher than in the general population, for example. Legislation covering prisons is expected to come into force in 2008.

Communication
Access to smoking cessation services, and help available to businesses, should be promoted through Local Authority community networks and

channels, e.g. libraries, leisure services, council, newspapers etc. Smoke free venues should also be publicised through local authority channels, e.g. shopping centres and other public/civil buildings.

Counterfeit and smuggled cigarettes
Counterfeit cigarettes generally contain increased levels of toxins compared to non-counterfeit cigarettes. They contain on average 3 times the level of arsenic, and almost 6 times as much lead. Trading standards officers play an important part in monitoring sales of counterfeit cigarettes.

They also have a role to play in cracking down on smuggled cigarettes from abroad. Tobacco smuggling seriously affects public health - not just government revenues - because it brings tobacco onto the markets cheaply. This is especially important to poorer smokers, who generally smoke for longer and find it harder to quit. The availability of cheap cigarettes, often for sale at a half to a third of their official price, removes or greatly weakens the price incentive for smokers to quit.

There is an Inland Revenue Public Service Agreement target to reduce the illicit market share for cigarettes to no more than 13% by 2007-08. Provisional published estimate for 2003-04 is 15% (http://www.hmrc.gov.uk/psa/tn05-08obj1.htm#tar2)

Workplace

The workplace has potential as a setting through which large groups of people can be reached to encourage smoking cessation. Employers have a role in supporting and encouraging employees who smoke to quit.

The NICE (National Institute for Clinical Excellence) guidelines recommend the following as the most effective and cost effective workplace approaches. NICE advises that employers can help their employees to give up smoking by:

- Making information on local stop smoking support widely available in your workplace
  - Contact the local stop smoking service and ask for help in providing information about the local support available. Local services can be found at www.gosmokefree.co.uk, or call the NHS Smoking Helpline on 0800 169 0169
  - Make information about the types of help readily available to all your staff, including when support is available, and where and how employees can access it.
  - Ask staff if there is extra information and support you can offer in the workplace
- Offer support to help employees who want to give up smoking
  - Think about allowing employees to attend stop smoking services during working hours without loss of pay. NICE has produced tools to help you calculate the cost of this, and see the benefits for productivity if your employees give up smoking. See www.nice.org.uk/PHI005

    - Be responsive to individual needs and preferences. If there is sufficient demand, ask your local stop smoking service to offer help on your premises. This might include an on-site stop smoking group
    - Work with other local businesses to see if there is an opportunity to share smoking cessation support.
- Work with your staff and their representatives to develop a stop smoking policy
    - Make the stop smoking policy part of an overall smokefree policy for your workplace
    - Think about whether staff will be allowed time off for smoking breaks during working hours
    - Think about whether any staff would like training to provide stop smoking advice.

(NICE, 2007)

Box 12
Examples of evidence for the effectiveness of smoking cessation interventions applicable to local authorities

- any contact time with a clinician (physician or non-physician) is effective at increasing abstinence rates in smokers (Odds Ratio [OR] 1.4 for 1-3 minutes total contact time). Effectiveness increases with increasing contact time, peaking at a total contact time of 31-90 minutes (OR 3.0).

- multiple sessions are significantly more effective, with 8 or more being most effective (OR 2.3).

- interventions using one format type are effective, but effectiveness is significantly increased when 3 or 4 format types are used (e.g. self-help, telephone counselling, group or individual counselling).

- Counselling delivered by a smoking cessation counsellor (i.e. excluding counselling delivered by doctors and nurses) increased the likelihood of smoking cessation compared to less intensive support (OR 1.55) (Naidoo, Warm, Quigley, & Taylor, 2004). However, there is likely to be a shortage of skilled smoking cessation officers (Wanless, 2004).

- A cognitive behavioural therapy approach may be effective in raising abstinence rates and decreasing the number of cigarettes smoked among smokers living in a deprived area (Marks & Sykes, 2002) (UK)

- the same smoking cessation interventions are effective for both men and women, and across different black and ethnic minority groups, and for those aged over 50 (Fiore, 2000)

- Analyses of UK data suggest that people less likely to give up smoking were from lower social classes, were not married and had less knowledge of the health consequences of smoking (Buck & Morgan, 2001) (UK)

- Training in opportunistic counselling takes half a day (HDA, 2005b), but staff may not have time available to carry out this training.

- Adding Nicotine Replacement Therapy NRT to current smoking intervention practice is cost-effective, with a relatively low cost per quitter (NICE, 2002), and can improve success rates from 2% with no help at all to 20% for those who have used a clinic and NRT (Wanless, 2004)

- The NHS rationing body is preparing to approve the prescription of a new anti-smoking drug, varenicline, that is twice as effective as current treatments, at least in the short term (NICE, 2007).

- The cost of nicotine patches and other aids to quitting smoking are to fall after the chancellor confirmed he would cut VAT on them from 17.5% to 5%.

  The year-long tax break will come into force on July 1, the day the smoking ban is introduced in pubs, offices and all public spaces in England. (Bowers S, 22 March 2007)

- Employers are advised to give workers who smoke extra time off or encourage them to quit when the smoking ban comes into force. Smokers should also receive nicotine patches paid for by their firms if necessary (NICE, April 2007).

- Interventions to decrease exposure to second-hand smoke 'de-normalise' tobacco use (HDA, 2005b) making smoking less acceptable and desirable. Far fewer young people will start smoking if their workplace is smokefree. With around 300,000 16 year olds starting work each year, this presents a unique public health opportunity (Taylor, Wohlgemuth, Warm, Taske, & Naido, 2005)

- Price increases as low as 10% are effective in encouraging smokers to quit (Ranson, Jha, & Chaloupka, 2002)

- Removing ashtrays from smokefree areas can be an effective deterrent (smokefreeengland.co.uk)

- A phoneline will be in operation for people to report incidents. The information will be passed to local councils to assist in building compliance with the law. The number will be 0800 587 1667 (smokefreeengland.co.uk)

- **Smokefree laws do not damage profits.** No independent, peer reviewed study has ever found a significant downturn in business from going smokefree (Cancer Research UK)

- **The Roy Castle Lung Cancer Foundation** have a stop smoking team known as Fag Ends, who offer friendly support and advice for those who wish to quit smoking. They can visit workplaces, as well as running 51 drop in sessions each week in Central, North and South Liverpool and across the whole of Knowsley. To find your nearest Fag Ends Team or for further help and support, contact the Fag Ends helpline on free phone number 0800 195 2131, or http://www.roycastle.org

Knowsley Council has a dedicated workplace stop smoking service for individuals working in the borough to access free stop smoking services and support. For information contact: smokefree@knowsley.gov.uk

- Materials such as booklets, posters and translated leaflets can also be downloaded or ordered from the website www.givingupsmoking.co.uk
  Text 'GIVE UP' and your full postcode to 88088
  NHS SMOKING HELPLINE: 0800 169 0 169

- **Ventilation systems are not effective**
  There is much evidence to show that these systems cannot remove all the harmful chemicals found in second hand smoke. Ventilation can remove the smell, make it more pleasant and extract some of the toxins if properly operated, but the remaining toxins circulate. It has been estimated that an effective ventilation system would need to be equivalent to a "tornado-style gale" (US Environmental Protection Agency, 1992)

- Consideration should be given to seconding PCT staff into environmental health departments in the short term to support the smokefree campaign, implementation of the legislation and signpost or deliver stop smoking support

Examples of good practice

ColorMatrix Europe Ltd , Colourant Manufacturer based on Knowsley Business Park
ColorMatrix Europe Ltd, a manufacturer of liquid colorant, employing 130 people, introduced an effective no-smoking policy on January 1st 2004. The company had decided to take a greater interest in the health and welfare of their staff and change their practice of allowing smokers to take unlimited, unscheduled smoke-breaks.

Introducing a no-smoking policy has saved the company around £60,000 in recouped productivity by providing a structure to staff breaks, which has in turn had a significant impact on the consistent availability of staff. There has been an improvement in staff health as smokers have quit coupled with the reduction in exposure to tobacco smoke.

The process was assisted by the local NHS 'SUPPORT' Stop Smoking Service who provided a free in-house stop smoking course to help smokers who chose to quit and gave the 30% of staff who were smokers, professional assistance in adjusting to the changes
http://www.cleanairaward.org.uk/info_casestudy2.htm

'Lift Your Lifestyle' in Sefton

'Lift Your Lifestyle' is a joint programme between Sefton PCT and Sefton Council, which aims to encourage employees aged 50 and over to be health aware and make healthy lifestyle choices. Employees can attend a short 15 minute appointment, in which they will be offered health advice and information about leisure activities in Sefton. In addition, they will be offered confidential screening including blood pressure, random cholesterol and carbon monoxide testing for smokers.

For more information, contact Gareth Lewis, gareth.lewis@seftonpct.nhs.uk

Heal 8 smoking cessation programme

Heal 8 is a "virtual healthy living centre" which aims to deliver fundamental health improvement for residents in the Liverpool 8 district over a five-year period. The centre is 'virtual' as it is not delivered from one physical building but instead is delivered out in communities within the geographical Liverpool 8 area.

This innovative new approach to improving health began in January 2004 with funding secured from the Big Lottery. Delivered in partnership with Fag Ends, this programme has successfully delivered smoking cessation sessions to over 300 people (20% from ethnic minorities) living within the L8 area.

For more information, contact Tony Boyle, Environmental Health Officer, Specialist Projects, anthony.boyle@liverpool.gov.uk

St Helens Local Area Agreement - Smoking in pregnancy

- Best Start Service – Dedicated specialist smoking cessation midwife based in Whiston Hospital offering the "Best Start" service.
- Intermediate advisors (smoking cessation) within all Sure Starts across St Helens.
- Community "SUPPORT" sessions within targeted areas.
  Specific care pathway including home visits for those fitting criteria which are needs assessed.
- Data has been collected regarding teenage parents smoking and geographical areas with high percentage of women smoking in pregnancy. This data is being analysed by the Public Health Intelligence Officer and a report will be produced by the end of November.

For more information, please contact Sue Lightup, Director Adult Social Care and Health, St Helens Council (suelightup@sthelens.gov.uk), or for local information Debbie Bishop (debbie.bishop@sthelens.gov.uk)

Smoking cessation in a Manchester school
A Learning Support Officer at Parrenthorn High School, in Bury, Manchester, trained as a smoking cessation officer with the local smoking cessation service, and now spends about one day a week on smoking cessation. The smoking cessation programme she delivers involves six sessions, which can be on an individual or group basis, discussing facts about cigarettes, effect on smoking on the body and benefits of giving up.

Results so far have shown that pupils do want help in giving up, and that they also want help for their parents to quit. Information and leaflets have been passed onto parents, and the service is aimed at staff as well as pupils.

See the website, www.teachernet.gov.uk/casestudies for more information

Counterfeit Cigarettes in Islington
It is believed that most of the tobacco products being sold along the Holloway Road, in Islington, are brought to this country from abroad by criminal gangs and sold through illegal street traders, with the proceeds funding organised crime.
A campaign is being co-ordinated by Islington Council, in co-operation with Islington Primary Care Trust, HM Revenue & Customs and the Metropolitan Police. Advertising will include bus and underground adverts, and posters and leaflets in the local shops, bars, restaurants, pubs, schools, colleges, council buildings, GPs' surgeries, libraries and other public buildings. For more information, see
http://www.islington.gov.uk/Search/results.asp?query=counterfeit+cigarettes

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