Public Document Pack

Health & Wellbeing Board

Tuesday, 11th December, 2018
5.30 pm

AGENDA

1. Welcome and Apologies

2. Minutes of the Meeting Held on 25th September 2018

Minutes 25th September 2018 — **3 - 8**

3. Declarations of Interest

4. Public Questions

To receive a Letter from Kate Davies OBE, Director of Health & Justice, Armed Forces and Sexual Assault services Commissioning, and Jackie Doyle-Price MP, Parliamentary Under Secretary

FAO Chairs of Health and Wellbeing Boards — **9 - 11**

5. Start Well Annual Update (Jayne Ivory)

6. Pan Lancashire Health and Wellbeing Board (Dominic Harrison)

7. Joint Commissioning and Better Care Fund Update (Sayyed Osman)

Joint Commissioning and Better Care Fund Update — **12 - 17**

8. Joint Strategic Needs Assessment Summary Review (Anne Cunningham)

HWBB - JSNA Summary Review paper — **18 - 73**
Summary Review 2018

9. Action on Air Quality (Dominic Harrison)

Air Quality for HWB 11th December — **74 - 103**
Air Quality and Public Health Report FINAL(2) Appendix 1
Appendix 2 L&C Air Quality Summit for HWB

10. Health and Wealth Report (Dominic Harrison)

Health for Wealth (2018) NHSA-REPORT-7pages **104 - 110**

Date Published: 4th December 2018
Harry Catherall, Chief Executive

BLACKBURN WITH DARWEN HEALTH AND WELLBEING BOARD
MINUTES OF A MEETING HELD ON TUESDAY, 25TH SEPTEMBER 2018

PRESENT:

Councillors	Mohammed Khan (Chair)
	Maureen Bateson
	Brian Taylor
Clinical Commissioning Group (CCG)	Roger Parr
Lay Members	Joe Slater
Voluntary Sector	Vicky Shepherd
	Angela Allen
Healthwatch	Abdul Mulla
Council	Sayyed Osman
	Dominic Harrison
	Kenneth Barnsley
	Rabiya Gangreker
	Wendi Shepherd
	Jayne Ivory
Council Officers	Firoza Hafeji
CCG Officers	Dr Penny Morris
Midland and Lancashire Commissioning Support Unit	Nicola Feeney

1. **Welcome and Apologies**

   The Chair welcomed everyone to the meeting. Apologies were received on behalf of Cllr John Slater and Kevin McGee.

2. **Minutes of the meeting held on 19th June 2018**

   RESOLVED – That the minutes of the last meeting held on 19th June 2018 were agreed as an accurate record and were duly signed by the Chair.

3. **Declarations of Interest**

   There were no declarations of interest received.

4. **Public Questions**

The Chair advised the Board on public questions received by Mr Patel as follows:

1) *Will the Chair including all associated bodies that commission local services, now ask or provide waiting lists for each contract in place for assessment and diagnosis, in the NHS and provide the total cost of clearing each waiting list?*
2) *Will the Chair request that the waiting list for all Social Care services are published on a monthly basis where people are waiting for a review emergency or otherwise, and the first assessment and provide a cost for each month to clear that waiting list?*
3) *Will the Board then provide the list to the Secretary of State for Health and Social Care, to make sure they are aware of the waiting list and hold them to account on funding the clearing of such waiting list under the Health and Social Care Act and the Care Act?*

The Board considered the questions and agreed for the response to be sent to Mr Patel on behalf of the Blackburn with Darwen Health and Wellbeing Board.

5. **Joint Health and Wellbeing Strategy**

The Board received a report from Dominic Harrison, Director of Public Health which had been previously circulated with the agenda.

The Director of Public Health explained that the purpose of the report was to present the final Joint Health and Wellbeing Strategy document to the Board for approval and outline the continued arrangements for delivery of the Strategy.

The Board heard that the "life course" approach of the previous strategy enabled the Health & Wellbeing Board and partners to truly consider the differing health needs that people experience at different points in their lives. Throughout the period of the last strategy, this evidence based approach had been fully embedded into the Health and Wellbeing Boards work.

The Director of Public Health shared the key issues that required a decision or agreement by the Board.

RESOLVED:

1) The Board approved the proposed Joint Health and Wellbeing Strategy for the period 2018 – 2021 and;
2) The Board noted the continued arrangements for delivery of the strategy.

6. **Joint Commissioning and Better Care Fund**

Sayyed Osman, Director of Adult Services, Neighbourhoods and Community Protection presented the report which had been previously circulated with the agenda.

The Director of Adult Services highlighted that the purpose of the report was to:

- Provide the Health and Wellbeing Board (HWBB) members with an overview of Better Care Fund (BCF) performance reporting for Q4 2017/18

- Provide HWBB members with the BCF and iBCF Finance position at Q1 2018/19
- Provide HWBB members with an overview of the forthcoming Local Learning Visit from the National BCF Team

The key issues were highlighted to the Board which included:

BCF Pooled Budget 2018/19 - The CCG minimum pooled budget requirement for 2018/19 is £11,381,000. The DCLG have confirmed the DFG capital allocation for 2018/19 at £1,739,476. The 2018/19 allocations as above plus carry forward amounts from 2017/18 are analysed as:

- Spend on Social Care - £6,501,650 (48.0%)
- Spend on Health Care - £4,252,828 (31.4%)
- Spend on Integration - £2,191,698 (16.2%)
- Contingency - £600,000 (4.4%)

iBCF Pooled Fund 2018/19 - Central Government consulted on the distribution of the Improved Better Care Fund as part of the Local Government Finance Settlement 2018/19. Allocations in the Core Spending Power recognised that authorities have varying capacity to raise council tax (including that through the adult social care precept). For Blackburn with Darwen the total allocations of Improved Better Care Fund are:

	Original iBCF	Additional iBCF for Social care – Spring Budget	Total
2017/18	£717,301	£3,589,451	£4,306,752
2018/19	£3,714,497	£2,186,064	£5,900,561
2019/20	£6,257,725	£1,081,454	£7,339,179

Local Authority Section 151 Officers are required to certify use of the grant and submit quarterly returns to the Secretary of State.

BCF 2017/18 Performance Metrics - Due to the timing of the national returns and year end reporting processes, the metrics described within the report related to Q4 2017/18 data. The 6 month 2018/19 position was to be reported to the HWBB at the end of Q3.

BCF Local Learning Visit - Blackburn with Darwen have accepted the opportunity to participate in a Local Learning visit from the National BCF Team which will take place on Tuesday 9th October 2018. The visit will offer an excellent opportunity to showcase our integrated care developments and receive feedback/learning from other areas.

RESOLVED:

1) The Board noted the BCF Q1 2018/19 finance position;
2) The Board noted the BCF Q4 2017/18 performance metrics; and
3) The Board noted the planned content of the forthcoming BCF Local Learning Visit

7. Update on CCG Leadership

Dr Penny Morris updated the Board on the CCG Leadership. It was noted that a Joint Accountable Officer had been selected and the CCG were awaiting

approval from the NHS England prior to appointing the candidate.

8. Pennine Plan

The Director of Adult Services, Neighbourhoods and Community Protection, Sayyed Osman, presented the Pennine Plan report which had been previously circulated with the agenda.

The Board noted that the report provided an overview of how the proposals for improving health, care and wellbeing services across Pennine Lancashire had been developed. It recommends the Pennine Plan for consideration and approval. This report also provided an overview of the engagement approach undertaken to test the Draft Pennine Plan and a summary of responses received during the engagement. It was noted that these had been used to shape the final version of the Pennine Plan.

The Health and Wellbeing Board was recommended to:

- Note the content of the Pennine Plan
- Note the engagement approach undertaken to test the Draft Pennine Plan and a summary of responses received during the engagement
- Provide any feedback and comments on the Pennine Plan
- Approve the Pennine Plan as the overarching blueprint for health and care transformation in Pennine Lancashire.
- Note that whilst this plan identified direction of travel and was for noting, that any key decisions required in the implementation of the plan, relevant and impacting on this council, was to be brought forward to the relevant boards for decision.

RESOLVED - That the Health and Wellbeing Board noted the recommendations and approved the Pennine Plan as the overarching blueprint for health and care transformation in Penning Lancashire.

9. Live Well Annual Update

The Director of Adult Services, Neighbourhoods and Community Protection, Sayyed Osman, presented the Live Well Annual update presentation which was noted by the Board.

Sayyed highlighted key areas to the Board which included:

- Early feedback from Primary Care Neighbourhood Groups indicated that Neighbourhood relationships had started to develop.
- The projects discussed at the groups included Diabetes, GP visits to Care Homes, Mental Health, Homelessness, Frailty, Referral Quality, Obesity, Social Isolation.
- Troubled families - 3 main aims to the phase 2 Troubled Families programme were shared with the group. To date the programme has worked with over 4,000 people who have presented with 15,000+ issues. Significant and sustained progress has been achieved by over 2,800 families or individuals. To date 155 people on the programme have gained employment and stayed employed for at least 6 months. A significant rise in volunteers has been identified each year.

- Homelessness - The enactment of the HRA has put significant pressure on the service. As a direct comparison 53 people were owed a statutorily homeless duty during the first 5 months of 17/18. In comparison 498 are owed this duty so far this year; over a 9 fold increase. In 2017/18 there were 145 homeless applications requiring a formal decision but with the new act being implemented based on the current applications the team will deal with 1322 applications this financial year.
- Making Every Adult Matter – The National Making Every Adult Matter programme was shared with the Board followed by the original objectives of BwD Making Every Adult Matters.

Next steps included:

- Development of the Local Integrated Care Partnership building trust and collaboration at the Neighbourhood Partnership level.
- Integration of Transforming Lives as part of the strategic response to demand management, community resilience and self-care, step down and asset based support.
- Investigation as to what can be done strategically to mitigate and manage the challenges we are facing on Homelessness, street begging and vulnerability.
- Support to deliver strategic objectives of Making Every Adult Matter.
- Make the links between UC and the strategy to support vulnerable people ensuring BwD residents are a priority.

The Board expressed their concerns that due to the delay of payment of Universal Credit people with Mental Health Issues were struggling to manage their budgets. It was noted that Homelessness was increasing and various causing challenges for the Borough.

RESOLVED - That the Board noted the Live Well Annual update and the next steps. The Director of Adult Services, Neighbourhoods and Community Protection, Sayyed Osman was thanked for the detailed presentation.

10. Age Well Annual Update

The Board received a presentation on Age Well Steering Group annual update from the Director of Adult Services, Neighbourhoods and Community Protection, Sayyed Osman, Vicky Shepherd and Public Health Specialist, Kenneth Barnsley.

The Challenges and next steps were identified as:

Challenges:
- Increase in both demand and complexity of need so capacity challenges for services
- Increase in old age mortality and the decline of increase in life expectancy
- Therefore increased need to focus on prevention but budgets being cut for early intervention and prevention services as financial situation gets ever more difficult
- Allied Discretionary services having an impact on Prevention

<u>Next Steps:</u>

- Continue to focus on neighbourhood level development not just for service delivery but for prevention/earlier intervention as well – utilising more fully community assets
- Learning from the ROSPA falls prevention programme target interventions at people who are at risk of falling but have not yet fallen/injured themselves to prevent in the first place
- Harness the assets of local businesses to work on dementia friendly and age friendly developments

The Board were informed that one of the recommendations was for all the Elected Members and the Health and Wellbeing Board Members to be trained on Dementia Awareness in 2018/19.

RESOLVED - That the Health and Wellbeing Board noted the recommendations.

Signed………………………………………………..

Chair of the meeting at which the Minutes were signed

Date…………………………………………………

Jackie Doyle-Price MP
Parliamentary Under Secretary of
State for Mental Health,
Inequalities and Suicide Prevention

39 Victoria Street
London
SW1H 0EU

Kate Davies OBE
Director of Health & Justice,
Armed Forces and Sexual
Assault Services Commissioning

NHS England
PO Box 16738
B97 9PT

To: Chairs of Health and Wellbeing Boards

Sent via email

13th November 2018

Dear Chairs,

DATA AVAILABLE FOR SERVICE PLANNING FOR VETERANS AND THE DELIVERY OF THE ARMED FORCES COVENANT

We are proud of the courage and dedication of our armed forces and for the vast majority their experience of serving is positive and their life chances are enhanced. The Armed Forces Covenant reminds us it is our duty to ensure they continue to receive the very best possible support and care as veterans. Carrying this out effectively requires a solid foundation of data to inform strategic policy direction and needs assessment at both national and local levels.

Following the introduction of the Armed Forces Covenant, there has been a real national commitment to helping the armed forces community across the public, charitable and private sectors. This was endorsed during the Ministerial Covenant and Veterans Board in April 2018, and it was agreed government will commit to a joint approach to improving the data that its departments hold on UK Armed Forces veterans, to ensure we can offer the services they deserve.

The first step of this was for the Ministry of Defence to publish the veteran data from the 2011 England and Wales Census at local authority and clinical commissioning group (CCG) levels for the working age UK Armed Forces veteran population. The data was published at the beginning of October 2018, in time for planning for 2019/20 and can be found on gov.uk, searching for: *Census 2011: Working age UK armed forces veterans residing in England and Wales: index*.

Joint Strategic Needs Assessments (JSNAs) are essential for evaluating the needs of the local population when planning and commissioning health, well-being and social care services. The inclusion of addressing the health and social care needs of veterans within JSNAs was a commitment made in the Armed Forces Covenant and Health and Social Care Act 2012, so we are keen to ensure this is carried out to its full effect.

The level of data currently used is not sufficient to fully inform decisions and the "*Call to Mind report: A UK Wide review: Common issues in meeting the mental and related health needs of veterans and their families*", carried out by Forces in Mind Trust, found that there were significant gaps in the coverage of veterans' health needs in JSNAs.

We do not believe this is an isolated issue. Problems around the identification of veterans and the armed forces community can further impact on the ability to provide the required health and social care. Our joint effort is required to improve this, which is why are working with the Royal College of GPs (RCGP) to improve clinical awareness in primary care through the veteran friendly GP practice accreditation scheme, and in hospitals via NHS Improvement's Veterans Covenant Hospital Alliance, to accredit 'veteran aware' hospitals. We have also improved GP registration forms to capture more information to make it easier to identify veterans, reservists and armed forces families, and launched a range of online training modules on armed forces health, which can be found on *e-learning for Healthcare*.

It is also important how the data is used. There is a diverse population spread of veterans, so an aggregated collection of data will not work as effectively as when broken down to address the local issues. A number of services provided to

veterans are tailored to address their specific needs, and we believe a tailored approach is the most suitable in many cases.

It seems appropriate that plans should be reviewed in response to this improved level of data from the Census. We are therefore asking that Health and Wellbeing Boards play their part by working with local government to use the available data to maximum effect, and that this is cascaded to the relevant bodies. We ask that there is a refreshment of joint strategic needs assessment criteria, reflecting the recently updated alcohol, drugs and tobacco Commissioning Support Pack, to include this additional data; all of which should contribute to ensuring there is no disadvantage to veterans.

We understand and support the importance of local decision making and so think it should be up to each Board how this is put into practice, however, do believe input from service charities and CCGs will be vital. Best practice and learning should be shared across a wide range of stakeholders and as illustrated by the *"Our Covenant, Our Community"*; a joint report between Forces in Mind Trusts and the Local Government Association.

We look forward to seeing how your plans will ensure that this improved dataset is incorporated into JSNAs ready for 2019/20.

JACKIE DOYLE-PRICE **KATE DAVIES OBE**

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Sayyed Osman, Director of Adult Services, Neighbourhoods and Community Protection, BwD LA Roger Parr, Deputy Chief Executive/ Chief Finance Officer
DATE:	11th December 2018

SUBJECT: Better Care Fund Update

1. PURPOSE

The purpose of this report is to:

- Provide Health and Wellbeing Board (HWBB) members with an overview of Better Care Fund (BCF) performance reporting for Q2 2018/19
- Provide HWBB members with the BCF and iBCF Finance position at Q2 2018/19
- Provide HWBB members with feedback from the Local Learning Visit from the National BCF Team

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board members are recommended to:

- Note the BCF Q2 2018/19 finance position
- Note the BCF Q2 2018/19 performance metrics
- Note the feedback from the National BCF Team Local Learning Visit
- Note that due to the timing of the national returns and data reporting processes, the metrics described within this report relate to data from Q1 2018/19 and up to July 2018 of Q2.

3. BACKGROUND

As outlined in previous reports, the Health and Wellbeing Board is accountable for the delivery of the Better Care Fund plan. The management of the plan is undertaken through Blackburn with Darwen joint commissioning arrangements.

The Blackburn with Darwen BCF plan for 2017/19 was approved on the 30th of October 2017, with an expectation that planned performance metrics are achieved as described. Quarterly reports have been submitted as per the national schedule, demonstrating the progress made against each scheme. The Q2 return was submitted on 17th October 2018 following sign off by Councillor Brian Taylor. Due to the timing of the national returns and year end reporting processes, the metrics described within this report relate to data from Q1 2017/18 and up to July 2018 of Q2.

4. RATIONALE

As outlined within previous reports to the HWBB, the case for integrated care as an approach is well evidenced. Rising demand for services, coupled with the need to reduce public expenditure, provides a compelling argument for greater collaboration across health, care and the voluntary sector.

The Spending Review set out an ambitious plan such that by 2020, health and social care is integrated across the country. This is also reflected in the NHS Planning Guidance 2016/17-2020/21 Delivering the Forward View. The Better Care Fund remains a key policy driver to support integration of health and care services at a local level.

5. KEY ISSUES

5.1 BCF Pooled Budget 2018/19

The CCG minimum pooled budget requirement for 2018/19 is £11,381,000. The DCLG have confirmed the DFG capital allocation for 2018/19 at £1,739,476.

The 2018/19 allocations as above plus carry forward amounts from 2017/18 are analysed as:

- Spend on Social Care - £6,501,650 (48.0%)
- Spend on Health Care - £4,252,828 (31.4%)
- Spend on Integration - £2,191,698 (16.2%)
- Contingency - £600,000 (4.4%)

As previously reported, the BCF budget for 2018/19 has been reviewed following further joint planning across LA, CCG finance and social care leads and includes the following:

- Inflationary uplifts
- Capital allocation assigned to Integrated Neighbourhood Team estates
- The realignment of available monies to fund a reshaped Take Home and Settle service.
- Review of Commissioning Transformation Lead - Integrated Care post with a view to recruitment in Qtr 1 2018.
- The balance of BCF of £600,000, ordinarily held as a contingency, has been allocated to the LA in 2018/19 to meet social care demand and acuity pressures. Any further pressures or savings identified in year will be shared between the LA and CCG in accordance with the S75 agreement.

5.2 iBCF Pooled Fund 2018/19

Central Government consulted on the distribution of the Improved Better Care Fund as part of the Local Government Finance Settlement 2018/19. The spending review set out the expected available revenue for Local Government spending through to 2019/20 and the Core Spending Power information for Local Authorities has now been issued, including the proposed allocations of the Improved Better Care Fund.

Allocations in the Core Spending Power recognised that authorities have varying capacity to raise council tax (including that through the adult social care precept). Further allocations of the Improved Better Care Fund have been made following the Spring Budget. For Blackburn with Darwen the total allocations of Improved Better Care Fund are:

	Original iBCF	Additional iBCF for Social care – Spring Budget	Total
2017/18	£717,301	£3,589,451	£4,306,752
2018/19	£3,714,497	£2,186,064	£5,900,561
2019/20	£6,257,725	£1,081,454	£7,339,179

Allocations will be paid directly to Local Authorities as Section 31 grant and Local Authorities must meet the conditions set out in the grant determination as part of locally agreed plans. The grant must be spent on adult social care and used for the purposes of:

- meeting adult social care needs (£4.0m allocation)
- reducing pressures in the NHS – including supporting more people to be discharged from hospital in a timely way as a means to avoid Delayed Transfers of Care (DToC) (£635k allocation).
- stabilising the social care provider market (£1.265m allocation)

Local Authority Section 151 Officers are required to certify use of the grant and submit quarterly returns to the Secretary of State. Local Authorities must pool the grant funding into the local Better Care Fund and work with CCG's and providers in line with the Better Care Fund Policy Framework and Planning Requirements 2017-19.

5.3 BCF 2018/19 Performance Metrics
Due to the timing of the national returns and year end reporting processes, the metrics described within this report relate to data from Q1 of 2018/19 and up to July 2018.
The 9 month 2018/19 position will be reported to the HWBB at the end of Q4.

Reduction in non-elective admissions

There has been an increase in emergency admissions during 2018/19 due to the 'zero day admissions' and activity through the Respiratory Assessment Unit (RAU) and Ambulatory and Emergency Care Unit (AECU). Although emergency admissions with a length of stay of 1 day or more are lower this year to date than in 2017/18 (-1.8%). Work continues to address this by integrated working at a neighbourhood level across health, care and the voluntary sector supporting people to avoid hospital admission and remain independent at home. This was referenced as a risk in the 17/18 Q 4 report and was referenced as an area of support need in the 18/19 Q 2 submission which is also being reviewed locally.

Rate of permanent admissions to residential care

The 2018/19 target has been set at the same numerical target as the previous year which is 175 admissions (817.1 per 100,000 population). The Q1Health and Wellbeing report presented the most up to date position at the time of reporting which was a final Q4 position which showed an increase of 17 placements. Following review, a proportion of placements will become long term and will then be reflected in future figures.

Progress against targets for both Q1 and Q 2 show a slight increase in admissions to both residential and nursing care due to the increase in demand, for example for residents with dementia needs. The target is 44 admissions per quarter. The final position for Q1 data shows 52 admissions. The estimated position for Q2 data shows 46 admissions (to be finalised next quarter).

Reablement

The reablement target relates to the proportion of people (65 and over) who were still at home 91 days after discharge from hospital into Reablement and /or rehabilitation services. The 2018/19 target is set at 91.7%. Performance against the target is on track at 91.9%. The Reablement service continues to expand the reablement offer across all of our integrated pathways. This involves supporting residents with increasingly complex needs onto the rehab programme. This process presents a challenge around maintaining outcomes across a wider cohort of residents with increasingly complex needs.

Delayed Transfers of Care (DToC) (delay days in hospital)

Performance against target for Q2 2018/19 DToC is not on track which has lifted the total reported planned levels above plan. The increase is due to a delay in transfers of care days reported in July 2018 due to both NHS and social care delays. This measure is typically subject to fluctuations in response to hospital pressures however the positive trajectory reflects several schemes which have been agreed to support the reduction in DToC and which are continuing to progress as planned:

- The enhanced Home First service within BwD is now fully established and working well to support patients with more complex needs to return home from hospital at the earliest possible point in their recovery mobilised.

- An integrated discharge pathways leadership post has been successfully recruited to and inducted across all agencies. This post leads the current Integrated Discharge function across health and care within Pennine Lancashire.

- The Reablement and Intermediate Care pathways and services are well established and can be seen to positively impact on patient flow across Q4 17-18 and Q1 18-19.

- The Discharge to Assess pathway is established and operating as planned as a means to enable a longer period of recovery outside of the hospital environment and prior to the completion of necessary assessments.

Additionally, there is significant work at hospital level to clearly identify and apportion DToC in line with current guidance. A series of improvement meetings have been organised to understand and address the current increase in demand and delays.

5.4 BCF Local Learning Visit

Blackburn with Darwen has participated in a Local Learning visit from the National BCF Team on Tuesday 9th October 2018. The visit offered an excellent opportunity to showcase our integrated care developments and receive feedback/learning from other areas. During the day, the BCF Team were introduced to senior leaders from across the partnership to discuss wider impact and priorities moving forwards. They also met colleagues from our Home First Service and the Integrated Neighbourhood Teams to enable them to hear from our practitioners first hand and discuss the impact of our integrated care developments and outcomes. We also intend to provide an opportunity for the team to meet with senior leaders from across the partnership to discuss wider impact and priorities going forward.

We have received excellent feedback from the team who were impressed with the collaborative partnership approach locally. We have been asked to continue providing case studies of our work

on a regular basis. The team particularly noted that Blackburn with Darwen had a well establish strategic partnership and integrated strategy which was delivered effectively and that they found this approach very encouraging. A thank you message has been shared with staff involved with the visit for their time and effort on the day.

6. POLICY IMPLICATIONS

The key policy drivers are outlined within the main body of this report and within previous BCF papers presented to HWBB members. Local areas are expected to fulfil these requirements. Any further impact due to changes in National Policy or planning guidance will be reported as they arise.

7. FINANCIAL IMPLICATIONS

No further financial implications have been identified for quarter 3. This report outlines the budget position at November 2018.

8. LEGAL IMPLICATIONS

Legal implications associated with the Better Care Fund governance and delivery has been presented to Health and Wellbeing Board members in previous reports. A Section 75 agreement is in place between the Local Authority and CCG which outlines risk sharing arrangements associated with the Better Care Fund and other funding streams aligned to integrated delivery locally.

9. RESOURCE IMPLICATIONS

Resource implications relating to the Better Care Fund plan have been considered and reported to Health and Wellbeing Board members as part of the initial plan submission.

10. EQUALITY AND HEALTH IMPLICATIONS

Equality and health implications relating to the Better Care Fund plan were considered and reported to Health and Wellbeing Board members prior to submission of the plan.
Equality Impact Assessments are ongoing as part of the development of all BCF and integrated care schemes, including new business cases, and are integral to service transformation plans.

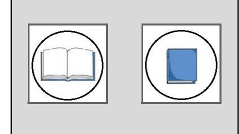
11. CONSULTATIONS

The details of engagement and consultation with service providers, patients, service users and the public have been reported to Health and Wellbeing Board members throughout development of the local BCF plan.

VERSION:	**2.0**

CONTACT OFFICER:	Samantha Wallace-Jones

DATE:	29th November 2018
BACKGROUND PAPER:	



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Dominic Harrison, Director of Public Health and Wellbeing
DATE:	11th December 2018

SUBJECT: Joint Strategic Needs Assessment (JSNA)

1. PURPOSE To ask the Health and Wellbeing Board to approve the recent Joint Strategic Needs Assessment [JSNA] Summary Review, and to inform it of plans for remaining JSNA work in the current year

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

- The Board is asked to approve the attached 2018 JSNA Summary Review as a key component of Blackburn with Darwen's Joint Strategic Needs Assessment;
- The Board is asked to grant permission for analysts to keep the web version of the JSNA Summary Review routinely updated as new data is released;
- The Board is asked to agree that the ISNA Leadership Group should have the delegated authority to approve additional self-standing chapters for inclusion in the JSNA, and to retire old material.

3. BACKGROUND

Department of Health (now DHSC) guidance[i] describes the central importance in the modernised health and care system of an enhanced Joint Strategic Needs Assessment (JSNA), which should consider all the current and future health and social care needs of the area to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area. Formal responsibility for preparing the JSNA rests with the Health and Wellbeing Board. The local authority and CCG should be guided by the JSNA when developing their Joint Health and Wellbeing Strategy.

The production of Blackburn with Darwen's JSNA is overseen by the Integrated Strategic Needs Assessment Leadership Group. We have recently reverted to using the standard term 'JSNA' when referring to the statutory exercise, as mandated by DHSC. However, the group continues to be known as the 'ISNA Leadership Group' to reflect the fact that its interests are wider than the JSNA alone.

4. RATIONALE

Subject to approval by the Health and Wellbeing Board, the attached JSNA Summary Review will be the main component of Blackburn with Darwen's JSNA in 2018/19. It begins with a profile of the borough's population and local economy ('Setting the Scene'), and is then arranged under the same three themes as the borough's Joint Health and Wellbeing Strategy: 'Start Well', 'Live Well' and 'Age Well'.

It is also proposed to resume the production of dedicated, self-standing JSNA chapters on individual topics of particular importance. There is capacity to complete two such chapters during

2018/19, and work is well under way on the first one, on the subject of Alcohol. The ISNA Leadership Group will consider the choice of topic for the second chapter at its December meeting.

5. KEY ISSUES

- As soon as each year's JSNA Summary Review is completed, new data starts to come out which renders it out of date. However, it has never proved feasible to keep editing the pdf document throughout the year.
- This time, a web-based version has also been created (https://bwd-ph.github.io/jsnabook/). It is hoped that it will be easier to update at least some of the content on this version as and when new data is released.
- Once approved by the Health and Wellbeing Board, both versions of the Summary Review will be made available via the Council's corporate website.
- It is intended that the JSNA will also ultimately be accessible via a new analytical website, which is being constructed under the guidance of the ISNA Leadership Group.

6. POLICY IMPLICATIONS

The new JSNA Summary Review forms a major component of the borough's Joint Strategic Needs Assessment (JSNA). The JSNA is a key input to the Joint Health and Wellbeing Strategy, and helps to inform a wide range of commissioning decisions.

7. FINANCIAL IMPLICATIONS

There are no direct financial implications arising from this paper.

8. LEGAL IMPLICATIONS

There are no direct legal implications arising from this paper. Under the Health and Social Care Act 2012, local authorities and clinical commissioning groups (CCGs) are jointly responsible for preparing a JSNA, through the Health and Wellbeing Board.

9. RESOURCE IMPLICATIONS

There are no direct resource implications arising from this paper.

10. EQUALITY AND HEALTH IMPLICATIONS

There are no direct equality and health implications arising from this paper.

11. CONSULTATIONS

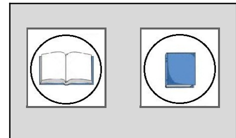
The development of the JSNA Summary Review has been overseen by the ISNA Leadership Group, which is a partnership organisation with representation from council departments, Blackburn with Darwen CCG, Blackburn College and the third sector.

The contents of the Summary Review also draw upon consultation exercises carried out by a range of bodies, such as One Voice Blackburn and Healthwatch Blackburn with Darwen.

VERSION:	**1.1**

CONTACT OFFICER:	Anne Cunningham
DATE:	29th November 2018

BACKGROUND PAPER:	JSNA Summary Review pdf version (provided separately) Also equivalent website at https://bwd-ph.github.io/jsnabook/



[i] DH (2013). *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*. Available from https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/18/files/2013/03/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

Joint Strategic Needs Assessment

Summary Review 2018

INTRODUCTION

Department of Health guidance[1] describes the central importance in the modernised health and care system of an enhanced Joint Strategic Needs Assessment (JSNA), which should consider all the current and future health and social care needs of the area. The local authority and CCG should be guided by the JSNA when developing their Joint Health and Wellbeing Strategy.

This document presents many of the key messages from Blackburn with Darwen's JSNA. It begins with a profile of the borough's population and local economy ('Setting the Scene'), and is then arranged under the same three themes as the borough's Joint Health and Wellbeing Strategy itself: 'Start Well', 'Live Well' and 'Age Well'.

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IF YOU HAVE ANY QUERIES OR COMMENTS, PLEASE CONTACT ANNE CUNNINGHAM, PUBLIC HEALTH INTELLIGENCE SPECIALIST: (anne.cunningham@blackburn.gov.uk)

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SETTING THE SCENE

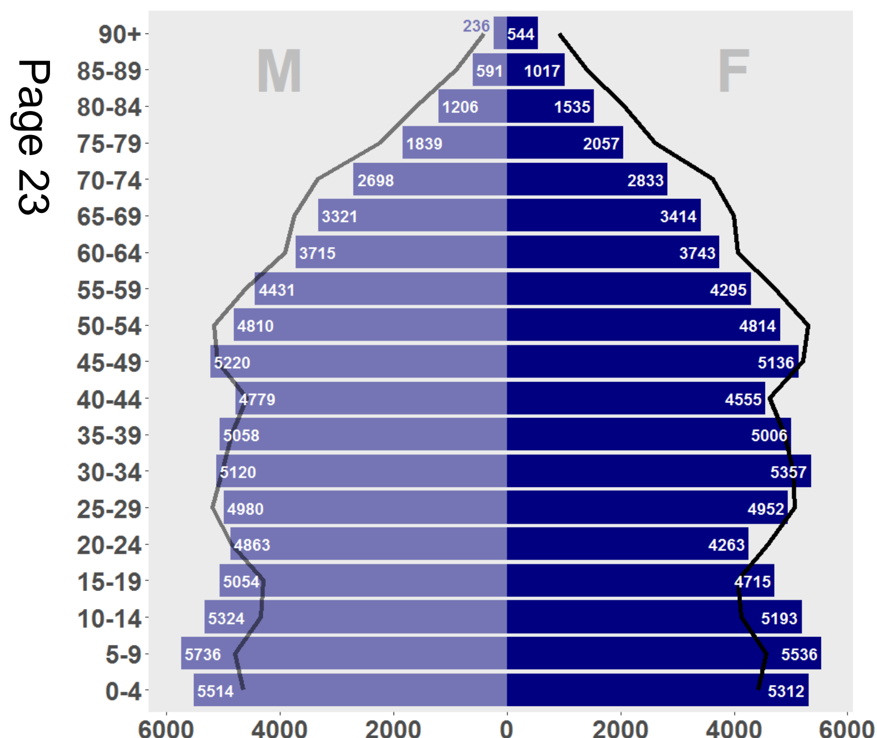
POPULATION

POPULATION ESTIMATES AND PROJECTIONS

Mid-2017 estimate[2]

The latest ONS population estimates are for mid-2017, and show that Blackburn with Darwen had a total of 148,772 residents (an increase of 310 since mid-2016). In Figure 1 below, the England age structure is superimposed for comparison. This illustrates that Blackburn with Darwen has a much younger age profile than average. 28.5% of its population is aged under 20, which is the 6th highest proportion in England.

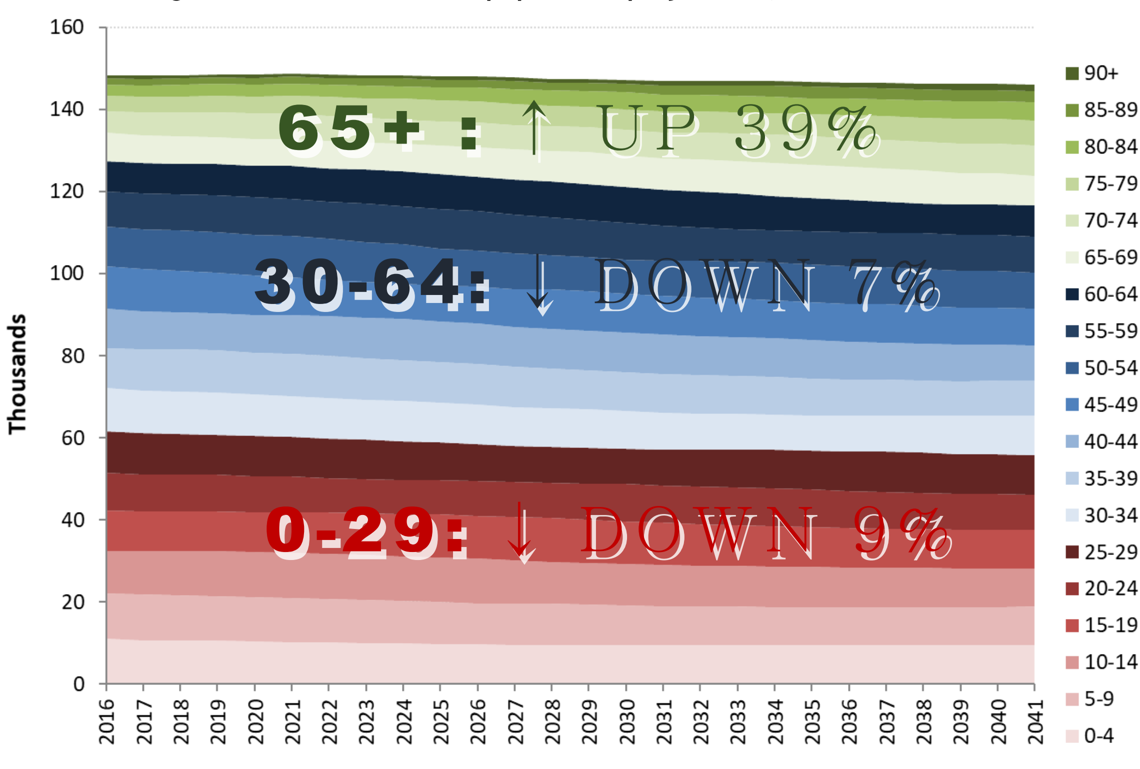
Figure 1 - ONS mid-2017 population estimate for Blackburn with Darwen (with England profile for comparison)



Population projections[3]

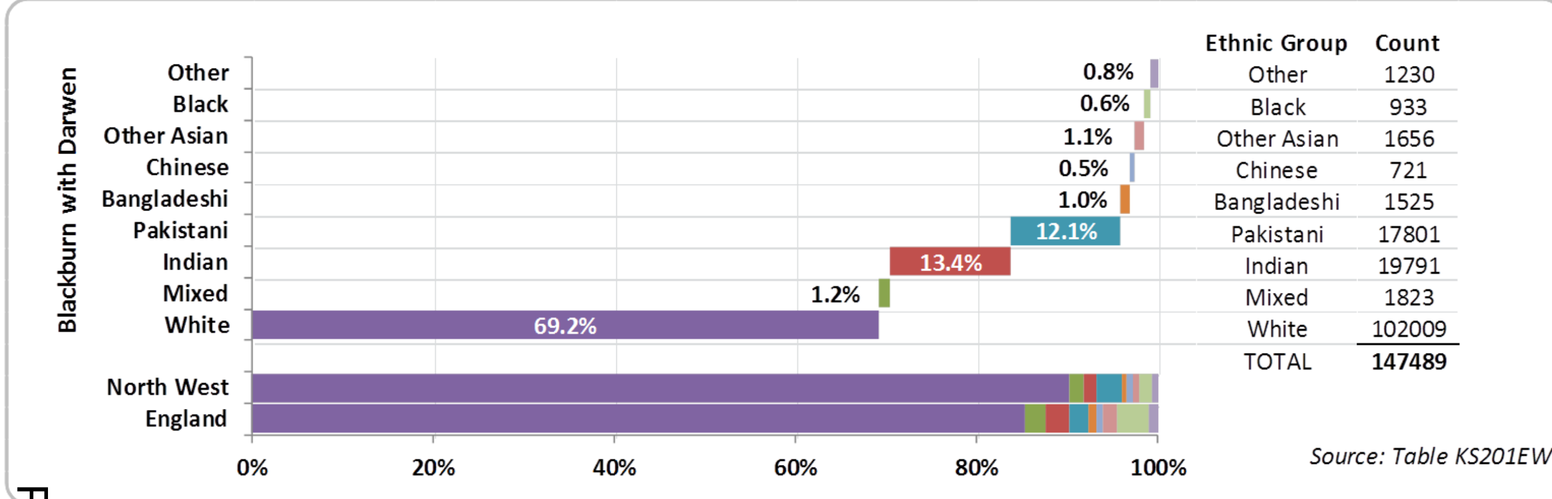
The latest population projections from ONS are still based on the population estimates for mid-2016, and look ahead to 2041. For Blackburn with Darwen overall, they predict a slow, almost imperceptible fall in population (Figure 2). However, the 65+ age-group (shown in green) is expected to rise by approximately 8,300 over the period - ie. by almost 40%. The 85+ group in particular is projected to rise by over 80%, from approximately 2400 to 4400.

Figure 2 - 2016-based ONS population projections, Blackburn with Darwen



2011 CENSUS DATA

Ethnicity



Ethnic Group	Count
Other	1230
Black	933
Other Asian	1656
Chinese	721
Bangladeshi	1525
Pakistani	17801
Indian	19791
Mixed	1823
White	102009
TOTAL	**147489**

The 2011 Census is still our best source of data on the ethnic breakdown of the borough's population, and the relationship between ethnic group and other social characteristics. The proportion of Blackburn with Darwen residents who described themselves as Indian or Pakistani are the 11th highest and the 6th highest respectively of any local authority in England.

Figure 3 - Ethnicity: Blackburn with Darwen v. NW and England, 2011 (showing counts for Blackburn with Darwen)

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The main ethnic groups have markedly different age profiles from each other (Figure 4), and are represented in varying concentrations across the borough (Figure 5).

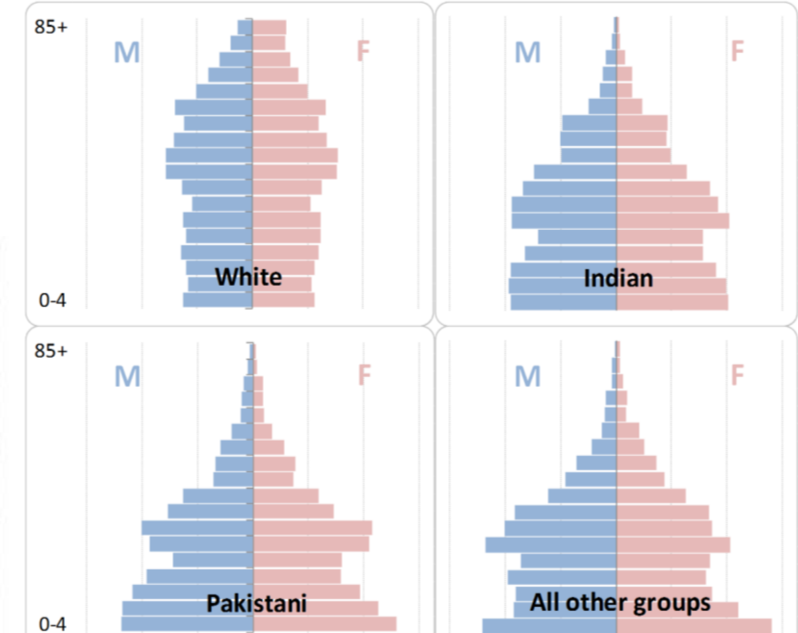
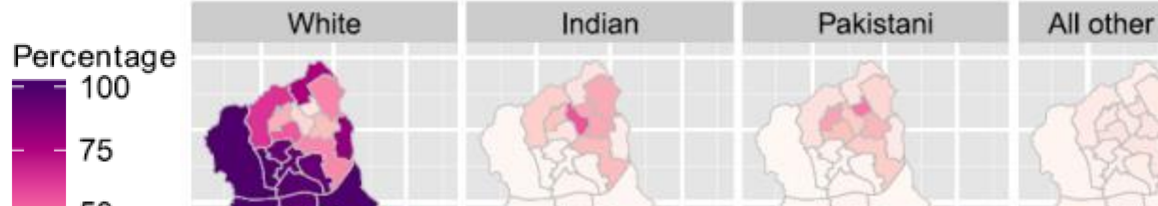
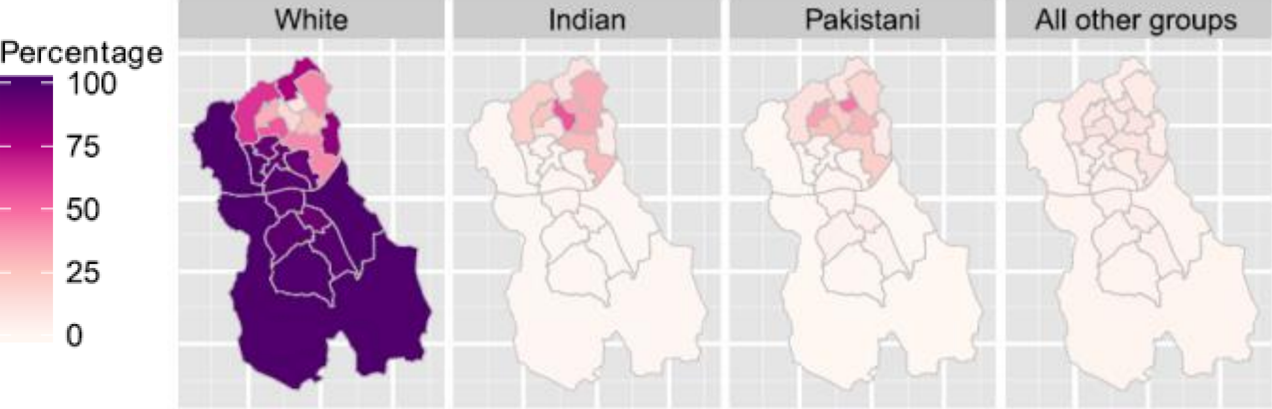


Figure 4 - Age profiles by ethnic group, Blackburn with Darwen, 2011

Figure 5 - Blackburn with Darwen - ethnicity by ward

Religion

At the 2011 Census, 77,599 Blackburn with Darwen residents (52.6%) identified themselves as Christian, and 39,817 (27.0%) as Muslim. 13.8% had no religion, and 5.6% did not answer the question. Religion and ethnicity are closely interlinked, with the vast majority of Christians in the borough being White, and almost all Muslims being Indian, Pakistani or members of other minority ethnic groups (Figure 6).

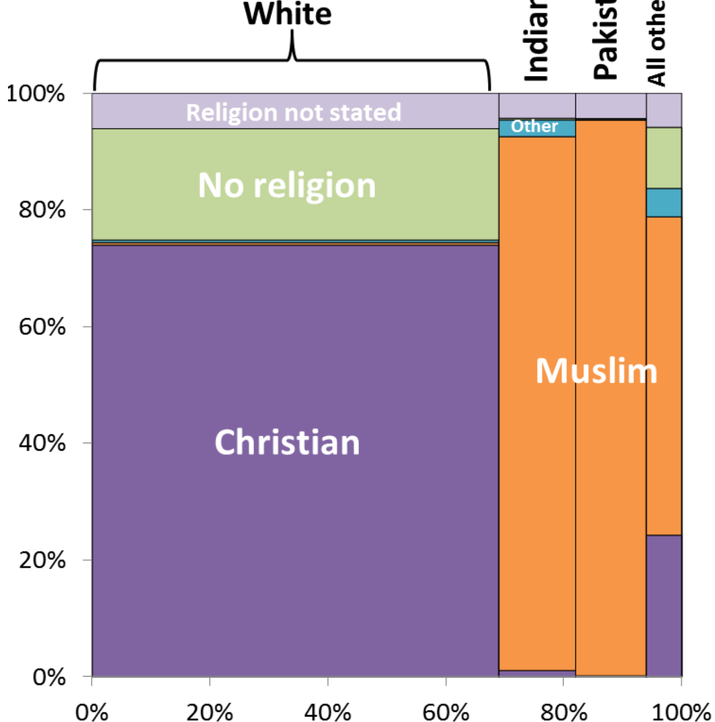


Figure 6 - relationship between ethnicity and religion in Blackburn with Darwen

Language

For the first time, the 2011 Census asked about the 'main language' of everybody aged 3 or above. Over 86% of Blackburn with Darwen residents had English as their main language, but a multitude of other languages were also represented:

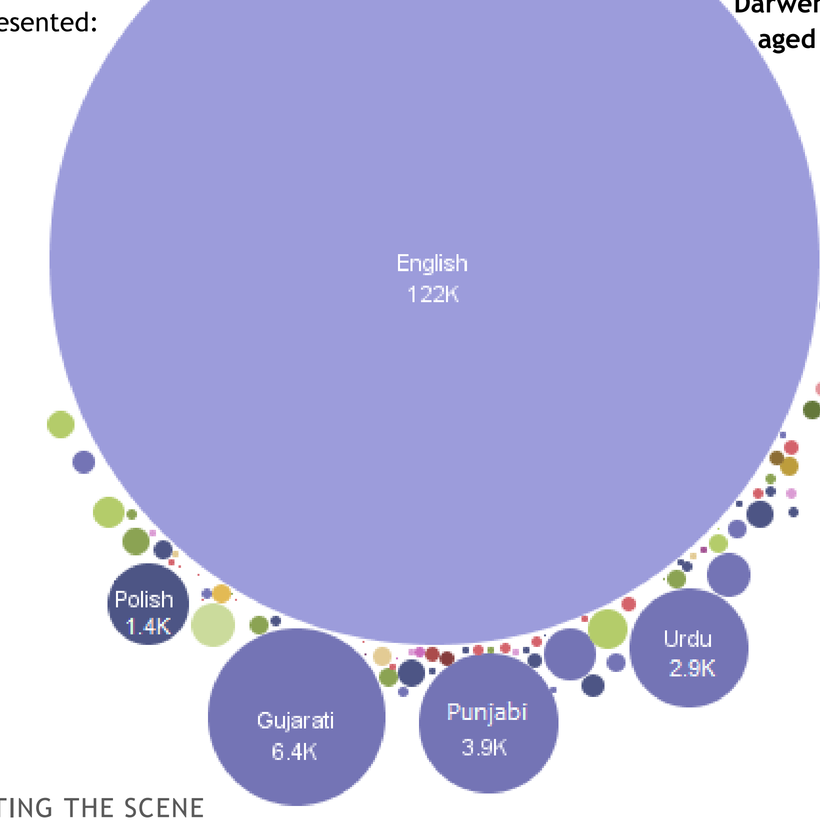


Figure 7 - Main language of Blackburn with Darwen residents aged 3+

Out of 57,353 households in Blackburn with Darwen, there were just over 4,000 where *nobody* had English as their main language, and just over 800 more where only children did:

Figure 8 - Main language by household

48,183 Households where all aged 16+ have English as main language

4,299 – Households where some but not all aged 16+ have English as main language

808 – Households where only child(ren) under 16 have English as main language

4,063 – Households where nobody has English as main language

However, it is important to appreciate that many of those with a main language other than English nevertheless speak English 'well' or 'very well'. Only 973 people in the borough could not speak it at all.

DEPRIVATION

The 2015 Index of Mutiple Deprivation[4] is still in use in 2018 (but expected to be replaced in Summer 2019). It is based on 37 indicators, mostly dating from around 2012/13.

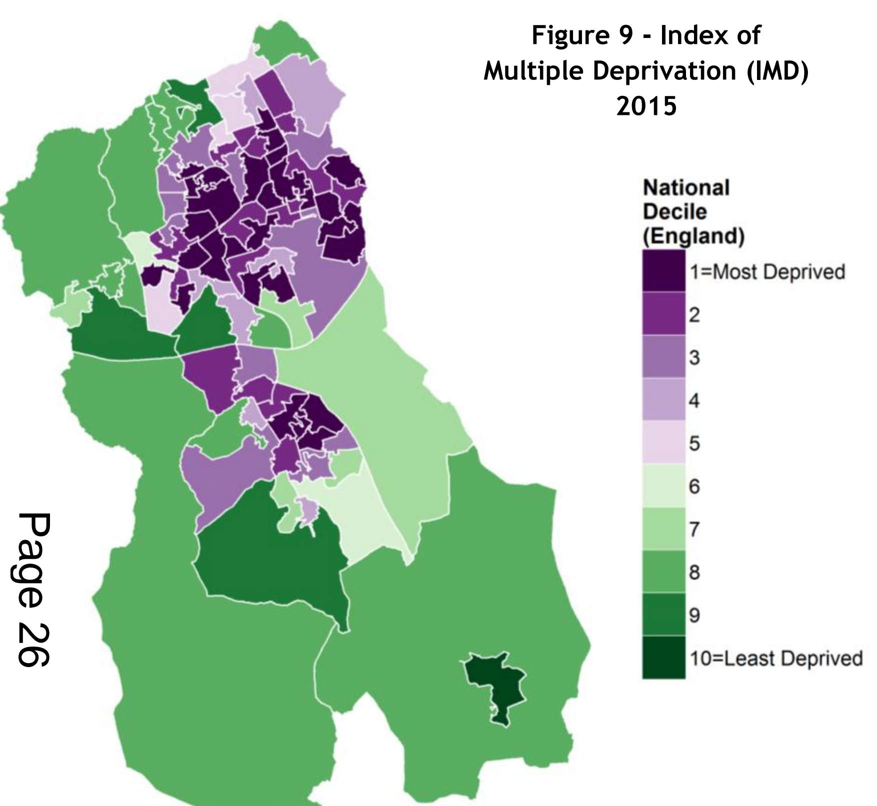


Figure 9 - Index of Multiple Deprivation (IMD) 2015

Deprivation at the Lower Super Output Area (LSOA) level

The Index of Multiple Deprivation (IMD) is calculated for small neighbourhoods known as Lower Super Output Areas (LSOAs). Figure 9 shows IMD 2015 mapped for Blackburn with Darwen's 91 LSOAs. Nearly half (45 out of 91, or 49%) of the Borough's LSOAs are in the worst two national deciles. By definition, each national decile accounts for 10% of all the LSOAs in England, so Blackburn with Darwen has well over its 'fair share' of deprived LSOAs.

Deprivation at the Borough level

There are various ways of summarising deprivation at the borough level. For example, the 'Rank of Average Score' method ranks authorities according to the average IMD score of their LSOAs. On that basis, Blackburn with Darwen ranks as 15th most deprived in 2015.

However, the summary indicator which is now most widely quoted is the proportion of LSOAs in the borough falling within the 10% most deprived in England (i.e. in National Decile 1). In Blackburn with Darwen, that proportion was 31% in 2015, which makes it the 12th most deprived borough.

DESTITUTION

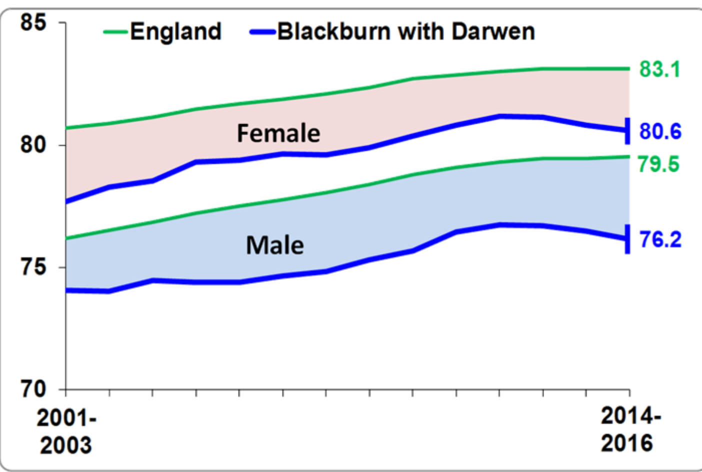
'Destitution' is a strong word, but the Joseph Rowntree Foundation estimates that over 1.5 million people in the UK were affected in this way at some point during 2017. It defines 'destitution' as being on an extremely low income, and/or unable to afford two or more of the listed essentials over the past month:[5]

- **Shelter** (had slept rough for 1+ nights)
- **Food** (have had < 2 meals a day for 2+ days)
- **Heating** (have been unable to heat their home for 5+ days)
- **Lighting** (have been unable to light their home for 5+ days)
- **Clothing and footwear** (appropriate for weather)
- **Basic toiletries** (soap, shampoo, toothpaste, toothbrush)

A survey of crisis service users in various parts of the country was used to produce modelled estimates for every local authority. Authorities are ranked on their estimated destitution levels for each of three separate sub-populations ('migrants', 'complex needs' and 'other'), and for all three groups put together. Blackburn with Darwen is in the most severe decile of destitution for two out of the three individual sub-populations. It just escapes being in the top decile for destitution overall, but only by one place.[6]

Sub-population	Definition	Destitution Decile (Blackburn with Darwen)
migrants	anyone born outside of the UK (who did not have complex needs)	4th most severe decile
complex needs	anyone who reported experience of two or more of: homelessness, substance misuse, offending, domestic violence or begging	Most severe decile
other	respondents not falling into the preceding two groups	Most severe decile
OVERALL	**all three groups combined**	2nd most severe decile

Figure 10 - Life expectancy in England and Blackburn with Darwen, 2001-03 to 2014-16



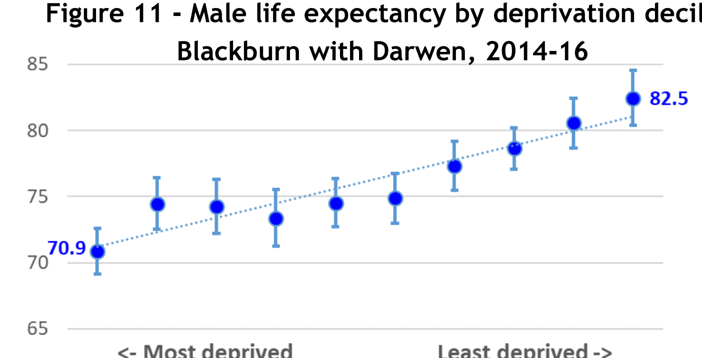
LIFE EXPECTANCY

Life expectancy in Blackburn with Darwen not only lags behind England (see shaded areas in Figure 10), but has plateaued in recent years, and shows some signs of actually starting to fall (though this decline is not statistically significant). In 2014-16, the borough had the 5th lowest life expectancy in England for males, and the 9th equal lowest for females, out of 324 lower-tier local authorities.

Even at a national level (green lines in Figure 10), the rate of improvement in life expectancy is much slower than it was. These trends are attracting increasing amounts of attention and comment, including an acknowledgement by ONS of their statistical significance, and an undertaking to investigate further.[7,8]

There is also striking inequality in life expectancy *within* Blackburn with Darwen. To illustrate this, Public Health England has ranked the borough's LSOAs by IMD score, divided them into ten equal groups ('deciles') of deprivation, and calculated the life expectancy for each.[9] As Figure 11 shows. the difference between the most and least deprived tenths of the borough was 11.6 years for males in 2014-16. For females, it was 8.4 years.

Figure 11 - Male life expectancy by deprivation decile Blackburn with Darwen, 2014-16

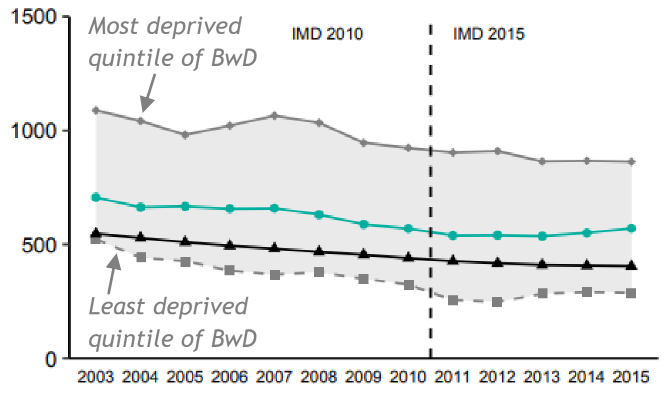


PREMATURE MORTALITY

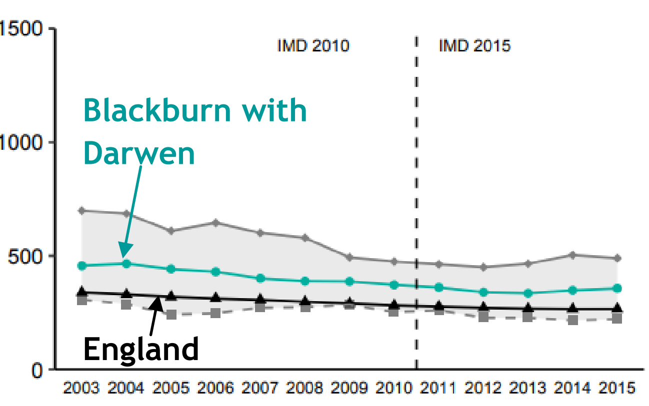
The inequalities between more and less deprived parts of the borough are also illustrated in the 2018 Health Profile for Blackburn with Darwen.[10] The gap in premature death rates is particularly stark for men:

Figure 12 - Premature mortality (under 75) for Blackburn with Darwen, England, & most/least deprived quintiles of Blackburn with Darwen for (a) males and (b) females

Source: PHE



(a) MALES



(b) FEMALES

[Directly Age Standardised Rate per 100,000. Rates are for three years pooled – e.g. '2015' is actually '2014-16']

LOCAL ECONOMY

Any analysis of health and social care needs would be incomplete without a quick introduction to the local economy, not only because it helps to set the context, but also because the economy is a major determinant of health.

Figure 13 - Relationship between employment rate and lack of qualifications *'Primary Urban Areas' in England. Source: Centre for Cities*

SKILLS

In 2017, there were estimated to be 11,000 people aged 16-64 in Blackburn with Darwen with no qualifications, or 12.1% of the working-age population (England 7.6%).[11] Clearly such a high rate (ranking 21st among upper-tier authorities) is undesirable. Data from the Centre for Cities provides a stark illustration of the relationship between lack of qualifications and the employment rate (Figure 13).[12]

At the other end of the spectrum, 21.4% of people aged 16-64 in Blackburn with Darwen had a degree or equivalent in 2017. This is still well below average (England 31.1%), but it continues a gradually improving trend, and means that the borough is on the verge of leaving the bottom quintile of local authorities.[12]

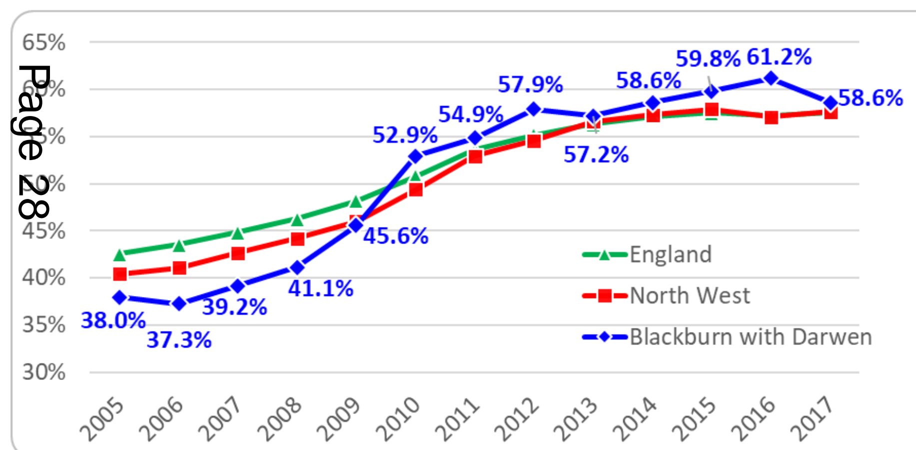
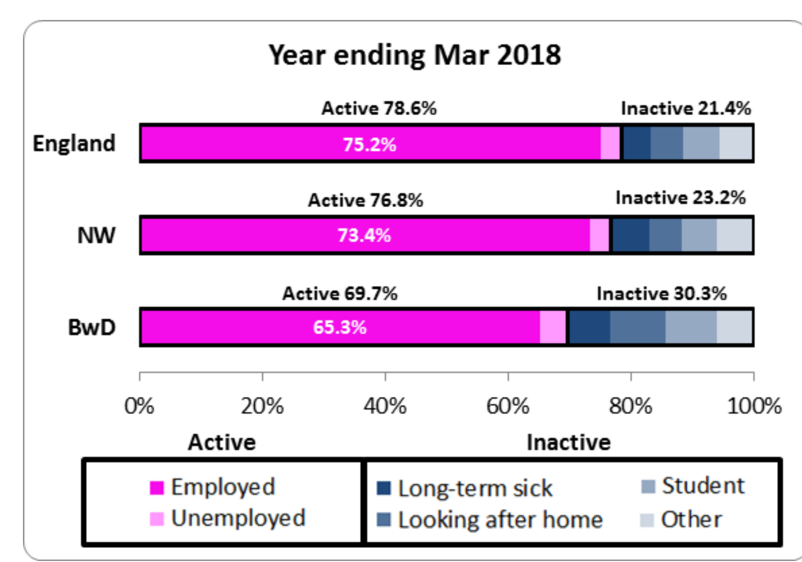


Figure 14 - Level 3 qualification at age 19[13]

The proportion of the borough's 19-year-olds qualified to Level 3 (i.e. two A-levels or equivalent) has also shown steady improvement over the years (Figure 14)[13]

Figure 15 - Economic activity and inactivity & employment rate (age 16-64, year ending March 2018)[12]



ECONOMIC ACTIVITY

As seen in Figure 15, an estimated 65.3% of the borough's residents aged 16-64 are employed. This is the 9th lowest rate out of 150 upper tier local authorities (not including the City of London and Scilly Isles).

Together with those who are officially unemployed (i.e. actively seeking work and available to start), it means that only 69.7% are 'economic active', which is the 2nd lowest rate in England (again not including the City of London or Scilly Isles).

LOOKING FOR WORK

Unemployment

Strictly speaking, unemployment is defined by whether people are actively seeking work and available to start, rather than by any benefits they may be claiming. This can only be ascertained from a sample survey, so the estimates for an area such as Blackburn with Darwen are subject to large confidence intervals (Figure 16). The latest results (for April 2017 – March 2018) suggest that there are approximately 4000 unemployed people of working age in Blackburn with Darwen. It is conventional to express this as a percentage of the *economically active* population, which gives a rate of 6.3%.

Figure 16 - Unemployment rate (age 16-64), Blackburn with Darwen, North West and England ***(showing 95% confidence intervals for BwD)***[12]

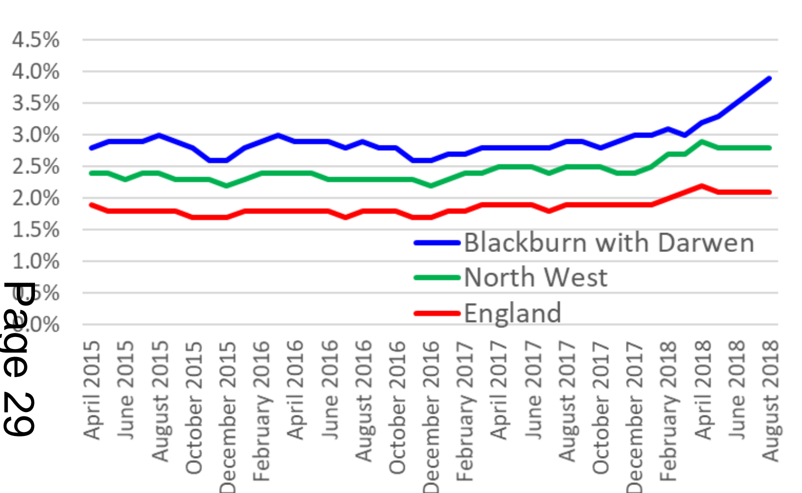


Figure 17 - Claimant Count as a % of residents aged 16-64[12]

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Claimant Count

It is obvious from Figure 16 that it would be useful to have a proxy for the official unemployment count, which does not depend on a survey. For many years, that need was met by the Claimant Count. Since the introduction of Universal Credit, however, things have not been quite so simple.

The Claimant Count now consists of the (diminishing) number of people still on Job Seekers Allowance, plus those claiming Universal Credit *who are required to seek work*.[14] It is available on this basis going back to April 2015 (Figure 17). The latest Claimant Count total for the borough (in August 2018) was 3575. As a percentage of the working-age population (*not* just the economically active), this gives a rate of 3.9%.

IMPACT OF UNIVERSAL CREDIT 'FULL SERVICE'

However, **Figure 17 must be interpreted with caution**. As Universal Credit is rolled out, the rules about who is required to seek work in order to receive benefit keep changing. This makes it difficult to interpret trends in the Claimant Count, and has led ONS to demote it to an 'Experimental Statistic'.

Judging by Figure 17, it might be thought that the Blackburn with Darwen economy has taken a turn for the worse since February 2018. However, that is not necessarily the case, because in February 2018, the borough became a '**Full Service**' area for Universal Credit.* More people are required to seek work under Universal Credit than under the legacy benefits that it replaces, so the recent sharp rise in the Claimant Count may well reflect the fact that the 'goalposts' have moved. A similar sharp rise was seen in areas which moved to Full Service last year (2017).[14]

CLAIMANT COUNT ACROSS THE BOROUGH

The fact that it is difficult to interpret the *trend* in the Claimant Count does not prevent us from looking at how it varies *across the Borough* at a snapshot in time. Figure 18 shows how the rate as at August 2018 ranged from 0.3% in North Turton with Tockholes, to 8.2% in Wensley Fold.

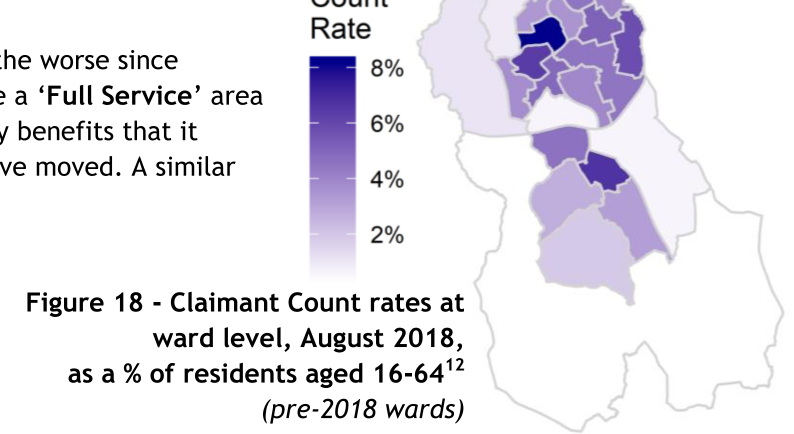
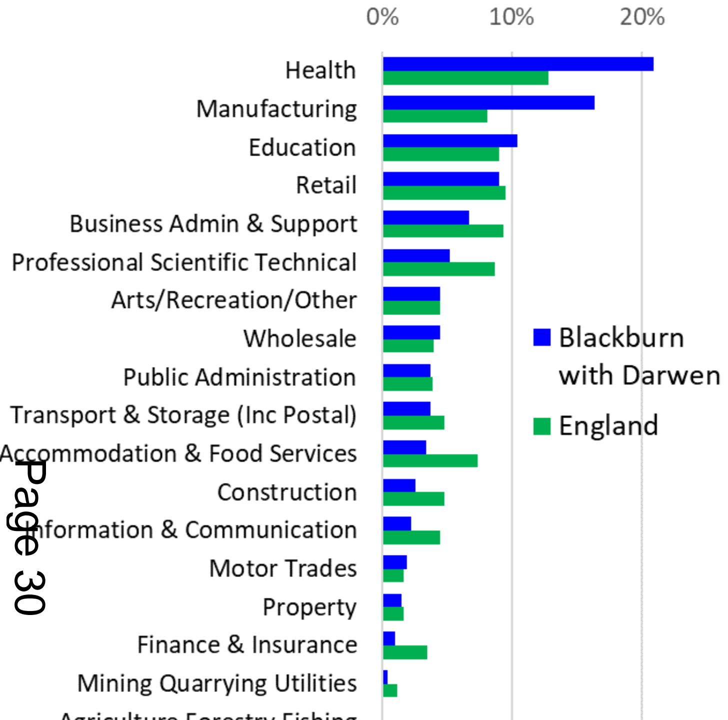


Figure 18 - Claimant Count rates at ward level, August 2018, as a % of residents aged 16-64[12]
(pre-2018 wards)

* *'Full Service' means that Universal Credit is available to all types of new claimants, rather than being restricted (as before) to those whose claims are relatively simple.*

Figure 19 - Employees by sector - Blackburn with Darwen compared with England (2017)

Source: BRES data from NOMIS[12]



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EMPLOYMENT BY SECTOR

Both locally and nationally, the biggest sector for employment is Health (Figure 19). Health, Education and Public Admininstration together account for just over a third of Blackburn with Darwen employees, compared with a national average of just over a quarter. 16.4% of employees in Blackburn with Darwen work in Manufacturing, which is more than twice the England average of 8.1%.

PRODUCTIVITY

Productivity describes the ability to produce outputs from a given amount of inputs such as labour. Economic output can only be increased by raising the amount of inputs (e.g. employees) or by raising their productivity, so productivity is vital to improving standards of living.[15]

The preferred sub-regional measure of productivity is Gross Value Added (GVA) per hour worked. On this basis, Blackburn with Darwen has the 12th lowest productivity out of 168 'NUTS 3' areas in the UK (Figure 20), at 77.6% of the UK average.[15]

Figure 20 - Productivity (GVA per hour worked) - 20 lowest ranking NUTS3 areas, relative to UK (2016)

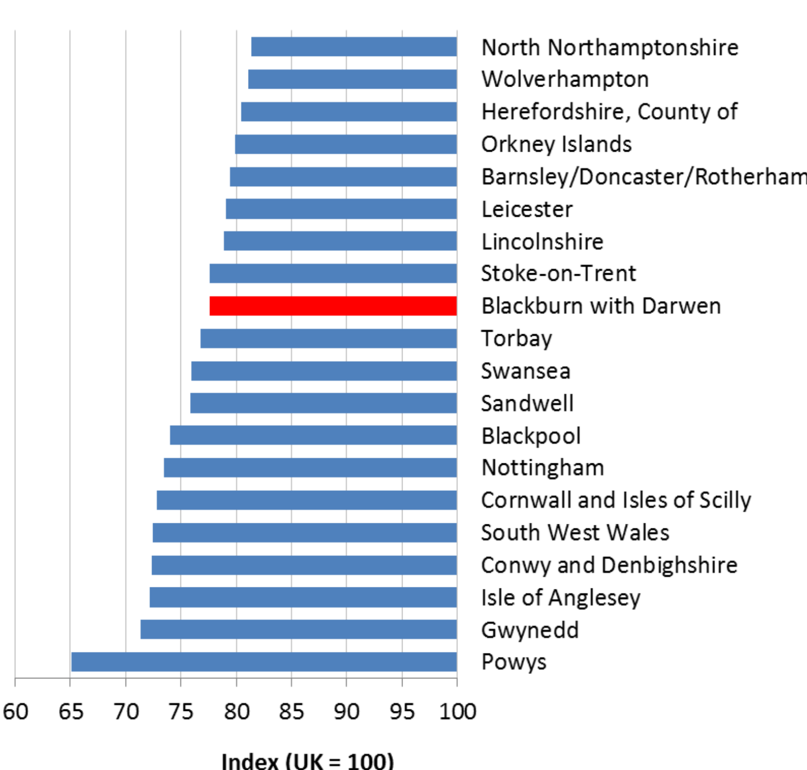
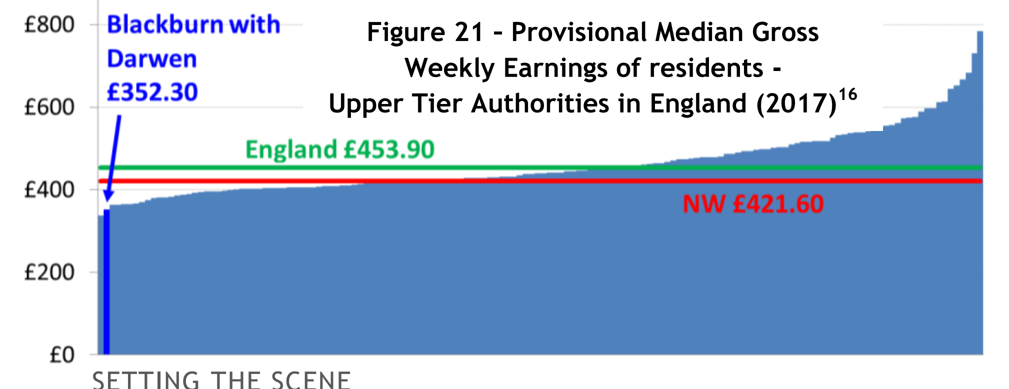


Figure 21 - Provisional Median Gross Weekly Earnings of residents - Upper Tier Authorities in England (2017)[16]



EARNINGS

Provisional median gross weekly earnings for Blackburn with Darwen residents in 2017 were £352.30. This puts Blackburn with Darwen second lowest (after Blackpool), out of 150 upper-tier authorities in England (Figure 21).[16]

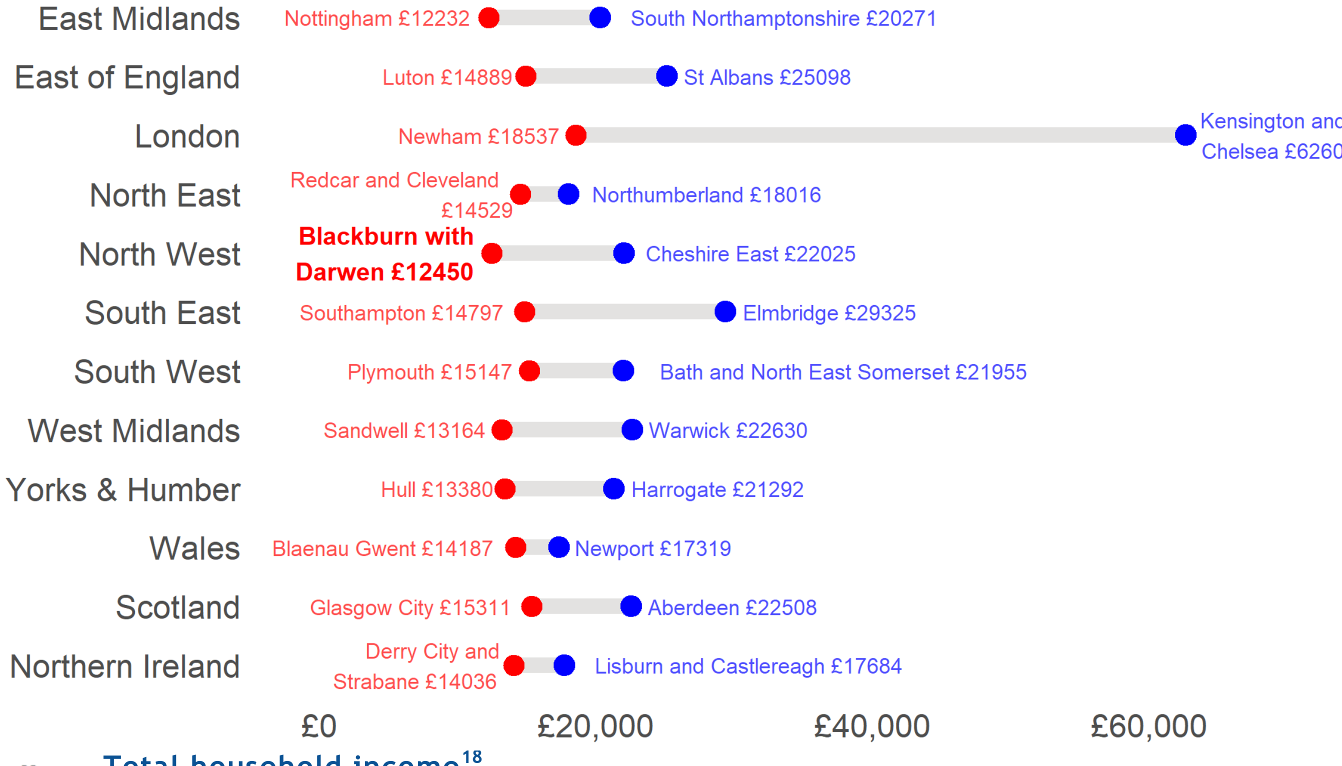
HOUSEHOLD INCOME

Gross Disposable Household Income

Gross Disposable Household Income (GDHI) is the amount of money that individuals in households have available for spending after taxes and benefits. Provisional estimates for 2016 are now available by local authority.[17]

The Blackburn with Darwen average of £12,450 per head is the 2nd lowest in the UK (after Nottingham), and the lowest in the North West. It compares with an England average of £19,878. Blackburn with Darwen has consistently been in 2nd or 3rd lowest place for the past six years.

Figure 22 - Gross Disposable Household Income per head (2016, provisional): lowest and highest local authority per region



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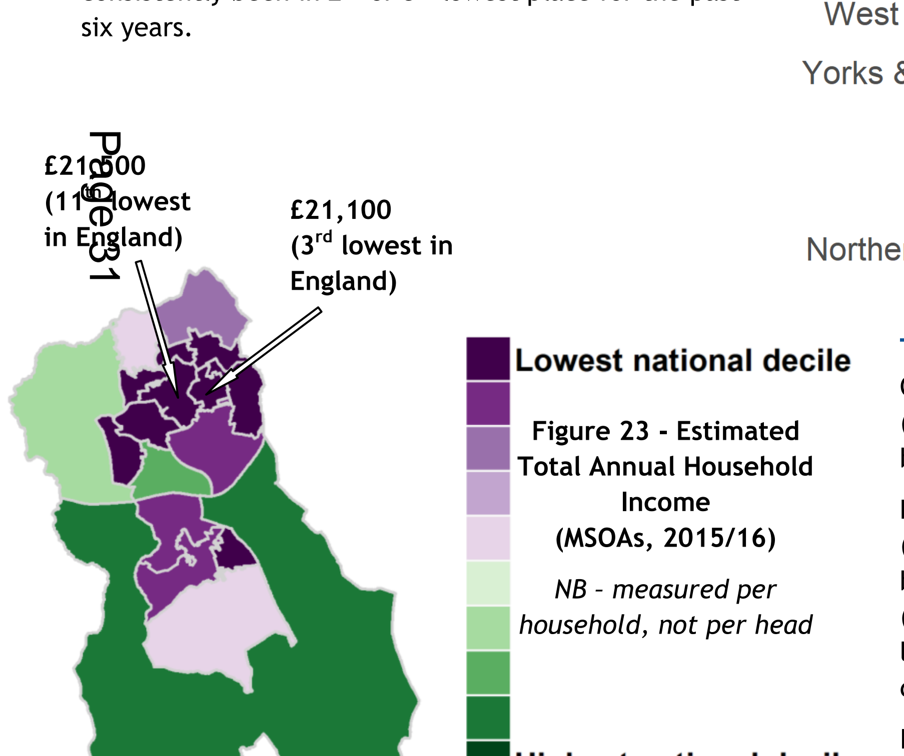

Figure 23 - Estimated Total Annual Household Income (MSOAs, 2015/16)

NB - measured per household, not per head

Total household income[18]

ONS also issues various modelled estimates of household income at the smaller Middle Super Output Area (MSOA) level. Figure 23 shows a map of how Total Annual Household Income (before tax) varies across the borough.

Half of Blackburn with Darwen's 18 MSOAs are in the bottom national decile for household income (darkest purple), with estimated average incomes ranging from £20,100 to £29,100. Eight of them form a broad swathe across Blackburn. The lowest of all is in Audley, and this MSOA ranks third lowest in England (out of 6791). The next lowest MSOA in Blackburn with Darwen, covering the town centre area, ranks 11th lowest in England. By contrast, Blackburn with Darwen also has one MSOA in the second-highest national decile (dark green), with an estimated average of £51,500.

It is stressed that these are only estimates, with a wide degree of uncertainty around them.

SAFE AND HEALTHY HOMES AND NEIGHBOURHOODS

HOUSING

"THE PRIVATE-RENTED SECTOR IN THE UK IS GROWING AND HAS WORSE HOUSING CONDITIONS THAN ANY OTHER SECTOR."

Parliamentary Office of Science & Technology[19]

Private Rented Sector

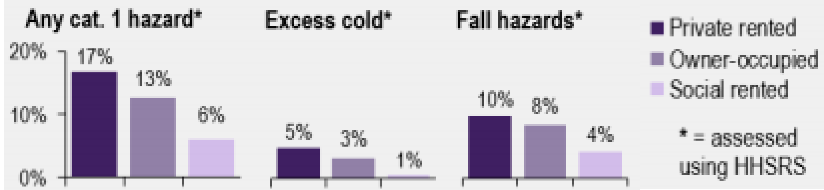

Figure 24 - National findings from the English Housing Survey (2015)[19]
('HHSRS' = Housing Health and Safety Rating System)

HOUSING CONDITIONS

Evidence from the English Housing Survey shows that the private rented sector nationally has the highest rate of serious ('Category 1') hazards, including excess cold and risk of falls (Figure 24).[19] Private rented housing was also the most likely to be old, to be non-decent (a broader classification, including problems of disrepair and ageing facilities), and to be suffering from damp.[19,20]

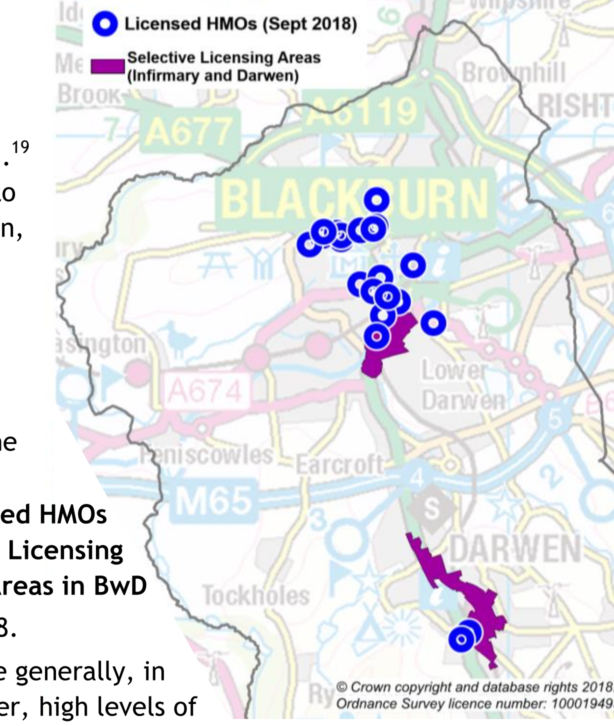

Figure 25 - Licensed HMOs & Selective Licensing Areas in BwD

LOCAL MARKET

Modelled estimates (which ONS stress are *not* official statistics) suggest that Blackburn with Darwen had approximately 8500 privately rented houses in 2012, and 1000 more by 2015.[21] Data from the Valuation Office Agency shows that median private-sector rents in Blackburn with Darwen (and in Burnley, Pendle and Hyndburn) in the year to March 2018 were in the bottom 15 nationally, and the rental for a non-self-contained room in Blackburn with Darwen was the lowest in the NW.[22]

REGULATION

Multi-tenanted 'Houses in Multiple Occupation' (HMOs) often house some of the most vulnerable people in society. Since 2004, large HMOs of three storeys or more have had to be licensed (Figure 25). New legislation means that many more HMOs will require to be licensed from October 2018.

Councils can also impose a selective licensing scheme for private rented housing more generally, in areas of low demand. Such areas may be suffering from problems such as high turnover, high levels of disrepair, and anti-social behaviour. Blackburn with Darwen currently has two such schemes, one in Darwen and one in the Infirmary area of Blackburn (Figure 25), and finds them to be an effective tool for driving up housing standards and reversing neighbourhood decline.[23,24]

Cold housing and fuel poverty

As well as being a major contributor to excess winter deaths, cold housing adds to the burden of circulatory and respiratory disease, colds and flu, exacerbates chronic conditions such as rheumatism and arthritis, and has a negative effect upon mental health across all age-groups.[25]

An estimated 8554 households in Blackburn with Darwen were classed as being in 'fuel poverty' in 2016. These are only modelled estimates, but they seem to be going up rather than down (from 8162 in 2015, and 7232 in 2014). At 14.4% of households (compared with 11.1% for England as a whole, and 12.8% for the NW), Blackburn with Darwen ranks 21st highest out of 326 districts in England.[26,27]

A Government target aims to raise as many fuel-poor homes as possible to energy efficiency Band C by 2030, but research by the IPPR think-tank suggests that this will be missed by more than half a century.[28] Blackburn with Darwen does its best to promote energy efficiency and available grants via initiatives such as its 'Heat and Eat' events.[29]

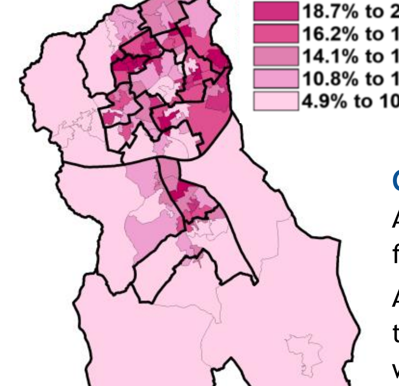

Figure 26 - % Households in Fuel Poverty, 2016 (modelled estimates)
Lower Super Output Areas overlaid with new (2018) Wards

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CRIME AND VIOLENCE

Crime and antisocial behaviour

Data about the type and whereabouts of every recorded incident of crime or antisocial behaviour is available from http://data.police.uk/. In Figure 27, the darkest pink shading denotes the areas with the greatest number of incidents in the year to December 2017.*

Figure 27 - Locations of recorded Crime and Antisocial Behaviour (January-December 2017)

Only includes crimes with a recorded type and location, and hexagons lying entirely within Blackburn with Darwen.

Violent and sexual offences

The Public Health Outcomes Framework[30] monitors the rate of violent crime and the rate of sexual offences. In 2016/17, both rates were higher than average in Blackburn with Darwen. They were also both rising, but this was the case in almost every district across England. The borough also had the 16th highest rate of hospital admissions for violence in 2014/15 – 2016/17. However, this indicator is generally high across the urban NW, and Blackburn with Darwen is no longer any worse than the region as a whole.

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* *All recorded crime figures have to be treated with caution, as they do not currently meet the standards required for National Statistics status.*

FAST FOOD OUTLETS

'Chips and a burger for a quid' – welcome to the takeaway capital of England [31]

Number and density

'CEDAR' ESTIMATES

Blackburn with Darwen became briefly notorious as the 'takeaway capital' of England in July 2017, when research from the 'CEDAR' Unit at Cambridge University[32] gave rise to newspaper headlines like the one above.[31] Blackburn with Darwen's 236 takeaways were not (quite) the highest number *per head* (that honour went to Westminster). However, they did represent the highest number of takeaways *as a proportion of all food outlets in the borough* (38%).

A subsequent Guardian article, also based on data from CEDAR, found that 400 schools in England had 20 or more fast food outlets within a 400m radius. St Anne's School, in the centre of Blackburn, was said to be in the top ten, with 46 nearby outlets.[33]

PHE ESTIMATES

Since then, Public Health England (PHE) has published its own analysis, using a different data source and definition*. The PHE data shows Blackburn with Darwen to have 219 'fast food outlets' as at 31st December 2017 (Figure 28).[34] This equates to 147.5 outlets per 100,000 population, which is the 13th highest density in the country. By comparison, the England average is 96.5, and the maximum (in Blackpool) is 232.2.

PHE's density map shows a clear north-south divide (Figure 28), and a strong link with deprivation. As well as Blackburn with Darwen, Burnley and Hyndburn also rank highly. PHE also provides ward-level counts, which let us see where the borough's 219 fast food outlets are concentrated.

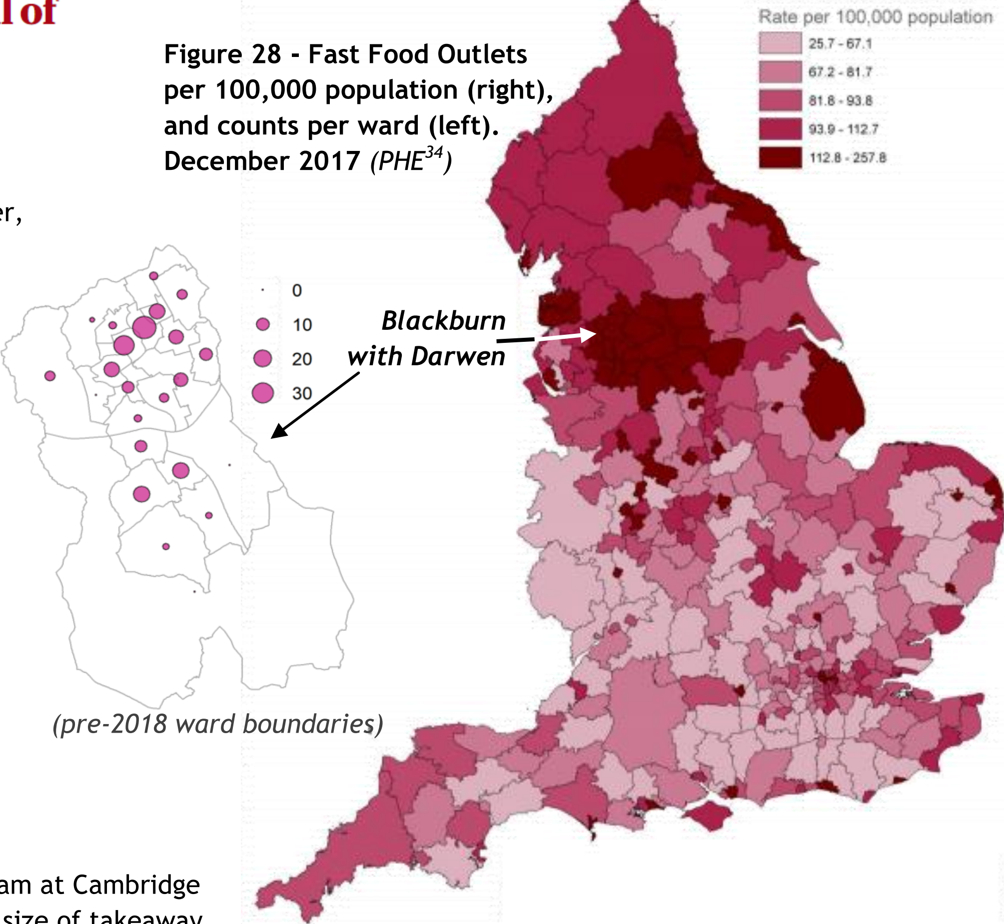

Figure 28 - Fast Food Outlets per 100,000 population (right), and counts per ward (left). December 2017 *(PHE[34])*

Evidence and policy

Giving evidence to the recent House of Commons Childhood Obesity Inquiry, the CEDAR team at Cambridge University drew attention to the typical cheapness, high-calorie content and large portion size of takeaway food, and the concentration of fast food outlets in deprived areas. They concluded that takeaways were linked to obesity (and to inequalities in obesity) in a way that supermarkets and restaurants were not.[35] Public Health England has also alluded to the 'growing body of evidence' connecting fast food outlets to obesity.[34]

Blackburn with Darwen's 'Eat Well Move More Shape Up' strategy acknowledges how fast food outlets are over-represented in deprived areas, the temptation they pose to young people in particular, and the need for tighter controls to regulate their growth.[36] Since April 2016, the borough has operated a policy of refusing permission for new takeaways within 400m of any primary or secondary school, madrassa, nursery or college, unless there are fewer than five such establishments already *and* the proposed opening hours are outside those of the educational institution.[37]

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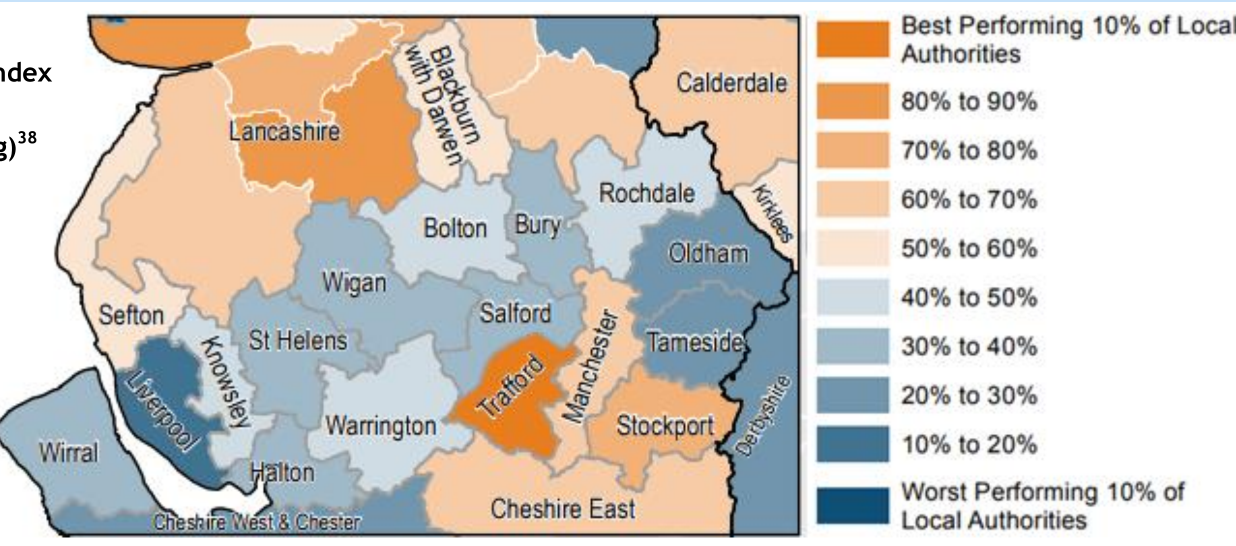
* *Public Health England is quite candid about the fact that the definition of a 'fast food outlet' is somewhat arbitrary.*

WELLBEING AND SOCIAL MOBILITY

THE SOCIAL MOBILITY INDEX[38]

The Social Mobility Commission has updated its Social Mobility Index, designed to identify places where people from disadvantaged backgrounds are more or less likely to make social progress during their lives. The Index is based on educational attainment before, during and after the school years, and the outcomes achieved by adults in terms of income, job status and home ownership.

Figure 29 - Social Mobility Index 2017 (overall ranking)[38]



Overall Index

On the overall Social Mobility Index, Blackburn with Darwen sits almost exactly mid-table, ranking **161st** out of 324 English lower-tier local authorities (where 1st is best). The authors of the report detect a growing gap between social mobility 'hotspots' and 'coldspots', with London pulling further ahead of the rest of the country. Prospects for disadvantaged people tend to be worst in remote, coastal or rural areas, and formerly industrial districts.

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Life Stage Indices

The overall Social Mobility Index is made up of four life-stage Indices, each based on between 2 and 5 indicators. **Figure 30** gives an overview of Blackburn with Darwen's relative performance on each indicator and for each life-stage as a whole.

Blackburn with Darwen continues to rank as a 'coldspot' (well below average) for Early Years social mobility, coming 31st from bottom in the rankings. However it then leaps to 70th best place at School age, and 65th best for Youth. Unfortunately, the borough does not compare so favourably on the economic indicators used to assess Adult social mobility, and it slips back to 82nd from the bottom.

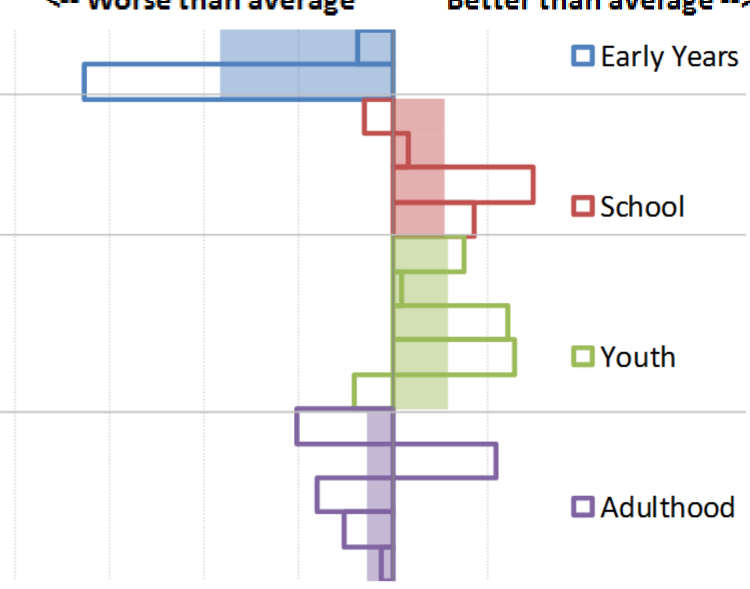

Figure 30 - Breakdown of Social Mobility Index for Blackburn with Darwen.

LOCAL WELLBEING INDICATORS

Commissioned by ONS and Public Health England, the new Local Wellbeing Indicator Set was developed by the What Works Wellbeing and Happy City think-tanks, and was first published at the end of 2017.[39] Designed to capture a holistic overview of local wellbeing and its determinants, the 23 indicators have deliberately *not* been combined into a single index, as the authors feel it is more important for local policy-makers to understand where the gaps and challenges lie.

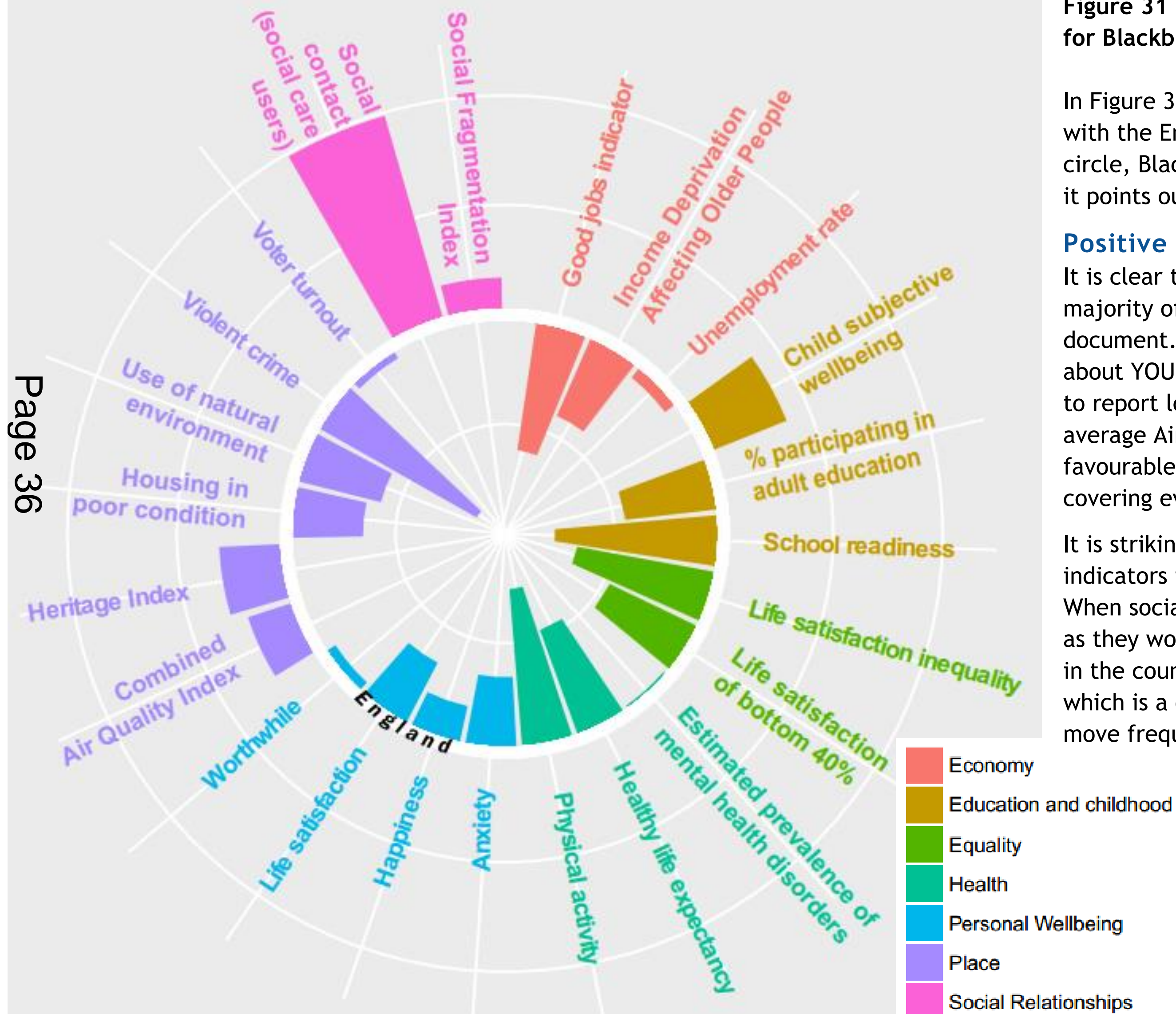

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Figure 31 - Local Wellbeing Indicators for Blackburn with Darwen

In Figure 31, Blackburn with Darwen's score on each indicator is compared with the England average. If the bar points inwards from the 'England' circle, Blackburn with Darwen is performing less well than England, and if it points outwards, it is performing better.

Positive signs

It is clear that Blackburn with Darwen scores below average on the majority of indicators, many of which are picked up on elsewhere in this document. However, there are some notable exceptions. In the 2014 'What about YOUth?' survey, the borough's children were less likely than average to report low life satisfaction. Blackburn with Darwen has better than average Air Quality (according to the 2015 Indices of Deprivation), and a favourable RSA 'Heritage Index' - built up of over 100 different indicators, covering everything from battlefields, to museums, to local delicacies.

It is striking that the borough performs better than average on both indicators in the 'Social Relationships' domain (shown in pink in Figure 31). When social care users are asked whether they have as much social contact as they would like, Blackburn with Darwen returns some of the best results in the country. It also has a relatively low 'Social Fragmentation Index', which is a census-based measure of the extent to which people live alone, move frequently, and/or live in private rented accommodation.

START WELL

DETERMINANTS OF HEALTH FOR CHILDREN/YOUNG PEOPLE

CHILD POVERTY

The Child Poverty Act of 2010 pledged that by 2020, no more than 10% of children should be living in families whose income is less than 60% of median household income (before housing costs). However, this target was removed by the Welfare Reform and Work Act of 2016.[40]

Children in Low Income Families Local Measure

HMRC continues to produce its Children in Low-Income Families Local Measure, as a local proxy for the target measure. However, it now attracts relatively little interest, both because the target has been dropped, and because it is always at least 2 years out of date.

‘End Child Poverty’ estimates

Much more timely estimates are now produced for the End Child Poverty coalition (http://www.endchildpoverty.org.uk/poverty-in-your-area-2018/). These also rely on two-year-old tax credit data, but researchers at Loughborough University have found a way of rolling them forward to reflect recent changes in the labour market. The End Child Poverty estimates are usually quoted ‘after housing costs’, so they cannot be compared with the old target or the HMRC measure.

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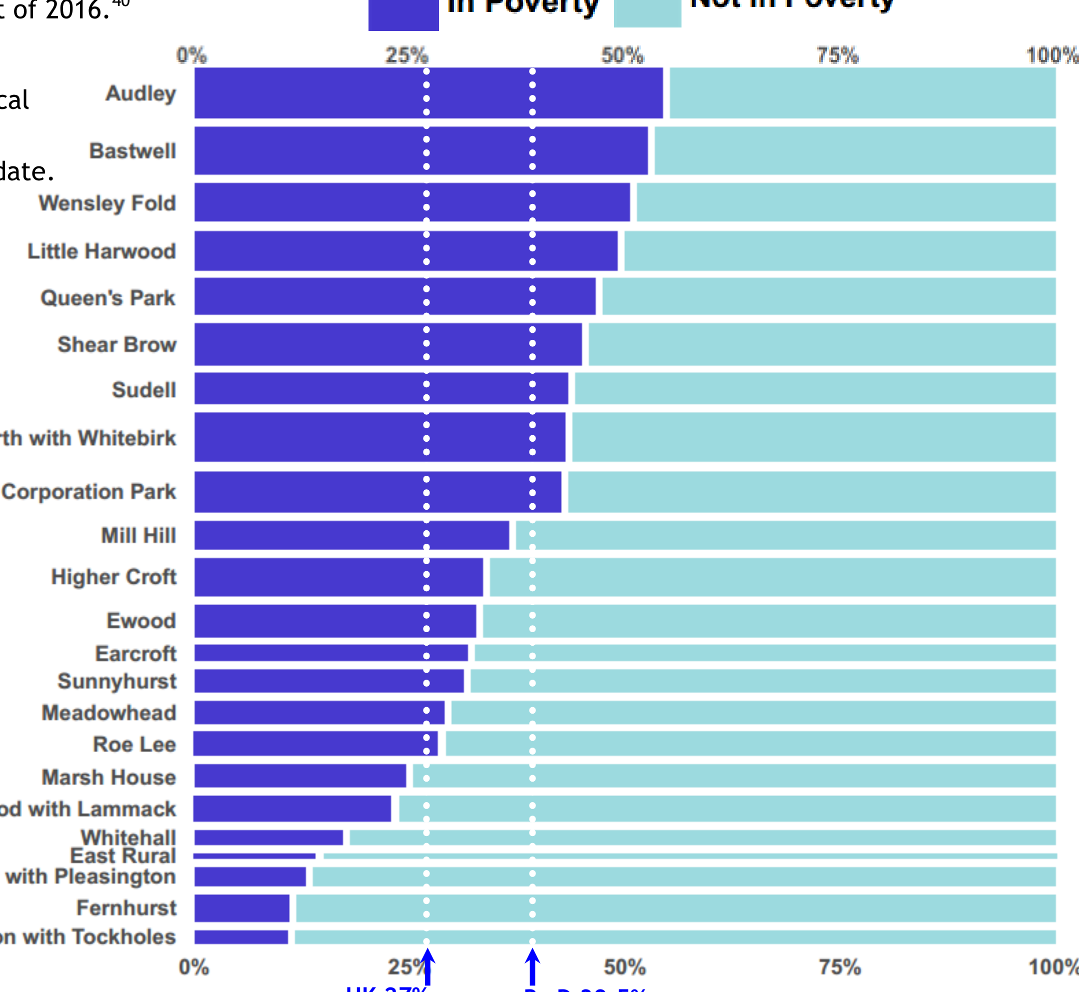
The latest release is a snapshot as at September 2017. On an ‘after housing costs’ basis, Blackburn with Darwen had an estimated **16,034** children living in poverty (**39.5%**), which is the 12th highest percentage of any local authority in the UK (average 27%). The parliamentary constituency of Blackburn - i.e. excluding Darwen - had **43%** of its children in poverty, putting it 22nd highest out of 650. This had risen from 35% in 2015, which was one of the ten highest increases in the country.

Figure 32 shows the proportion of children living in poverty in each BwD ward. The depth of each bar reflects the child population of the ward. With **54.9%** of its children living in poverty, Audley has the 21st highest ward rate in the UK.[41,42]

What the papers say …..

New research from the LSE[43] finds strong evidence that the poorer outcomes observed among children from low-income families are not solely due to associated factors such as parental education. Household income *in itself* is important for children’s physical health and social, behavioural & cognitive development.

Figure 32 - 'End Child Poverty' estimates for Blackburn with Darwen wards (September 2017, after housing costs)



See p44 for icon references

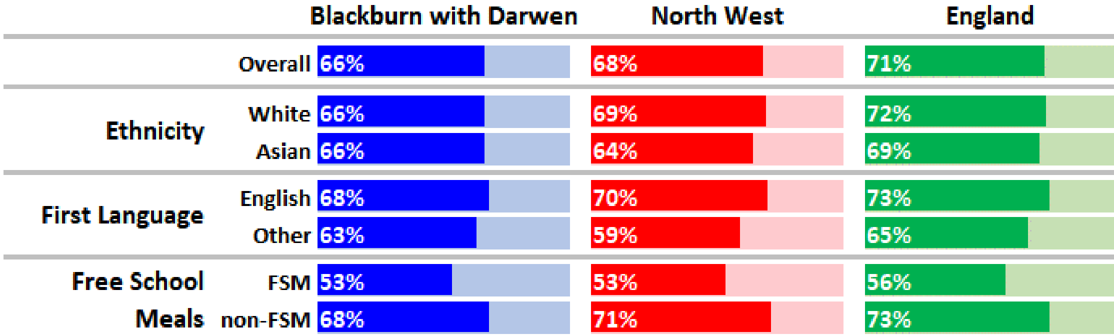
EDUCATION

Early Years Foundation Stage

The Early Years Foundation Stage profile measures children's development at the end of the school year in which they turn 5. Figure 33 shows that in 2017, 66% of Blackburn with Darwen children were deemed to have a 'good' level of development, compared with 56% two years ago. It means that Blackburn with Darwen has risen from third lowest to joint 12th lowest place.

Within the borough, the inequality between White and Asian pupils has now disappeared. There continues to be a gap between those with and without English as their first language, but it is relatively small. Blackburn with Darwen's Free School Meals (FSM) pupils still lag their non-FSM peers by 15 percentage points, although the borough's ranking has improved.[44]

Figure 33 - Foundation Stage: percentage of children achieving a good level of development, 2017
(overall, and broken down by ethnicity, first language, and Free School Meals status)



Primary education – Key Stage 2

At the end of primary education, 60% of Blackburn with Darwen pupils in 2017 achieved the new more stringent 'expected standard' in reading, writing and mathematics (England 62%).[45] There is little difference, either locally or nationally, in the performance of White and Asian pupils, or those with or without English as their first language (Figure 34). Blackburn with Darwen children entitled to Free School Meals (FSM) still do less well than their non-FSM peers, although the gap is not as big as regionally or nationally. On the previous tests, the borough had the second best results outside London for FSM pupils, but that has now slipped to 12th best (or 41st place overall).

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Figure 34 - Key Stage 2: % achieving 'expected standard' in reading, writing and mathematics, 2017
(overall, and broken down by ethnicity, first language, and Free School Meals status)

		Blackburn with Darwen	North West	England
	Overall	60%	61%	62%
Ethnicity	White	59%	62%	61%
	Asian	61%	60%	64%
First Language	English	61%	62%	62%
	Other	58%	56%	61%
Free School Meals	FSM	47%	43%	43%
	non-FSM	62%	65%	65%

GCSE attainment

The measurement of GCSE attainment becomes ever more complicated, and difficult to compare with previous years. Starting in 2017, English and Maths exams are now graded on a scale of 9 to 1 (where 9 is best). The simplest headline measure of attainment is the percentage of pupils obtaining grade 5 or better in both those subjects.

On this basis, Blackburn with Darwen's overall score is 42% (Figure 35), not far off the England average.[46] The performance of its White pupils, however, is the 19th lowest out of 149 local authorities. It is striking how by this stage, Blackburn with Darwen pupils whose did *not* have English as their first language are performing better than those who did. The borough's results for Free School Meals (FSM) pupils may not seem impressive, but are actually very good compared with most other NW authorities.

Figure 35 - GCSE: % achieving Grade 5 or better in English & Maths, 2017
(overall, and broken down by ethnicity, first language, and Free School Meals status)

		Blackburn with Darwen	North West	England
	Overall	42%	40%	43%
Ethnicity	White	34%	40%	42%
	Asian	52%	46%	50%
First Language	English	38%	40%	43%
	Other	50%	41%	44%
Free School Meals	FSM	29%	19%	22%
	non-FSM	44%	44%	46%

VULNERABLE CHILDREN AND YOUNG PEOPLE

CHILDREN IN NEED

'**Children in Need**' is the DfE's term for all those referred to the local authority and assessed to be in need of services. Blackburn with Darwen had a total of 1781 Children in Need at the end of March 2017, compared with 1617 two years previously. This equates to 464 per 10,000, against an average of 372 in the NW and 330 for England, putting Blackburn with Darwen just within the highest 20 authorities.[47]

Figure 36 shows the primary reason why these children were assessed as being in need. 'Abuse or neglect' outstrips other reasons by an even greater margin than in the previous Summary Review.

Primary need	Number
Abuse or neglect	1161
Family dysfunction	254
Family in acute stress	209
Child's disability or illness	127
Absent parenting	19
Socially unacceptable behaviour	7
Other	4

Figure 36 - Children in Need in Blackburn with Darwen, by primary need at initial assessment (March 2017)

LOOKED AFTER CHILDREN

One category of 'Children in Need' is those looked after by the local authority. As at 31st March 2017, there were 370 Blackburn with Darwen children in local authority care, up from 315 two years previously. This equates to 96 per 10,000 children under the age of 18, which remains significantly higher than average (England rate 62 per 10,000), and places the borough in the top quintile nationally.[48]

NEETS

Vulnerable young people are at particular risk of becoming **NEET** ***(Not in Education, Employment or Training)***, which in turn can lead to increased risk of poor health, depression, early parenthood, and other negative outcomes. The figures are now collected in a new way, tracking only those aged 16 and 17. In 2016, Blackburn with Darwen was estimated to have 240 young people aged 16-17 in the NEET category, or 6.1% of the age-group, which is not significantly different from the England average of 6.0%.[9]

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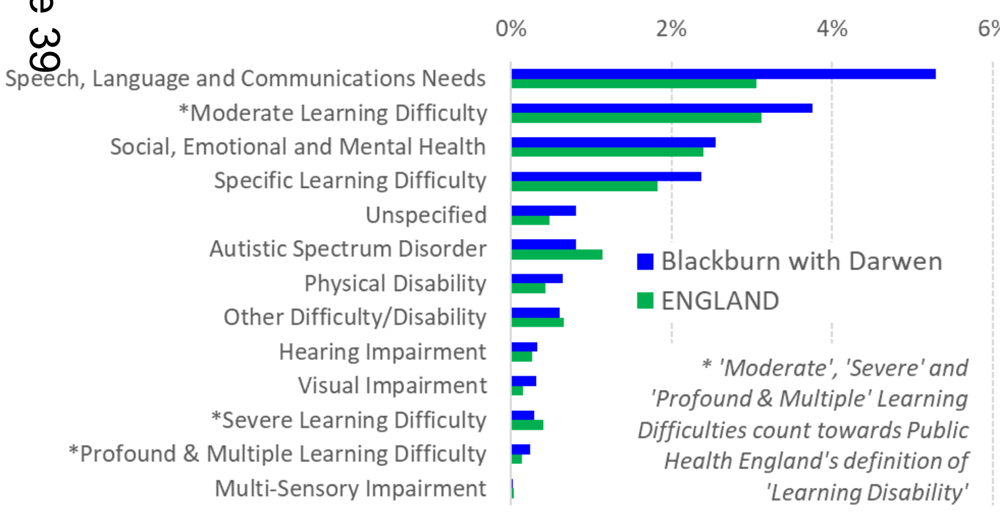

Figure 37 - Prevalence of particular types of Special Educational Need, January 2018 (maintained schools only, primary type of need only)

SPECIAL EDUCATIONAL NEEDS

As at January 2018, 5171 children in Blackburn with Darwen schools had a **Special Educational Need** (SEN), or 17.7% of all pupils. This is significantly higher than the average for England (14.6%) or the North West (14.8%).[49]

Figure 37 shows the proportion of all pupils in the maintained sector having a Special Educational Need of each particular type.[50] The rate of 'Speech, Language and Communication Needs' in Blackburn with Darwen is strikingly higher than average. The overall rate of SEN in the borough's state-funded primary schools (19.5%) is the highest in the country.[50]

'**Specific Learning Difficulty**' describes conditions such as dyslexia. The other three categories of learning difficulty, marked with an asterisk, combine to form what Public Health England refers to as '**learning disabilities**'. Based on the 2017 figures, PHE calculates that Blackburn with Darwen's combined rate of learning disability known to schools was significantly higher than average, and it came sixth highest in England for 'Profound & Multiple Learning Difficulty'.[51]

LIFESTYLE FACTORS AND THEIR CONSEQUENCES

TEENAGE PREGNANCY

The number of under-18 conceptions in Blackburn with Darwen fell to a new low of 59 in 2016, in what was the lowest year nationally since records began.[52,*] Expressed as a rate, Blackburn with Darwen is not significantly different from the new lowest-ever England average. At the launch of the government's Teenage Pregnancy Strategy in 1998, the borough had 169 under-18 conceptions. The reduction since then puts it in the second most improved quintile of upper-tier local authorities (Figure 39):

Figure 38 - Under-18 conception rate (per 1000 females aged 15-17)

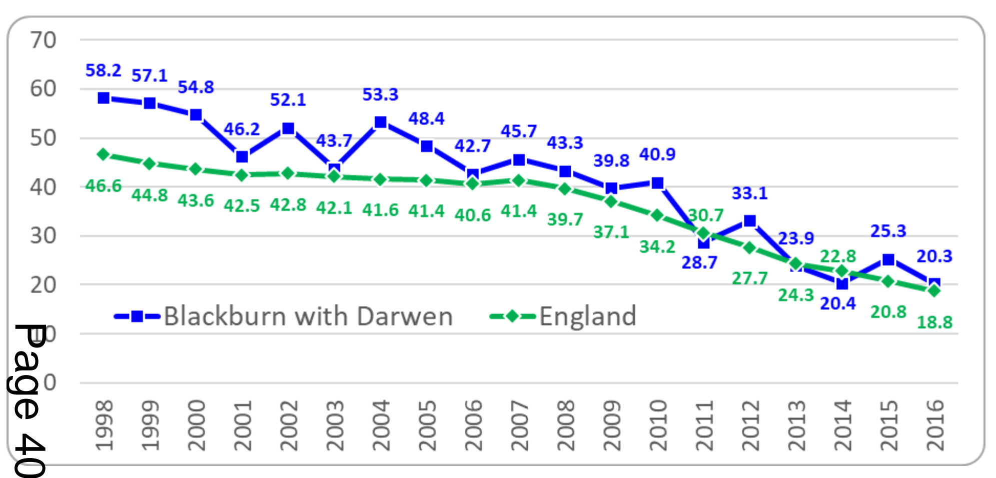

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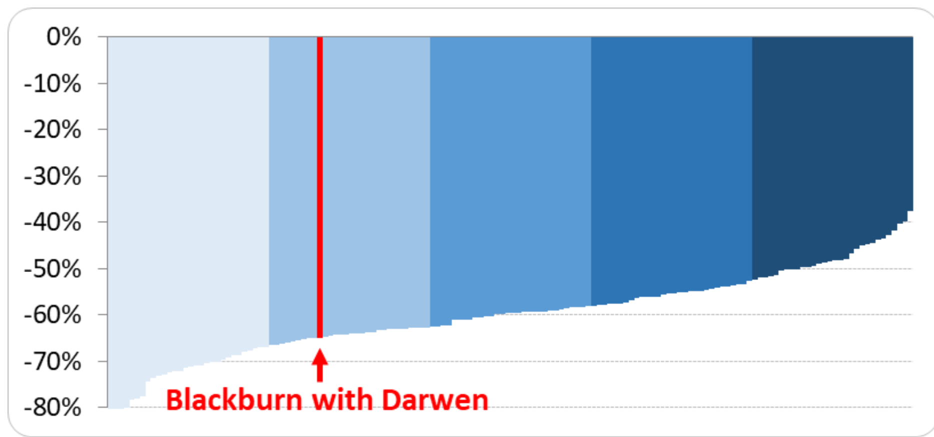
Figure 39 - % change in under-18 conception rate between 1998 and 2016 *(upper-tier local authorities)*



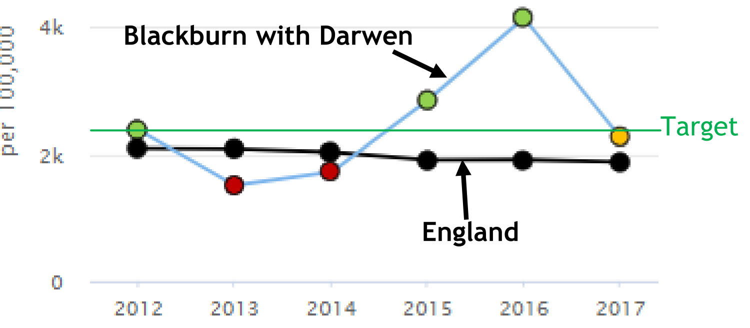
Under-16 conceptions involve even smaller numbers, and ONS now combines them for three years. With 35 such conceptions in 2014-16, Blackburn with Darwen had a rate of 4.0 per 1000, which is very close to the England average (3.7 per 1000) and not significantly different from it.[52]

CHLAMYDIA SCREENING[53]

Chlamydia is a largely hidden condition, so cases are most often discovered through opportunistic screening. The National Chlamydia Screening Programme aims to diagnose and treat as many cases as possible in young people, and local authorities are encouraged to aim for a 'Chlamydia Detection Rate' of at least 2300 per 100,000 15-24 year-olds.

Latest figures for 2017 imply that Blackburn with Darwen's detection rate is very close to that target, at 2263 per 100,000 (Figure 40). The apparent spectacular performance in 2016 is now thought to have been due to data collection issues.

Figure 40 - Chlamydia detection rate per 100,000 (15-24 year-olds, 2012-2017)

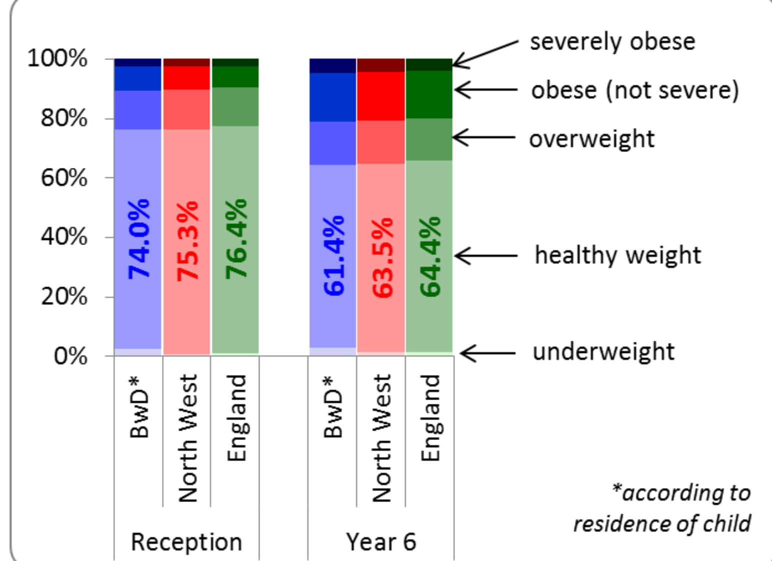


* *Teenage conception rates are worked out using the new revised population estimates issued in March 2018*

CHILD OBESITY AND UNDERWEIGHT

Figure 41 shows the results of the latest National Child Measurement Programme (NCMP) survey in 2016/17.[54] Most of Blackburn with Darwen's results are fairly close to average.

Figure 41 - National Child Measurement Programme 2016-17



Underweight children

One statistic which is significantly higher than average is the proportion of Year 6 children who are underweight. In both Reception (2.5%) and Year 6 (3.0%), Blackburn with Darwen has the third highest proportion of underweight children. It should be noted that nationally, pupils of Asian heritage are much more likely than average to be underweight.

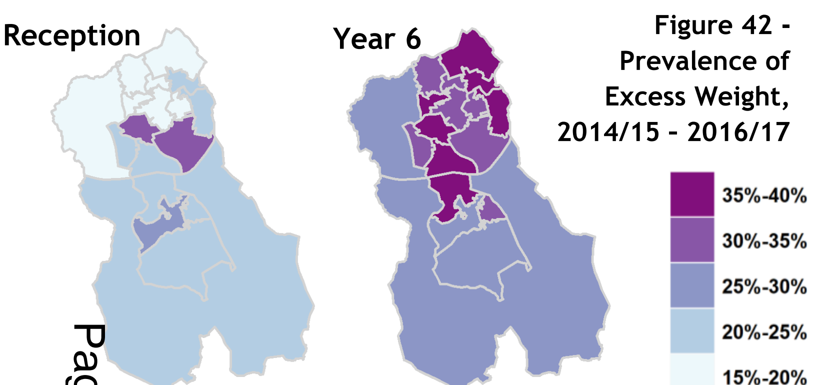


Figure 42 - Prevalence of Excess Weight, 2014/15 - 2016/17

Severe obesity

For the first time, the 2016/17 survey tells us how many pupils are *severely* obese, putting them at risk of serious acute and chronic health problems. Blackburn with Darwen had 58 Reception pupils in this category (2.59%), and 99 Year 6 pupils (4.8%). These proportions are slightly higher than average, but not significantly so.

Inequalities

Figure 42 shows that there are marked spatial inequalities in 'excess weight' (i.e. 'overweight' upwards) across Blackburn with Darwen. Public Health England has also looked at obesity alone, for five years combined (2012/13-2016/17), to see how it varies with deprivation. They found a strong relationship within most local authorities, including Blackburn with Darwen, with obesity tending to be highest in the most deprived quintile and lowest in the least deprived.[54]

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CHILDREN'S ORAL HEALTH

Dental health of 5-year olds

In the previous (2015) survey of 5-year olds' dental health[55], Blackburn with Darwen had 56% of children with one or more decayed, missing or filled teeth, which was the highest proportion in England. The latest (2017) survey shows a generally improved picture, with this proportion falling to 42.6% in Blackburn with Darwen versus 23.3% in England.[56] Blackburn with Darwen is now 4th or 7th highest, depending whether we compare with other upper- or lower-tier authorities. All the other worst-affected authorities are also in the North West.

Figure 43 - Hospital admissions for tooth extraction 2016/17 (with caries as primary diagnosis, as % of age-group)

	Blackburn with Darwen	England
Age 0-4yrs	0.8%	0.2%
Age 5-9yrs	2.1%	0.7%
Age 10-14yrs	0.3%	0.2%
Age 15-19yrs	0.2%	0.1%
Total 0-19yrs	0.9%	0.3%

Hospital admissions for tooth extraction

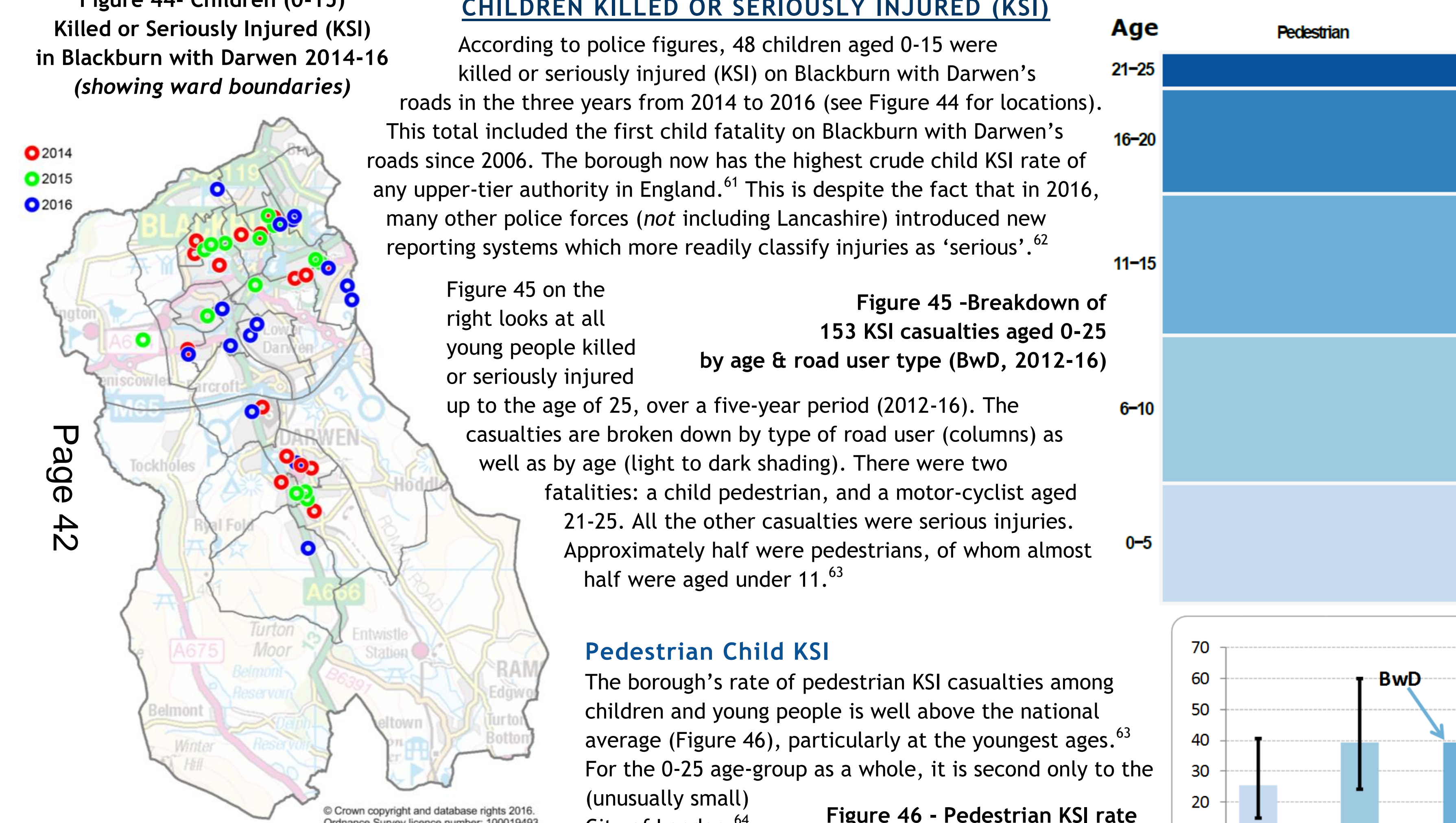
In 2016/17, there were 371 admissions of Blackburn with Darwen children to have teeth out because of dental caries, up from 337 the year before. This represents a higher than average proportion of the population in every age-group, particularly those aged 5-9 (Figure 43).[57] Across the country, many children also have teeth extracted in primary care.[58]

Child attendance at NHS dentists

One encouraging statistic is that 68.1% of Blackburn with Darwen children saw an NHS dentist in the 12 months to March 2018, compared with only 58.4% nationally.[59,60]

ROAD ACCIDENTS

Figure 44- Children (0-15) Killed or Seriously Injured (KSI) in Blackburn with Darwen 2014-16 ***(showing ward boundaries)***



CHILDREN KILLED OR SERIOUSLY INJURED (KSI)

According to police figures, 48 children aged 0-15 were killed or seriously injured (KSI) on Blackburn with Darwen's roads in the three years from 2014 to 2016 (see Figure 44 for locations). This total included the first child fatality on Blackburn with Darwen's roads since 2006. The borough now has the highest crude child KSI rate of any upper-tier authority in England.[61] This is despite the fact that in 2016, many other police forces (*not* including Lancashire) introduced new reporting systems which more readily classify injuries as 'serious'.[62]

Figure 45 on the right looks at all young people killed or seriously injured up to the age of 25, over a five-year period (2012-16). The casualties are broken down by type of road user (columns) as well as by age (light to dark shading). There were two fatalities: a child pedestrian, and a motor-cyclist aged 21-25. All the other casualties were serious injuries. Approximately half were pedestrians, of whom almost half were aged under 11.[63]

Figure 45 -Breakdown of 153 KSI casualties aged 0-25 by age & road user type (BwD, 2012-16)

Pedestrian Child KSI

The borough's rate of pedestrian KSI casualties among children and young people is well above the national average (Figure 46), particularly at the youngest ages.[63] For the 0-25 age-group as a whole, it is second only to the (unusually small) City of London.[64]

Figure 46 - Pedestrian KSI rate per 100,000 children/young people (BwD versus England, 2012-2016) *showing 95% confidence intervals*[63]

ALL CHILD ROAD CASUALTIES

If we broaden our scope to include all recorded child casualties on the road, whether serious or not, Blackburn with Darwen still compares badly. When we add up the total number of casualties aged 0-15 during the years 2012 to 2016, and express it as a crude rate (relative to the 0-15 year-old resident population), the borough ranks 4th highest out of 152 upper-tier authorities in England.[65]

CHILD HEALTH OUTCOMES

Figure 47 - Key child health outcomes[61]

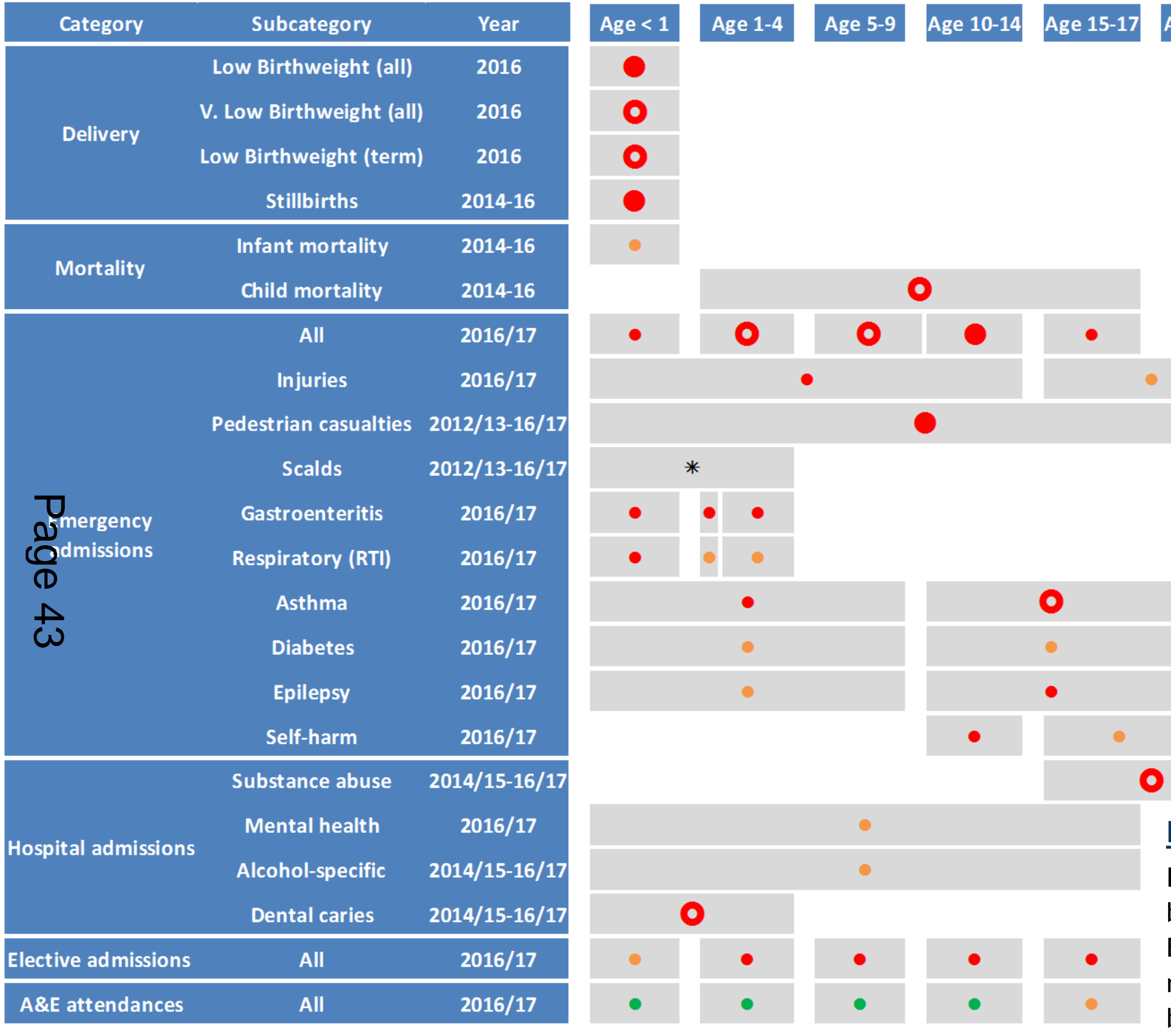


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Figure 47 shows how Blackburn with Darwen compares with England at various ages, on a cross-section of key outcomes:[61]

KEY

- Worst in England
- One of worst five authorities in England
- Significantly worse than England
- Not significantly different from England
- Significantly better than England
- ✳ Suppressed (small numbers)

AT DELIVERY

Blackburn with Darwen has some of the highest rates of low birthweight nationally, whether measured for all babies or those born at term. It also experienced 50 stillbirths over the three years 2014-16, which gave it the highest rate of any upper-tier authority. Comparative figures for 2015-17 are not yet available, but the borough had 12 stillbirths in 2017, which is at least a step in the right direction.[66]

NHS action on stillbirths

It is the NHS's ambition to halve the national stillbirth rate by 2025 (compared to 2013/14).[67] An initiative called the Saving Babies Lives Care Bundle, piloted in 19 maternity units, has been shown to have the potential to save 600 stillbirths a year nationally.[68] The evaluation, by Manchester University, does however caution:

'Socioeconomic factors remain important contributors to stillbirth and without parallel initiatives to address inequality; healthcare interventions can only have limited impact.'[69]

INFANT AND CHILD MORTALITY

Infant mortality (i.e. death under the age of one), and child death (aged 1-17) both involve very small numbers, with 32 and 21 occurrences respectively in Blackburn with Darwen over a three-year period. The resulting infant mortality rate is not significantly different from the England average, but the borough's child mortality rate is the fourth highest in the country.

HOSPITAL ADMISSIONS AND ATTENDANCES

The remainder of Figure 47 focuses on hospital admissions or attendances by Blackburn with Darwen children of various ages. Overall, the borough has significantly higher than average emergency admissions at all stages of childhood, and comes highest in the country for age 10-14. It is the top upper-tier authority for child admissions due to pedestrian casualties, second highest for asthma in the 10-17 age-group, and also ranks in the top five for substance misuse and dental caries (i.e. hospital admissions for tooth extraction). Given all this, its rate of child A&E attendances is perhaps surprisingly low.

LIVE WELL

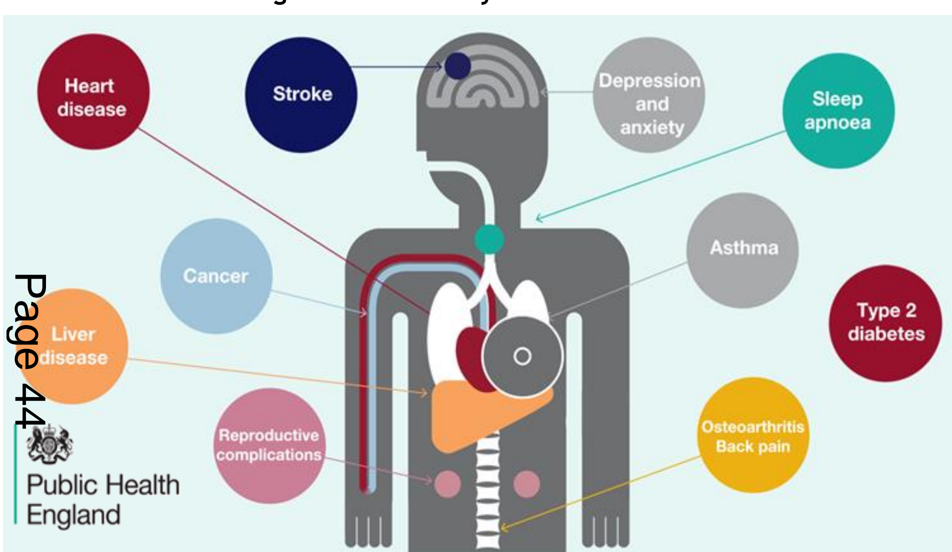
LIFESTYLE FACTORS

OBESITY AND HEALTHY EATING

'Eat Well Move More Shape Up' is Blackburn with Darwen's 2017-2020 strategy to make physical activity and healthy eating an easy choice for all.[36]

Eat Well Move More Shape Up Strategy Vision: 'For everyone in Blackburn with Darwen to move more, eat well and maintain a healthy weight'

Figure 48 - 'Obesity harms health' [71]



Adult obesity

In 2016/17, an estimated 66.4% of Blackburn with Darwen adults were overweight or obese.[70] This is significantly higher than the England average of 61.3%, which of course is far from ideal in itself. Given that they are based on survey responses, these estimates may well be understating the size of the problem.[70]

Public Health England estimates that obesity reduces life expectancy by an average of three years, and severe obesity by 8-10 years.[71] It has produced an infographic summary of the many ways in which obesity can harm health (Figure 48).

New data from NHS Digital (Figure 49) shows that Blackburn with Darwen has a rapidly rising rate of hospital admissions where obesity was listed as a factor (though not necessarily the main reason).

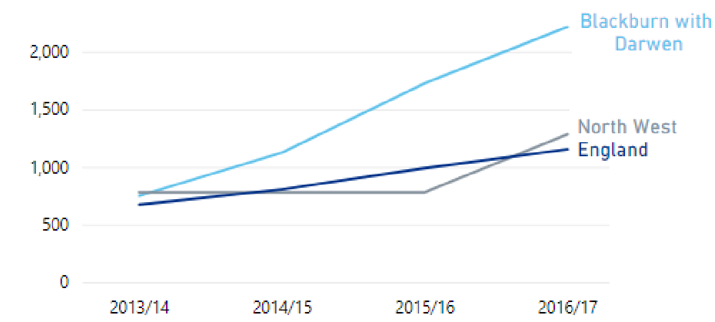


Figure 49 - Hospital admissions with a primary or secondary diagnosis of obesity (age-standardised rate, all ages)

The rise over time may be partly due to an increasing tendency to record 'obesity' when logging admissions, but it means that in 2016/17, Blackburn with Darwen comes 13th highest out of 152 upper-tier authorities.[72]

Diet

58.5% of adults in Blackburn with Darwen claimed to achieve the recommended '5-a-day' portions of fruit and vegetables in 2016/17, which is similar to the England average of 57.4%. Fruit consumption is close to average, but intake of vegetables in Blackburn with Darwen (2.55 portions per day) is significantly lower than the England average (2.70 portions).[30]

Declaration on Healthy Weight

The Local Authority Declaration on Healthy Weight, signed in April 2017 by Blackburn with Darwen Borough Council and Blackburn with Darwen CCG, is the first of its kind in the country.[73,74] Taking a 'whole systems' approach, it contains a range of commitments designed to promote healthy weight and improve the health and wellbeing of the local population.

LOCAL GOVERNMENT DECLARATION ON HEALTHY WEIGHT

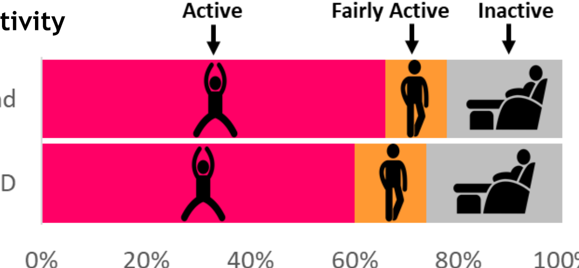
See p44 for icon references

PHYSICAL ACTIVITY

Levels of activity

Public Health England considers us 'physically active' if we do the equivalent of 150+ minutes of moderate intensity sporting or fitness activities per week, in bouts of at least 10 minutes. Below 30 minutes is 'inactive'. With 60.1% of adults 'active' and 26.2% 'inactive', Blackburn with Darwen is significantly worse than England on both counts (Figure 50).[70]

Figure 50 - Physical activity in adults, 2016/17 [70]



Walking and cycling

In 2016/17, only 67.0% of Blackburn with Darwen adults walked for over 10 continuous minutes, for any purpose, at least once a month (England average 78.4%). This was the lowest proportion out of 326 lower-tier authorities. Blackburn with Darwen is still the lowest if we say 'walked or cycled', with only 68.1% doing either at least monthly (England 80.0%).[75]

Health benefits

A growing body of evidence testifies to the importance of physical activity for general health (see right).

Figure 51 - Benefits of Physical Activity *according to the UK's 4 Chief Medical Officers*[81]

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What the papers say ....

Research led by King's College London has found that those who meet the NHS's '150 minutes per week' physical activity guidelines are 31% less likely to develop depression than those who do not.[76,77]

This adds to the growing body of evidence that exercise can help to reduce the risk of diabetes, various cancers, hip fractures and cardiovascular disease, improve the health of those who already have chronic disease, and enable older people to remain independent for longer.[78,79] The Academy of Medical Royal Colleges goes so far as to call it the 'Miracle Cure'[78], and PHE has published advice for health professionals on how to persuade patients of its benefits.[80]

Physical activity in Pennine Lancashire

In recognition of these benefits, Sport England invited bids in 2017 for 12 National Lottery-funded **Local Delivery Pilot** areas. Pennine Lancashire (which includes Blackburn with Darwen) was one of the successful bidders.

TOGETHER AN ACTIVE FUTURE

The Sport England project in Pennine Lancashire, known as **Together an Active Future**[82], aims to reach out to the many local people who are physically inactive, experiencing poor mental wellbeing, or both. It particularly seeks to harness the benefits of physical activity for mental health, and as a response to stressful life events (Figure 52).

One of the main objectives is to improve our understanding of *why* people are not more active. Creative engagement techniques, including a 'Life Course Reflection Tool', are used to explore how each person's attitudes and experiences at different ages may have shaped the way they relate to physical activity now.[83] These conversations have also uncovered a lack of awareness of the physical activity offers that already exist.

For their part, many service providers are unsure how to approach those who are less active, so they welcome the opportunity to talk, think and work together to bring change.

Life events
with relevance for physical activity and mental health

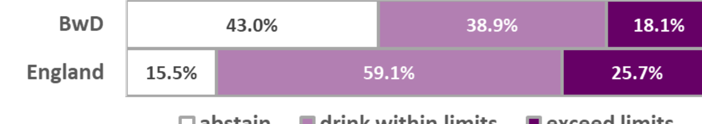
Bereavement/Loss
Carers
Trigger Combinations/Resilience
Job Loss
Ill Health
Children leave home
Marriage/cohabitation/relationship
Children start school
Bereavement/Loss
New Job/starting job/job change
Educational Transition
First children/family
Adverse Childhood Experiences (ACEs)
College to work/university
Secondary to college
Primary and secondary

Figure 52 - Lifecourse Transition Model from 'Together an Active Future'

See p44 for icon references

ALCOHOL (ADULTS)

Figure 53 - Estimated Alcohol Consumption 2011-14 (Blackburn with Darwen v. England)



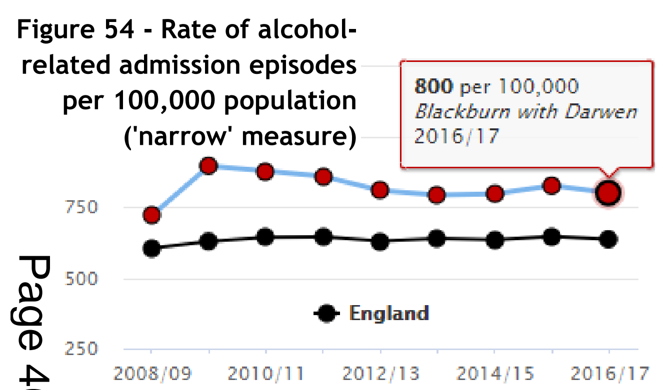
Alcohol consumption

The most recent estimates of alcohol consumption are for 2011-14. They suggest that 43% of adults in Blackburn with Darwen abstain from alcohol altogether (Figure 53), which is the 5th highest proportion in England. Only 18.1% are estimated to exceed the recommended limit of 14 units per week (England 25.7%), putting the borough in the lowest quintile. Binge drinking rates (not shown) are significantly lower than average at 8.2% (England 16.5%).[84]

The Alcohol Harm Paradox

Given all of the above, it might be assumed that Blackburn with Darwen would have relatively low levels of alcohol-related ill-health. However, it has been known for some time that although deprived populations may *drink less* than more affluent groups, they are likely to suffer *greater harm* as a consequence.[85] Research into this 'Alcohol Harm Paradox' suggests that any given level of alcohol consumption is likely to do more damage to those who also smoke, are overweight or have an unhealthy lifestyle.[86]

Figure 54 - Rate of alcohol-related admission episodes per 100,000 population ('narrow' measure)



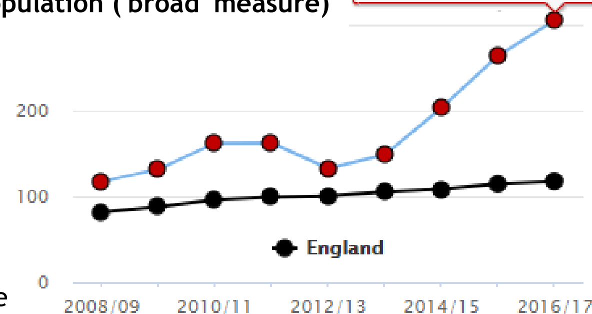
Hospital admissions

ALCOHOL-RELATED

A headline indicator of the health consequences of drinking is the rate of alcohol-related hospital admissions (weighted according to whether the patient's condition is wholly or partly attributable to alcohol). Blackburn with Darwen's rate has been consistently higher than England for several years (Figure 54). This is largely a male problem, as the borough's female rate is close to average.*[84]

Blackburn with Darwen's admission rate for alcohol-related circulatory conditions is the second highest in England. Its admission rate for alcoholic liver disease has risen steeply, and is now the highest in the whole country (Figure 55).*[84]

Figure 55 - Rate of admission episodes for alcoholic liver disease condition per 100,000 population ('broad' measure)



ALCOHOL-SPECIFIC

In 2016/17, Blackburn with Darwen had the 7th highest admission rate for alcohol-specific conditions (i.e. those which are invariably due to alcohol).[84] An analysis of the 2015/16 figures shows that in Blackburn with Darwen, the crude rate of patients being admitted for alcohol-specific conditions for the 3rd or subsequent time in 24 months was more than twice the national average. These repeat admissions may suggest a lack of effective contact with treatment services.[87]

Alcohol-related mortality

Blackburn with Darwen's alcohol-related mortality rate in 2016 was significantly higher than average. Its 2014-16 death rate from chronic liver disease stands out as being the fourth worst in the country overall, and the second worst for females.[84]

Alcohol-related incapacity

In 2016, Blackburn with Darwen had 300 claimants of incapacity benefits (mainly Employment & Support Allowance) whose main disabling condition was Alcohol Misuse. This equates to 334.4 per 100,000 people of working age, which puts it third highest out of 326 lower-tier districts (after Blackpool and Burnley).[84]

Treatment services

In 2016, 182 people successfully completed alcohol treatment in Blackburn with Darwen and did not re-present within 6 months. As a proportion of all those in treatment, this equates to a 53.8% success rate, which makes Blackburn with Darwen the 9th best performing authority in the country (England average 38.7%).[84] PHE has estimated that the 2016-17 investment in treatment for alcohol-only clients in Blackburn with Darwen has brought social and economic benefits totalling £317,361.[87]

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* *Rates described as 'narrow' are based on the primary reason for admission only. Those described as 'broad' include admissions where the relevant condition was a secondary diagnosis.*

SMOKING (ADULTS)

Prevalence

Latest estimates show that approximately 16.7% of adults in Blackburn with Darwen were current smokers in 2017.[88] This is no longer significantly higher than average (see light bars in Figure 56).

Smoking rates tend to be higher in the 'Routine & Manual' (R&M) group (dark bars in Figure 56) than in the general population.[89] They are also higher among males than females (not shown).

Figure 56 - Estimated smoking prevalence for adults aged 18+
(showing 95% confidence intervals)

	Blackburn with Darwen	North West	England
Overall (2017)	16.7%	16.1%	14.9%
Routine & Manual (2017)	27.0%	26.0%	25.7%

Source: Annual Population Survey (via Tobacco Control Profiles)

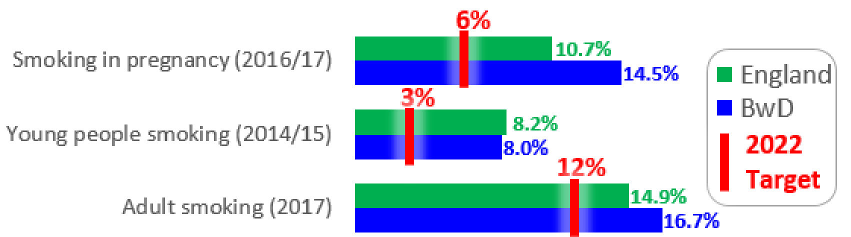

Figure 57 - Targets for 2022 (compared with latest figures)

AMBITIONS

In its *Tobacco Control Plan for England*, the Department of Health aims to get several smoking rates down to substantially lower levels by the end of 2022 (Figure 57).[90] The *Tobacco Free Lancashire* strategy pledges to match these ambitions across Lancashire, incluing Blackburn with Darwen.[91] To achieve this, it will need to heed the words of Duncan Selbie, Chief Executive of Public Health England:[92]

TFL Tobacco FREE Lancashire

> *'the war on tobacco … will only be won if we make more progress in helping people from deprived areas and people suffering from poor mental health, where we know smoking rates remain stubbornly high'.*

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Outcomes

Blackburn with Darwen had approximately 250 smoking-attributable deaths each year during 2014-16, and was in the worst quintile for eight out of the nine mortality indicators in PHE's Local Tobacco Control Profile. The borough was also in the top quintile in 2016/17 for smoking-attributable hospital admissions._

Costs

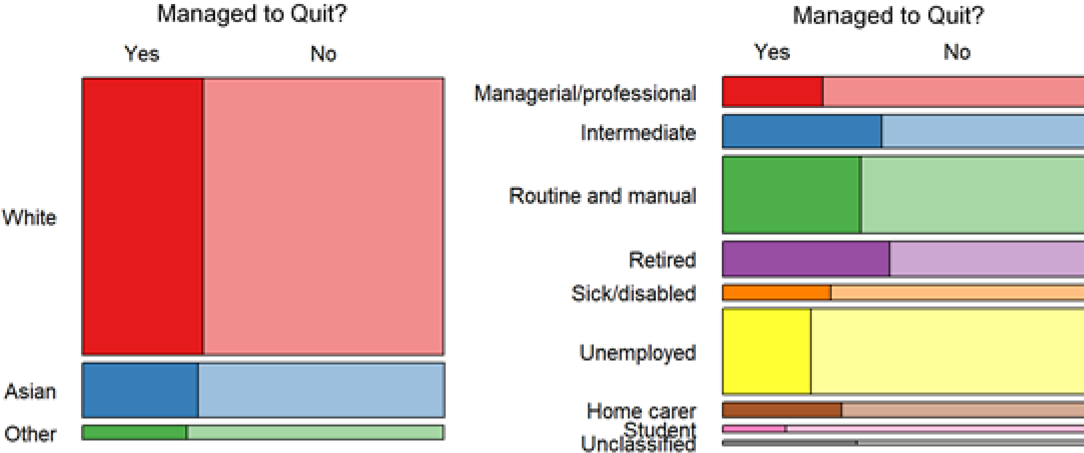
Latest estimates from ASH put the cost to society of smoking in Blackburn with Darwen at **£34.2m**. This may be a slight over-statement, as it is based on the 2016 prevalence of 19.5% (rather than 16.7%). The biggest element is lost productivity (£22.1m), followed by costs to the NHS, cost of social care, and cost of fires.[93]

Public Health England has calculated that Blackburn with Darwen is in the highest quintile for the cost per head of smoking-attributable hospital admissions.[94]

Stop Smoking services

Usage of 'Stop Smoking' services continues to decline, both locally and nationally. In 2017/18, 1287 Blackburn with Darwen clients set a quit date, of whom 425 (or 33%) had quit at four-week follow-up (England average 51%).[95] Figure 58 shows the number of 'setters', and their success or failure, broken down by ethnic group and by socio-economic group.

Figure 58 - Blackburn with Darwen 'Stop Smoking' services 2017/18; 'Setters' by ethnic group and socio-economic group, showing whether or not they managed to quit[95]



'Quitters' divided by 'setters' is not, however, the only way of measuring success. When compared to the number of smokers *in its population*, Blackburn with Darwen's 425 quitters actually represent a *better* than average quit rate.[95]

DRUG MISUSE (ADULTS)

Prevalence

New estimates of the prevalence of opiate and/or crack cocaine use (OCU) were issued in 2017, relating to the year 2014/15.[96] Blackburn with Darwen had an estimated 1363 OCU users in all (Figure 59 and Figure 60). This gives it a rate of 14.47 per 1000 population, significantly higher than the England average of 8.57.

The overall change since 2011/12 is only slight (Figure 60). However, there *has* been a significant fall in users aged 25-34, and a corresponding rise in those aged 35+.

Figure 59 - Estimated users of Opiates and/or Crack, Blackburn with Darwen 2014/15[96]

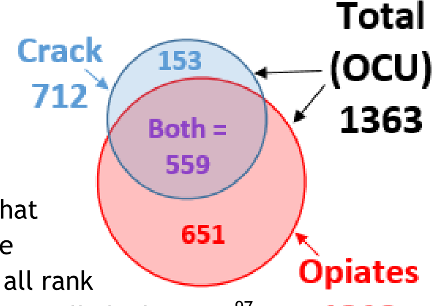
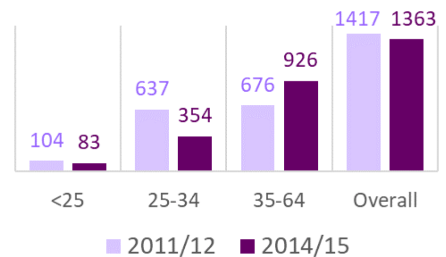


Figure 60 - Estimated OCU users by age (Blackburn with Darwen)



Drug-related deaths

ONS figures for heroin and morphine-misuse deaths in 2014-16 show that many of the highest rates (brown hexagons in Figure 61) are in seaside locations. However, Blackburn with Darwen, Burnley and Hyndburn all rank in the top 10 in England, and form a distinctive *inland* cluster of unusually high rates.[97]

Blackburn with Darwen (outlined), Burnley and Hyndburn

Figure 61 - Rate of heroin and morphine deaths by misuse (2014-16, districts in England & Wales)[97]

More generally, in the three-year period 2015-17, there were 46 deaths in Blackburn with Darwen from drug poisoning (involving legal or illegal drugs), of which 37 are classed as drug misuse (i.e. involving illegal drugs). The resulting drug poisoning and drug misuse death rates are both significantly higher than the England average, and in the top quintile of local authorities nationally.[98]

With high drug mortality rates across Blackpool, Blackburn with Darwen and parts of Lancashire, a pan-Lancashire multiagency preventable harms group has been set up to share best practice.[99]

Hospital admissions

Among upper-tier local authorities in 2016/17, Blackburn with Darwen had the 4th highest admission rate where the primary diagnosis was a drug-related mental health or behavioural disorder, and the 6th highest where it was poisoning by illicit drugs.[100]

Treatment

Treatment activity among both opiate and non-opiate users in Blackburn with Darwen rose in 2016-17 compared with the year before, as did the number of successful completions.[101] The borough's success rate for both groups is in the top twelve nationally.[102] Furthermore, it is estimated that those receiving treatment in Blackburn with Darwen committed 1000's fewer crimes than they would otherwise have done. This alone delivered local social and economic cost savings of over £9.5m in just one year.[101]

The vast majority of those presenting for treatment are White British[101], but there is a growing awareness of drug and alcohol problems among the borough's South Asian community. Support services are now being signposted by a network of local 'Friends of the Service' and 'ambassadors', and actively promoted by imams in their mosque sermons.[103] One person's journey to recovery is highlighted in a video produced by One Voice and Inspire. Called ***Drug and Alcohol Misuse is Everybody's Business***, the video has attracted over 50,000 views and been widely acclaimed.[103,104]

Prescription Drugs

There is an increasing recognition of the issue of patients becoming dependent upon prescribed drugs. Research shows that long-term opioid prescribing, which can lead to addiction, is highest in deprived, northern areas, with Blackburn with Darwen identified as one of the top ten CCGs (2010-2014).[105,106]

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LEARNING DISABILITIES

HEALTH AND CARE OF PEOPLE WITH LEARNING DISABILITIES

2016-17 saw the third year of a data collection from GP systems, enabling the demographics and health status of patients who are on their practice's Learning Disability register to be compared with those who are not. Participation rates varied around the country, but was better than average in Blackburn with Darwen (91% coverage).[107]

Demographics

We know from the Quality and Outcomes Framework (QOF) that the total number of Blackburn with Darwen patients on GP Learning Disability registers at the end of March 2017 was 832 (or 0.48%).[108] The Learning Disability Health and Care dataset contains data on 751 of those patients, including their age/sex profile (Figure 62).[107]

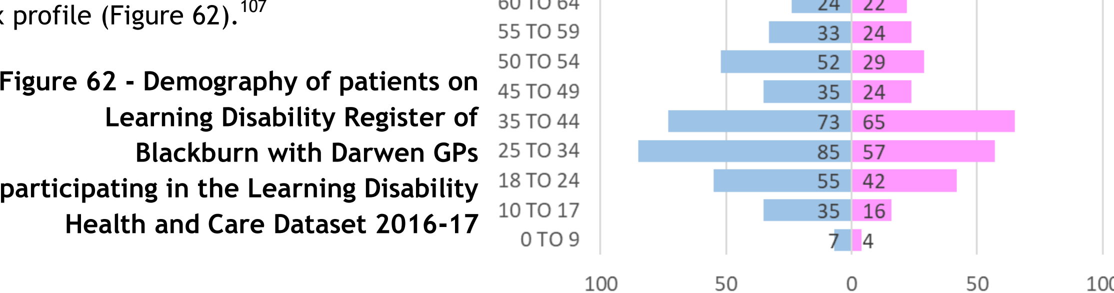
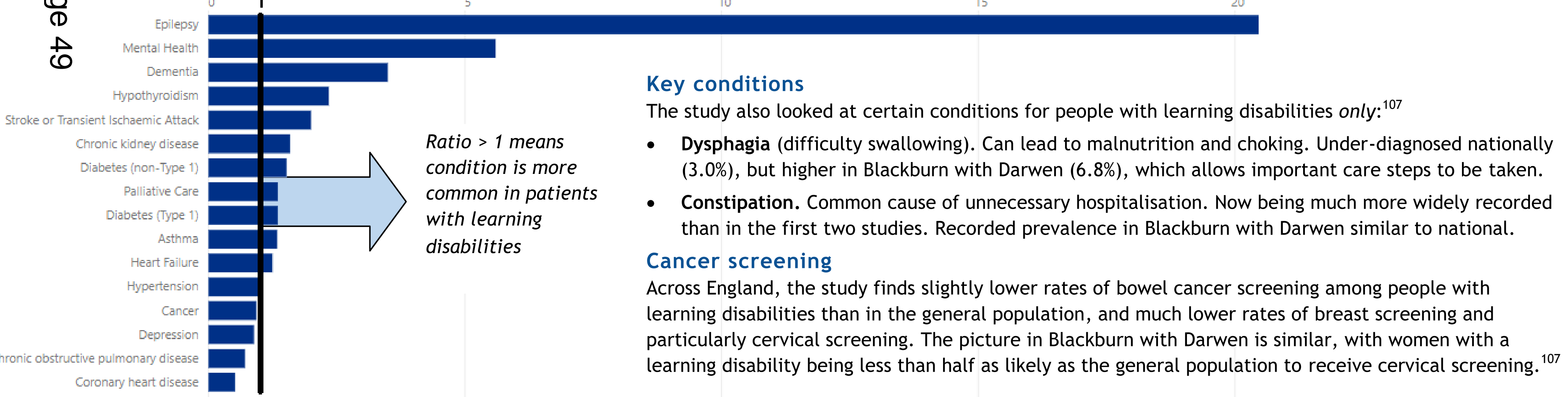


Figure 62 - Demography of patients on Learning Disability Register of Blackburn with Darwen GPs participating in the Learning Disability Health and Care Dataset 2016-17

Health problems

Figure 63 shows how much more (or less) likely a Blackburn with Darwen patient on the Learning Disability Register is to have various conditions recorded than Blackburn with Darwen patients generally. For example, epilepsy is more than 20 times as common among patients with learning disabilities as it is in the general population. The equivalent ratios for England as a whole are broadly similar.

Figure 63 - Standardised Prevalence Ratio of various conditions: patients on the Learning Disability Register v. general population (Blackburn with Darwen 2016-17)[107]



Key conditions

The study also looked at certain conditions for people with learning disabilities *only*:[107]

- **Dysphagia** (difficulty swallowing). Can lead to malnutrition and choking. Under-diagnosed nationally (3.0%), but higher in Blackburn with Darwen (6.8%), which allows important care steps to be taken.
- **Constipation.** Common cause of unnecessary hospitalisation. Now being much more widely recorded than in the first two studies. Recorded prevalence in Blackburn with Darwen similar to national.

Cancer screening

Across England, the study finds slightly lower rates of bowel cancer screening among people with learning disabilities than in the general population, and much lower rates of breast screening and particularly cervical screening. The picture in Blackburn with Darwen is similar, with women with a learning disability being less than half as likely as the general population to receive cervical screening.[107]

ACCOMMODATION AND SOCIAL CARE

Blackburn with Darwen performs well on the provision of settled accommodation for working-age adults with a learning disability, and had nobody living in severely unsatisfactory accommodation in 2015/16. However, it had the 11th *lowest* rate of supported working age adults with learning disability in paid employment (just 1.4%).[109]

HEALTH OUTCOMES

CANCER

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Figure 64 - Fraction of cancer cases attributable to lifestyle factors in 2015 (UK)

What the papers say.....

A new study led by Cancer Research UK[110] has produced updated estimates of how many cases of cancer could be prevented through lifestyle changes. It found that in 2015, almost four in ten (37.7%) cancer cases were attributable to avoidable factors. Figure 64 gives an impression of their relative impacts.

The study confirms that smoking has by far the biggest effect, accounting for 15.1% of all new cancer cases in the UK in 2015, although it is hoped that this proportion will fall in future as smoking rates continue to decline.[111] The next biggest risk factors is overweight and obesity, which accounted for 6.3% of new cancers in 2015, and is on an upward trend. The authors conclude that for maximum effect on cancer incidence, prevention efforts should be concentrated on both smoking and obesity.

Cancer Incidence

The number of new cases of cancer diagnosed each year is known as the **incidence**. This has tended to rise over time, reflecting both changing risk factors and better diagnosis and recording.[112,113] Blackburn with Darwen is generally not significantly different from England.

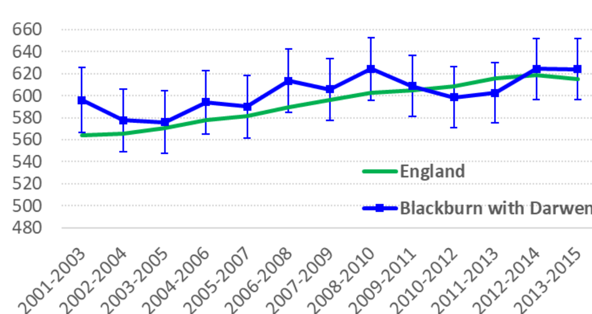


Figure 65 - Age-Standardised Incidence Rate (All Cancers, M+F)
showing 95% confidence intervals for BwD

Routes to diagnosis

Patients who are first diagnosed with cancer when they present as an emergency are known to have a substantially lower survival rate.[114] Emergency presentations are particularly common in bowel and lung cancer (Figure 66), and for both these types, the proportion detected this way is significantly higher than average in Blackburn with Darwen:

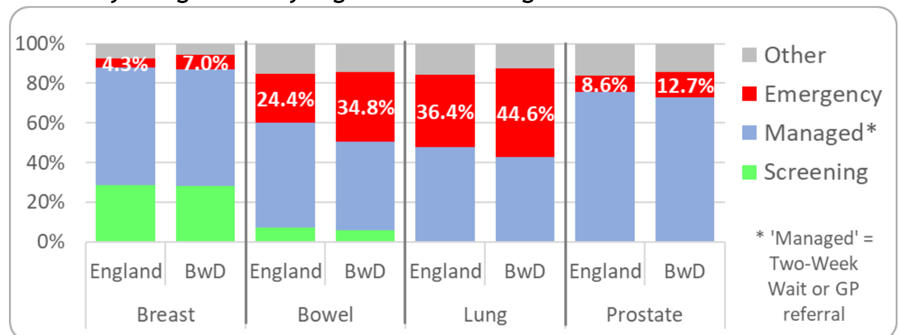
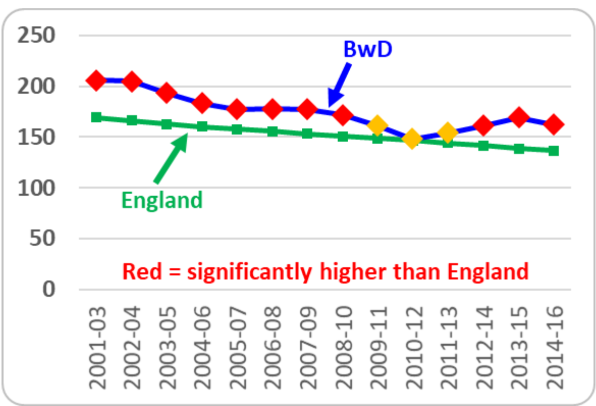


Figure 66 - Routes to Diagnosis for 'Big 4' Cancers (Blackburn with Darwen v. England, 2006-2015)[112]

See p44 for icon references

Figure 67 - Premature (age < 75) mortality from all cancers (Age Standardised Rate)[30]



Mortality and Survival

PREMATURE MORTALITY

Even though cancer incidence has been increasing, improved survival means that premature mortality from the disease has been gradually declining across England as a whole. For a few years, Blackburn with Darwen's premature mortality rate was similar to the national average, but unfortunately it is now higher again (Figure 67). Over half of cancer deaths in this age-group are considered preventable through public health interventions (see Figure 64 for relevant lifestyle factors).

ONE-YEAR SURVIVAL

When all patients aged 15-99 diagnosed with cancer in 2015 were followed up for a year, Blackburn with Darwen had a 'survival index' of 69.4%, compared with an England average of 72.3%. Survival has improved steadily since 2000, both locally and nationally, but there has always been a significant gap. Blackburn with Darwen's one-year survival from breast cancer and bowel cancer is now similar to average, but its lung cancer survival is 15th lowest at 35.4% (England 40.7%).[115]

Prevalence

The term 'cancer **prevalence**' is used to refer to the number of people alive who have ever had a diagnosis of cancer, however long ago. This group are also known as 'cancer **survivors**'. By the end of 2015 (the most recent year available), there were **4093** cancer survivors in Blackburn with Darwen who had been diagnosed since 1995[116] This is a rise of more than 500 since the 2010 prevalence figure quoted in the previous Summary Review. Some of these survivors will experience emotional, practical, medical and financial problems which continue long after treatment has finished.[117]

Figure 68 - BwD cancer survivors as at end 2015
showing breakdown by age and sex

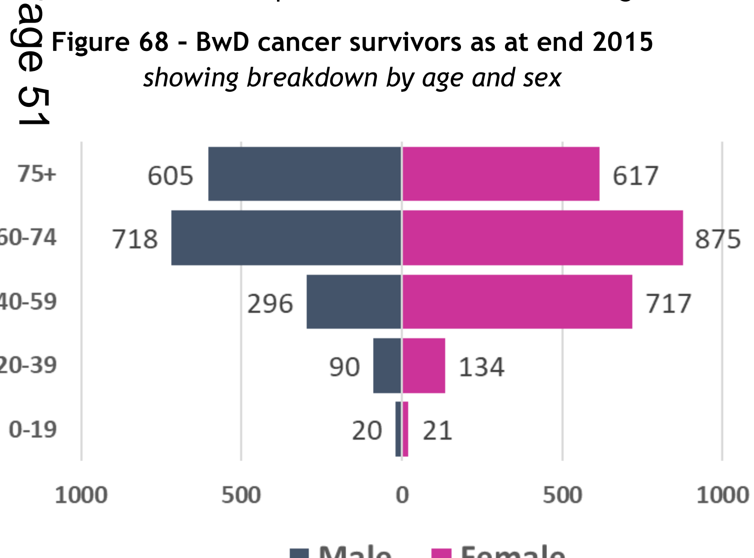
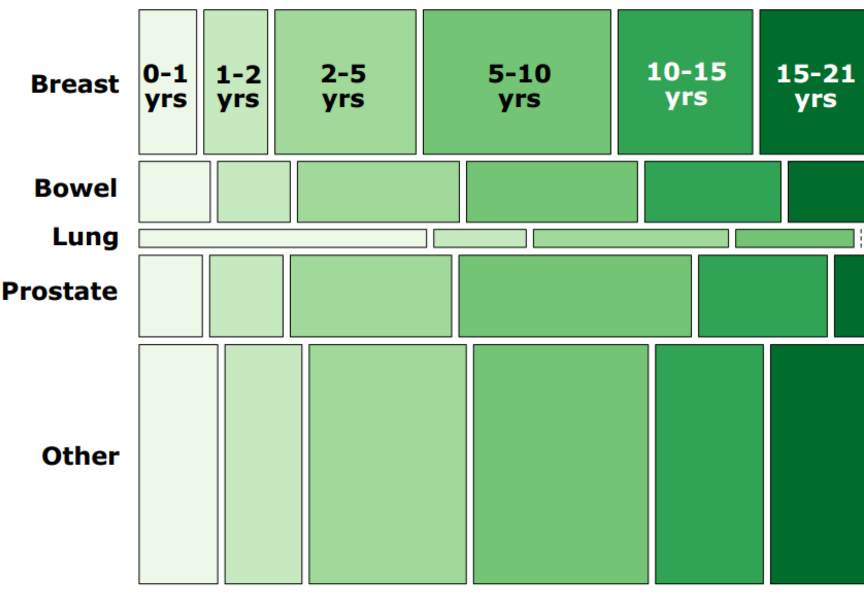


Figure 68 shows the age and sex breakdown of Blackburn with Darwen's 4093 cancer survivors. Figure 69 gives a schematic representation of the time elapsed since their diagnosis, and the broad type of cancer they were diagnosed with.

For those diagnosed since 2006 (2956 of Blackburn with Darwen's survivors), an ethnic breakdown is also available. The vast majority (2618, or 88.5%) are shown to be White, with only 282 being of Asian heritage. This will partly reflect the contrasting age profiles of the borough's two main populations. However, a BBC report, citing research undertaken in the NW, suggests that there may be a reluctance among Asian women in particular to come forward for diagnosis.[118]

Figure 69 - BwD cancer survivors as at end 2015
showing type of cancer and length of survival

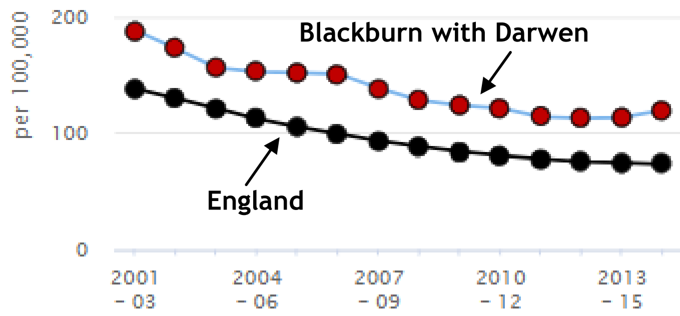


CARDIOVASCULAR DISEASE

Cardiovascular disease, or CVD, is an umbrella term for conditions of the circulatory system, such as coronary heart disease (CHD), stroke, heart failure and rhythmic heart disorders. Together these accounted for 25.4% of all deaths in Blackburn with Darwen in 2016, which is the same proportion as in England as a whole.[119]

Figure 70 - CVD mortality under age 75 (directly standardised rate per 100,000 persons)

●Red = significantly worse than England



CVD mortality

Rates of premature mortality from CVD (under age 75) have been declining over the years, but Blackburn with Darwen remains stubbornly worse than average (Figure 70). In 2014-16, it ranked second highest out of 152 upper-tier authorities in England. Two-thirds of these deaths were from types of CVD from which premature death is considered to be largely preventable, either via behaviour change or through public health measures. Blackburn with Darwen had the second highest rate of these preventable deaths too.[30]

Blackburn with Darwen's CVD mortality rate for older people (aged 65+) is also significantly and consistently above average, ranking 6th highest out of 152 upper-tier authorities in 2014-16.[120]

Coronary Heart Disease (CHD)

Well over half of CVD deaths locally are from Coronary Heart Disease (CHD). In 2014-16, Blackburn with Darwen had the 3rd highest rate of CHD mortality out of 207 CCGs in England. In 2016/17, there were 6488 patients in Blackburn with Darwen who had ever been diagnosed with CHD, and 938 hospital admissions for CHD, which is the fifth highest admission rate in the country.[121]

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Stroke

Blackburn with Darwen is not significantly different from average in terms of the proportion of people who have ever had a stroke, the admission rate for stroke, or the premature (under-75) mortality rate from stroke. However the mortality rate for age 75+ was significantly above average in 2014-16, ranking 15th highest out of 207 CCGs.[121]

CVD risk factors

New easy-read evidence-based guidance from NICE sets out some of the conditions and behaviours which can represent an increased risk of CVD, and how to manage and address them (see Figure 71).[122]

NHS Health Checks

The risk factors identified by NICE are exactly the sort of thing clinicians are looking out for in the NHS Health Check for 40-74 year-olds. Three years ago, the rate at which the eligible population was receiving these checks was significantly below average in Blackburn with Darwen. Since then, the situation has been turned around, so that in 2017/18 the proportion of eligible patients receiving a check was 23rd *highest* out of 152 upper-tier authorities. This is due to a rise in the number of invitations issued, rather than the proportion of invitations accepted (which has actually gone down).

Figure 71 - CVD risk factors identified by NICE[122]

6 high-risk conditions
- High blood pressure
- High cholesterol
- Atrial Fibrillation
- Chronic Kidney Disease
- High blood sugar
- Diabetes

Behaviour
- Smoking
- Diet and obesity
- Physical activity

Severe mental illness

People with **severe mental illness** are at risk of dying **15-20 years earlier** than others, often from avoidable **physical illnesses such as CVD.**

increased risk of CVD

51.2% of the eligible population of Blackburn with Darwen have now had a Health Check since the scheme started. Although better than England (44.3%), the Borough still has some way to go to match Walsall, at 98.9% - or even Bolton, which comes second with 91.7%.[30]

See p44 for icon references

Green / Amber / Red = significantly better than England / no significant difference / significantly worse than England

Measures prefixed with '' relate to Type 2 diabetes only*

DIABETES

Figure 72 - Blackburn with Darwen performance on Diabetes care pathway
Main sources: National Diabetes Audit[125] &. PHE profiles at fingertips.phe.org.uk

Prevalence

Blackburn with Darwen's overall recorded prevalence of diabetes is 8.4%.[108] This is the joint highest in the NW, and 12th highest in England. Type 2 diabetes accounts for 94% of the local caseload.[125] Figure 73 gives a rough impression of how diagnosed diabetes may be distributed across the borough:[*,127]

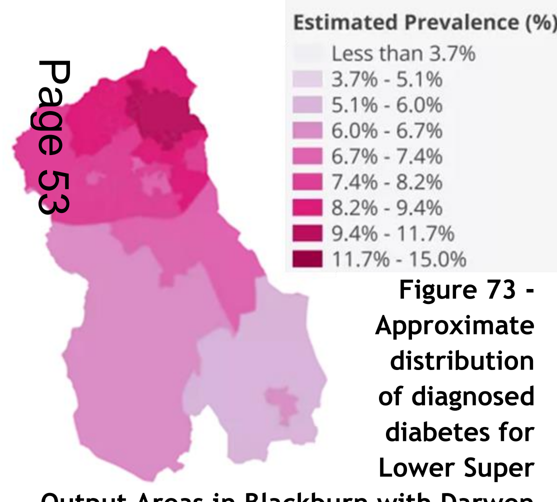

Figure 73 - Approximate distribution of diagnosed diabetes for Lower Super Output Areas in Blackburn with Darwen
(as estimated by House of Commons Library)*

Before diagnosis — **Prevention**
- 4-5 yr olds excess weight (2016/17)– 23.5%
- 10-11 yr olds excess weight (2016/17) – 35.6%
- Adults excess weight (2016/17)– 66.4%
- Physically inactive adults (2016/17) – 26.2%

Diagnosis
- Recorded diabetes (2016/17) – 8.4%

Once diagnosed — **Structured education**
- *Offered within 1 year (2016/17) – 73.3%

Once diagnosed — **9 care processes**
- Eye screening uptake (2016/17) – 83.2%
- **All* 8 other care processes (2016/17) – 57.1%

(checks on eyes, feet, cholesterol etc, which all diabetic patients should have at least annually)

Intermediate outcomes — **3 treatment standards**
- *Good blood sugar control (2016/17) – 64.7%
- *Good blood pressure control (2016/17) – 76.7%
- *Good cholesterol control (2016/17) – 77.7%
- *Good for all three (2016/17) – 41.0%

Final outcomes — **Complications**
- Extra risk of MI/angina/heart failure /stroke/renal replacement therapy (2015/16) – all amber
- Rate of diabetic lower-limb amputations (2014/15-16/17) – amber (major), red (minor)

Final outcomes — **Early death due to diabetes**
- Extra risk of mortality (2013/14-14/15) – 27.2%

What the papers say ….

The British Heart Foundation has estimated that the number of people nationally suffering heart attacks and strokes as a result of diabetes will rise by 29% by 2035.[128]

* *Map produced by House of Commons Library[127] by taking recorded ('QOF') prevalences for each practice, and apportioning to LSOAs according to the number of registered patients living in each.*

See p44 for icon references

MENTAL HEALTH AND WELLBEING

Prevalence of mental illness

In 2017, 11.1% of Blackburn with Darwen patients aged 18 or over were recorded on their GP's 'QOF' register as having **depression**. This is significantly higher than the England average of 9.1%, and puts the CCG in the top quintile nationally.[129] There is also a QOF register for **severe mental illness**, defined as those diagnosed with schizophrenia, bipolar disorder or other psychoses, or on lithium therapy. Blackburn with Darwen has the 13th highest rate out of 207 CCGs, at 1.27% (England 0.92%).[130]

Services

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

The IAPT programme focuses on providing 'talking therapies' for people experiencing common mental health problems such as anxiety and depression. Referral rates are generally higher in deprived areas, but success rates are lower.[131] Blackburn with Darwen's referral rate is consistently above average, and currently in the top quintile.[129]

An IAPT referral has '**moved to recovery**' if their symptoms of anxiety or depression were severe enough to be regarded as a clinical case at the start of their treatment, but not by the end of it.[132] In 2016-17, 49% of eligible IAPT referrals in Blackburn with Darwen 'moved to recovery', which is close to the national average of 49.3%, and the government target of 50%.[132,133] A less stringent success measure is '**reliable improvement**'. 64% of Blackburn with Darwen patients 'reliably improved' on IAPT in 2016/17, against an England average of 65%.[131] However, it was one of only 6 CCGs where 10% or more had 'reliably deteriorated'.[131]

SPECIALIST MENTAL HEALTH SERVICES

At the end of 2017/18, the proportion of adults in Blackburn with Darwen in contact with adult specialist (or 'secondary') mental health and learning disability services was the highest in the country, at 6405 per 100,000 (England average 2329).[134] This figure does not include people who are only in contact with the IAPT programme.

Greater Preston and East Lancashire CCGs follow in second and third place, creating a distinct geographical cluster of high access to services. This pattern is also reflected in an all-age version of the indicator (see Figure 74).[131] The differing rates across the country are likely to be a reflection of the nature and extent of mental health service provision, as well as of need.

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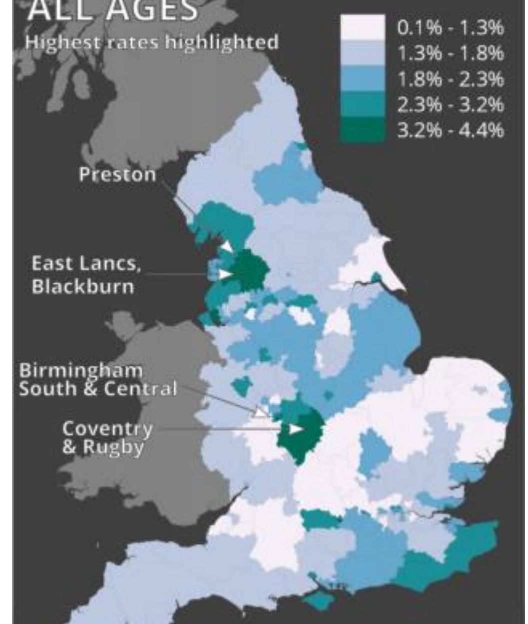
Figure 74 - People in contact with secondary mental health services (all ages, December 2017)
Source: House of Commons Library, Briefing Paper 6988[131]



Being in contact with specialist mental health services does not equate with being in hospital. In Blackburn with Darwen, at the end of 2017/18, only 1% of mental health service users were in hospital, which is half the England average for this group.

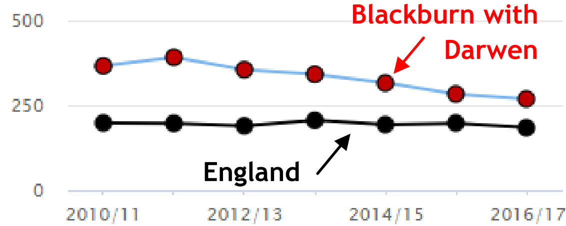


Figure 75 - Emergency Hospital Admissions for Intentional Self-Harm (Directly age-standardised rate per 100,000)[30]

Outcomes

SUICIDE AND SELF-HARM

Blackburn with Darwen's **suicide rate** in 2015-17 was in the highest quintile of upper-tier local authorities. However, because of the small numbers involved, the difference with England is not statistically significant. With 12 recorded suicides in 2017, we have to go back to 2008 to find a lower count.[135]

A related indicator with much bigger counts is the rate of emergency hospital admissions for intentional **self-harm**. In 2016/17, Blackburn with Darwen had over 400 such admissions. As a rate, this is both in the top quintile and significantly higher than average, although it has been gradually improving over recent years (Figure 75).[30]

Engaging with Blackburn with Darwen on Mental Wellbeing

A major muti-agency engagement exercise in 2017-18 collected survey responses about mental wellbeing needs from nearly 1600 Blackburn with Darwen residents, followed by 1:1 interviews, focus groups, case studies and stakeholder events. Some of the key lines of enquiry are summarised in very broad terms in Figure 76.

The full research report explores how the findings vary by key demographics such as age-group, gender and ethnicity.[136,137] Four key cross-cutting themes have emerged (see right), which will now inform the design and delivery of a wide-ranging mental wellbeing initiative for Blackburn with Darwen.

Figure 76 - Engaging with BwD on Mental Wellbeing (2017): survey results by broad line of enquiry

Cross cutting themes

1. Help people connect at a local level
   "A cup of tea and space to connect"
2. Targeted mental health awareness and supporting self help
   "Mental health workshops or lessons are really needed for my community"
3. The promotion of a good life balance
   Feeling in control and balancing the demands of life with a healthy lifestyle were seen as crucial
4. GPs seen as most important asset for people's health and wellbeing
   Other services were identified, GPs seen as most important

Time to Change Hub

The experience of mental ill-health is often compounded by stigma, discrimination and lack of understanding. In 2017, Blackburn with Darwen became a Time to Change Hub. This means that local organisations and employers, together with 'Time to Change Champions' who have personal experience of mental health problems, will work in partnership to improve attitudes and behaviours towards those affected by mental illness.[138]

SEXUAL HEALTH

Sexually Transmitted Infections (STIs)

In terms of new cases of STIs, Blackburn with Darwen in 2017 compares favourably with England (Figure 77). Chlamydia in young people is omitted, because the aim is to achieve as *high* a detection rate as possible in this group (see page 19).[139]

Figure 77 - Incidence of STIs
(source https://fingertips.phe.org.uk/)[139]

Indicator	Period	Blackburn Count	Blackburn Value	Region Value	England Value	England Lowest	England Range	England Highest
New STI diagnoses (exc chlamydia aged <25) / 100,000 (Persons, 15-64 yrs)	2017	552	582	718	794	267		3,215
Syphilis diagnostic rate / 100,000 (Persons, All ages)	2017	9	6.1	10.9	12.5	0.0		154.1
Gonorrhoea diagnostic rate / 100,000 (Persons, All ages)	2017	46	31.0	64.0	78.8	4.8		654.4
Chlamydia diagnostic rate / 100,000 aged 25+ (Persons, 25+ yrs)	2017	209	216	179	189	0.0		1,012
Genital warts diagnostic rate / 100,000 (Persons, All ages)	2017	103	69.4	103.4	103.9	0.0		249.5
Genital herpes diagnosis rate / 100,000 (Persons, All ages)	2017	52	35.0	55.4	56.7	0.0		262.2
New HIV diagnosis rate / 100,000 aged 15+ (Persons, 15+ yrs)	2017	2	1.7	7.7	8.7	0.0		44.6

Benchmark Value — Lowest, 25th Percentile, 75th Percentile, Highest

Across England, the number of STI diagnoses was similar to 2016, although gonorrhoea and syphilis both rose by around 20%.[140] Blackburn with Darwen saw its highest number of gonorrhoea cases for several years, but no significant upward trend. Gonorrhoea is of particular concern nationally because of the emergence of antibiotic-resistant strains of the disease.[140]

HIV

The UK as a whole has seen a steep fall in HIV diagnoses in the two years to 2017. Blackburn with Darwen was always relatively low, and is now the 8th lowest in England.[139]

It is reassuring that the borough only had three 'late' diagnoses in the three years up to 2017. Being diagnosed late greatly increases the patient's mortality rate, and Blackburn with Darwen has not always performed well on this indicator in the past.[139] With numbers as small as this, there are bound to be random fluctuations. However, it is encouraging to note that HIV test uptake, which involves far larger numbers, has also been on an improving trend, and is now significantly better than average.

As at 2017, the total number of people living with HIV in the borough was 89, or 1.02 per 1000. Anything below 2 per 1000 is considered a 'low' prevalence.[139]

LIVER DISEASE

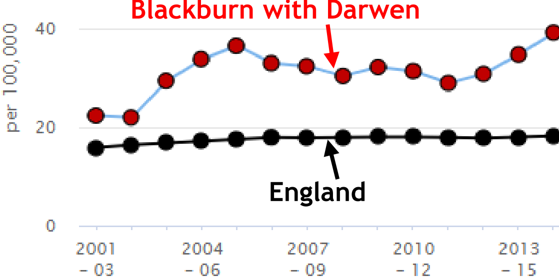


Figure 78 - Under-75 mortality rate from liver disease[141]
(directly age standardised)

Mortality

As can be seen from Figure 78, premature mortality from liver disease in Blackburn with Darwen is high and rising.[141] In 2014-16, the borough had the second highest under-75 death rate after Blackpool.

Mortality from liver disease is strongly associated with deprivation[141,142], and disproportionately affects younger people.[142] 85% of all those dying from liver disease in Blackburn with Darwen in 2014-16 were under the age of 75.

The main risk factors for liver disease are **alcohol** (see page 25), **obesity** (page 23), and **viral hepatitis**.[143,142]

Viral Hepatitis

Hepatitis B and C are blood-borne viruses, most commonly spread through sexual contact and injecting drug use respectively.[143] They do not always give rise to symptoms, so a high proportion of cases go undetected.[143] Public Health England estimates that Blackburn with Darwen may have around 1207 residents infected with Hepatitis C, including 869 current or former drug users. Most of the remaining cases are assumed to be among people with links to Pakistan, which has a high background prevalence.[144]

The Pennine Lancashire Liver Disease Framework emphasises the importance of awareness-raising, immunisation (Hep B) and testing among groups particularly susceptible to viral hepatitis.[145] Engagement and testing initiatives organised by Baiter Sehat ('Better Health') have been positively received by the Pakistani heritage community.[146,147]

"I feel it is important to raise awareness because of the lack of knowledge people have of this type of disease within the Asian community"
[Mosque committee member]

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WORKING-AGE INCAPACITY

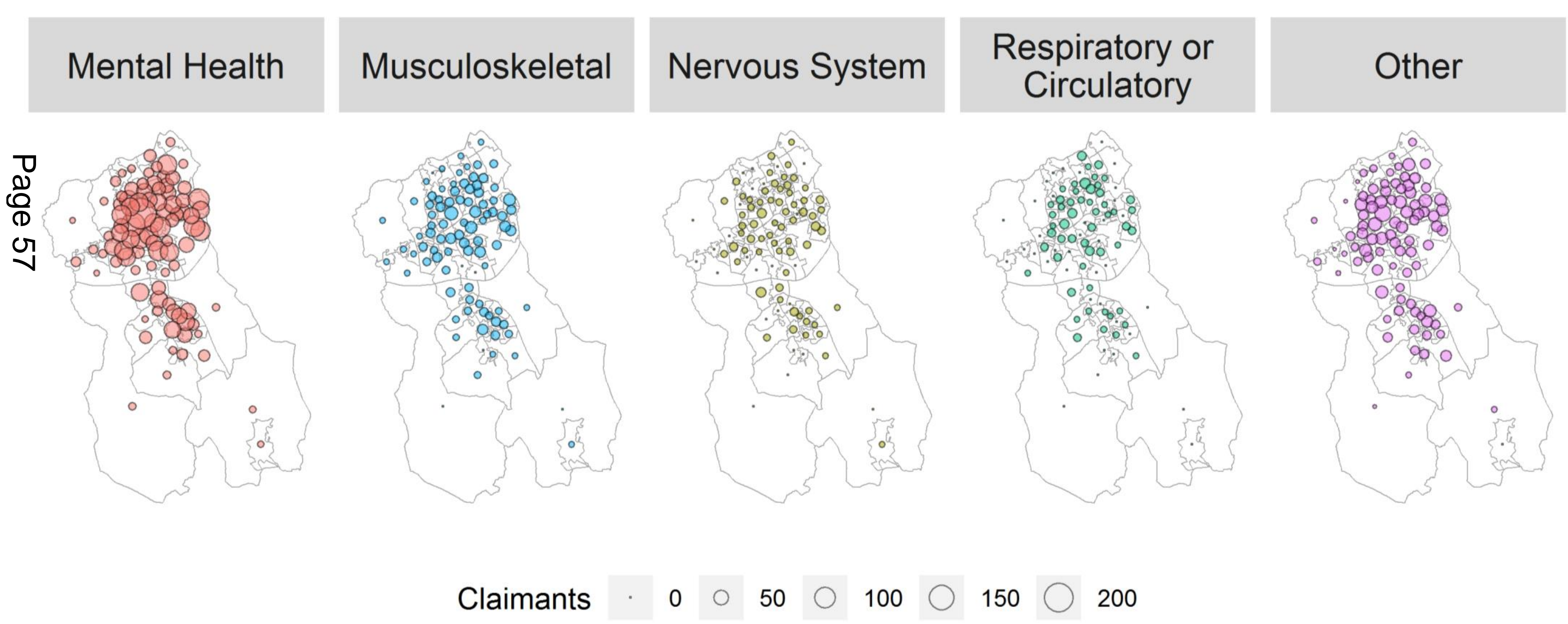
Employment Support Allowance (ESA) claimants

In February 2018, Employment Support Allowance (ESA) was being claimed by 8096 Blackburn with Darwen residents unable to work because of long-term health problems.[148] A further 150 people in this position were still claiming legacy benefits such as Incapacity Benefit or Severe Disablement Allowance.[12,148,*] The 8096 recipients of ESA equates to 8.7% of the working-age population of Blackburn with Darwen, which is the 11th highest rate out of 152 upper-tier authorities. There were approximately 780 ESA claimants in the old Wensley Fold ward alone, followed by 770 in Shadsworth with Whitebirk.[12]

Conditions leading to ESA claims

By far the biggest category of condition resulting in the receipt of ESA is mental health problems, which account for just over half of all claims in the borough (Figure 79):

Figure 79 - Recipients of ESA by main qualifying condition (Lower Super Output Areas in Blackburn with Darwen, February 2018)[148]



* *The numbers of ESA claimants will gradually reduce as Universal Credit replaces income-related ESA. However, that process was only just beginning in Blackburn with Darwen in February 2018.*

VISUAL IMPAIRMENT

Risk factors and impacts[153, 149, 150, 151, 152]

Sight loss is related to many of the other topics in this review, either as a cause or a consequence (Figure 80). Several of the risk factors in the diagram are modifiable, and it is roughly estimated that about 50% of sight loss can be avoided.[153]

Blind and partially sighted residents

In 2015/16, 99 new patients in Blackburn with Darwen were certified as blind or partially sighted.[154] Registering with the council is optional, but as at March 2017, Blackburn with Darwen had approximately 620 residents registered as blind, and 825 as partially sighted.[154,155] Approximately half were over the age of 75.

Modelled estimates

The RNIB estimates that the true number of people affected by sight loss in Blackburn with Darwen may be in the order of 3,630.[154]

Figure 80 - Sight loss: risk factors and impacts

SIGHT LOSS
1 in 5 people aged 75+
1 in 2 people aged 90+
have sight loss
age
Asian people are at higher risk of cataract & diabetic eye disease
ethnic group
obesity
diabetes
hypertension
stroke
Smokers double their risk of AMD and develop it earlier
smoking
lower socio-economic status
Older people with sight loss are 1.7 x more likely to fall; many restrict activities due to fear of falling
trips & falls
depression
Older people with sight loss are 3 times more likely to be depressed....
loneliness & isolation
...and also more likely to be lonely
loss of independence
poverty
40% of people with sight loss have difficulty making ends meet
worklessness
Only 1/3 of registered blind/partially sighted people of working age are in employment

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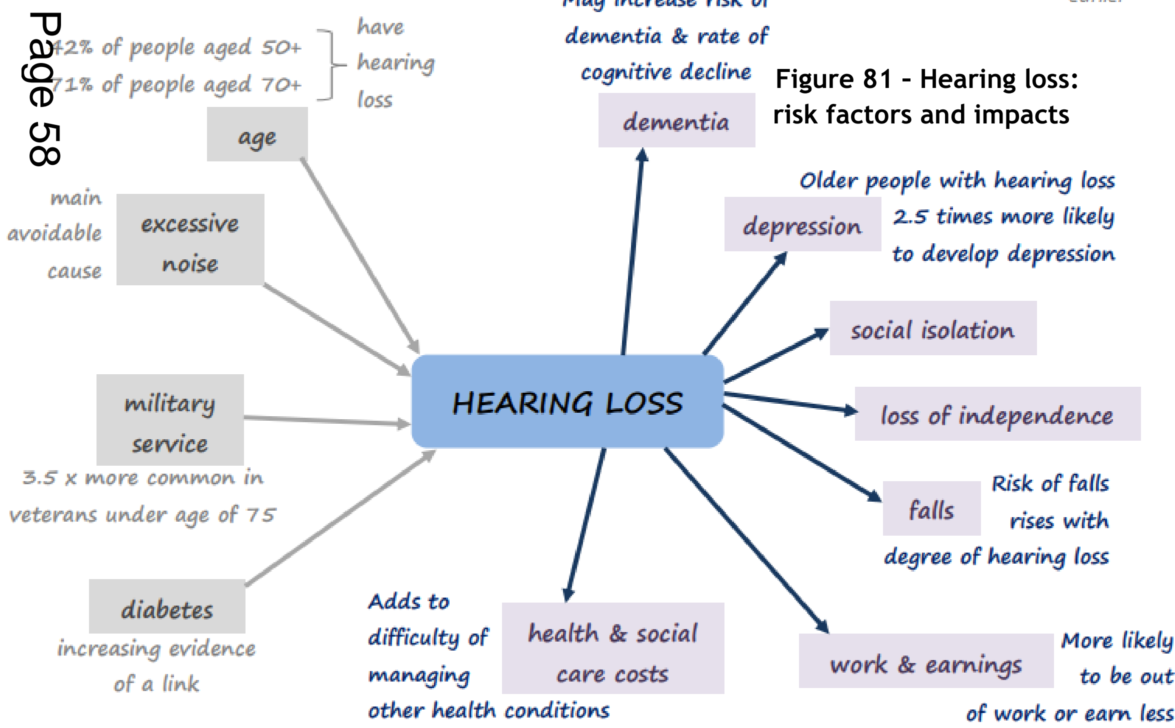

Figure 81 - Hearing loss: risk factors and impacts

HEARING LOSS

Risk factors & impacts[156,157]

Like visual impairment, hearing loss is closely related to many of the other issues considered in this JSNA (Figure 81). NHS hearing aids have been shown to be a cost-effective way of reducing many of the negative impacts shown.[156,157]

Figure 82 - Modelled prevalence of hearing loss in adults (*NCHA*[159])

Prevalence of hearing loss in adults:
>26%
24-26%
20-23%
17-19%
10-16%
Blackburn with Darwen

Modelled estimates

Modelled prevalence estimates suggest that Blackburn with Darwen had about 21,000 people affected by hearing loss in 2014, which was projected to rise to 23,000 by 2019.[157,158,159] This is a lower prevelance than in many surrounding areas, reflecting the borough's young population.

ROAD SAFETY

Overall casualties

In Blackburn with Darwen in 2016 there were 552 recorded road traffic casualties (of all ages), compared with 569 in 2015, and 553 the year before that. This puts Blackburn with Darwen 16th highest out of 152 upper-tier authorities in England when expressed as a rate per resident (or 29th highest as a rate per billion vehicle miles travelled).[160]

481 of these injuries were slight*, 69 were serious, and two were fatal, giving a total of 71 killed or seriously injured **(KSI)** in 2016. If we look at three years combined, Blackburn with Darwen had the 21st highest KSI rate out of 151 upper-tier authorities in 2014-16, and was significantly worse than England.[9] This is despite the fact that many other police forces (*not* including our own Lancashire Constabulary) switched to a new reporting system in 2016, which classifies more injuries as 'serious'.[62]

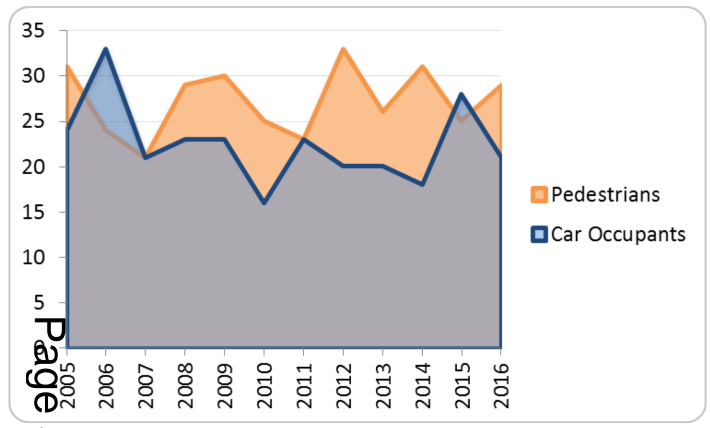

Figure 83 - Number of KSI casualties (BwD, 2005-16)

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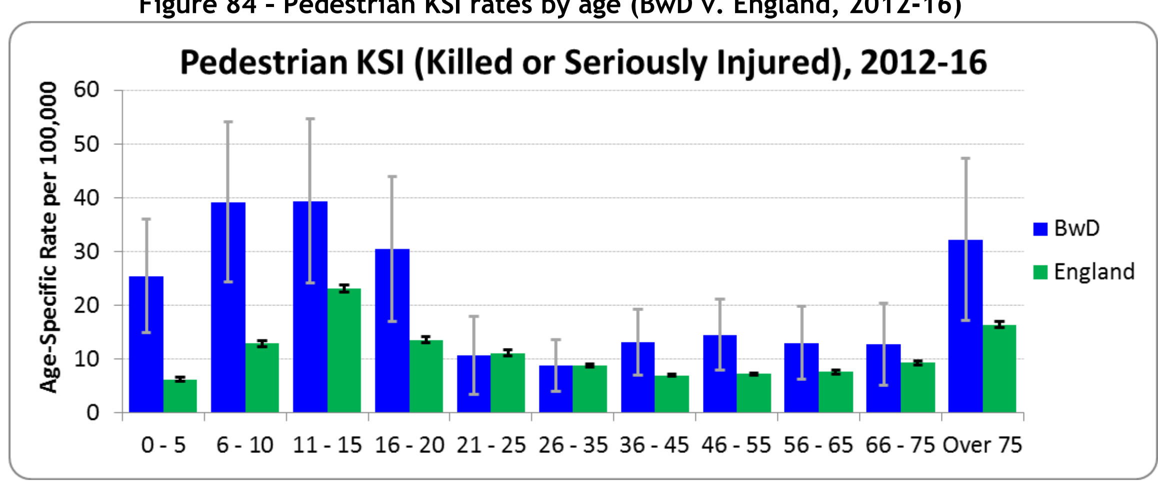
Pedestrian casualties

In 2016, Blackburn with Darwen had the 7th highest overall rate of pedestrian casualties in England (per 100,000 population), and the highest of all outside London.[160] If we focus on the more serious injuries, Blackburn with Darwen usually has more pedestrian KSIs than car occupant KSIs (Figure 83). This is the opposite of the national picture, where there are consistently at least 50% more car occupant KSIs than pedestrian KSIs.[160]

The *rate* of pedestrian KSI casualties in Blackburn with Darwen is higher than average for almost every age-group (Figure 84), and significantly so for the youngest residents (aged 0-10) and the oldest (aged 75+).

Figure 84 - Pedestrian KSI rates by age (BwD v. England, 2012-16)



Alternative rates

All the analysis so far relates to accidents *occurring* in Blackburn with Darwen, whether the casualty was local or not. Dividing by the resident population to obtain a rate may not therefore seem particularly logical.

An alternative is to count casualties according to where they *come* from, regardless of where their accident occurred. This is done in a recent report, but for constituencies rather than local authorities.[161]

Looking at things this way, the rate of KSI casualties from Blackburn constituency in 2011-16 was 28% higher than the Great Britain average, and for those from Rossendale & Darwen constituency it was 37% higher.

When all severities of casualty are considered (not just KSI), Blackburn constituency comes 13th highest out of 632 constituencies in Great Britain. If we focus on pedestrian casualties alone (of all severities), Blackburn constituency comes second highest in the country, with more than twice the national average rate.[161]

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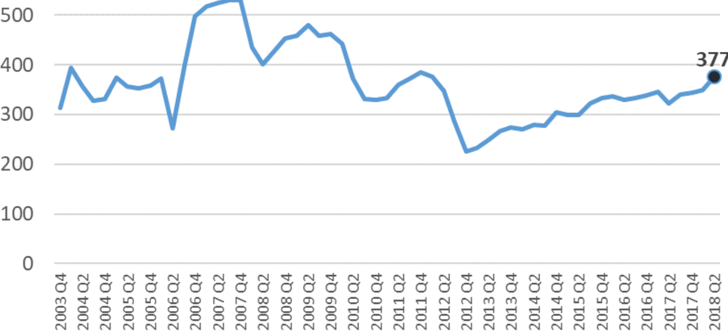
* *The recording of non-serious injuries is often less than complete.*

ASYLUM SEEKERS AND REFUGEES

Asylum seekers are those who have entered the UK and applied for refugee status, and are waiting for their claim to be assessed. They are allocated Home Office accommodation on a no-choice basis, are not allowed to work for twelve months, and rely on cash payments to meet their 'essential living needs'.

There is a notional cap of 350 on the number of asylum seekers placed in Blackburn with Darwen at any one time[162], although this has recently been exceeded (Figure 85):[163]



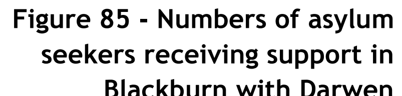


Figure 85 - Numbers of asylum seekers receiving support in Blackburn with Darwen

HEALTH NEEDS

The *Asylum Seekers and Refugees Health Needs Assessment*[162] recently carried out by the Public Health Department at Blackburn with Darwen Council, and the *Asylum Seeker and Refugee Community Report*[164] undertaken by Healthwatch Blackburn with Darwen, both explore these issues in detail via engagement work with local asylum seekers, refugees and service providers.*

Mental health

Asylum seekers are typically fleeing conflict, political upheaval and persecution, and it has been suggested that over 30% may be suffering from post-traumatic stress disorder (PTSD) as a result.[162,164] Consultation work with asylum seekers and refugees in Blackburn with Darwen found high levels of depression and anxiety, which may be exacerbated by isolation, boredom, culture shock, money worries, dealings with the Home Office, and the feeling of lack of control over their personal situation.[162]

Physical health

The *Blackburn with Darwen Asylum Seekers and Refugees Health Needs Assessment* highlights the issue of food poverty and malnutrition among this group. Cooking skills may be inadequate, especially among single men, and familiar foods are often unavailable. Asylum-seeking parents are often unaware of their entitlement to free school meals.[162]

Asylum seekers and refugees are at higher risk of infectious diseases than the general population, which may partly reflect their living conditions before and during migration. They also present with a high level of chronic non-communicable disease, often including poor dental health and a lack of awareness of dental hygiene.[162]

Access to health services

Lack of awareness, compounded by the fear of being charged, acts as a barrier to take-up of health services by asylumn seekers and refugees. Strenuous efforts have been made to try and ensure that all those in Blackburn with Darwen register with a GP, but there is a concern that this process is not always seen through to completion.[162,164]

Asylum seekers and refugees report feeling that appointments are rushed. This may partly be due to conflicting expectations, but also reflects the extra time needed to deal with complex issues and language barriers. Translation services may not always be in place, or able to cope with the variety of dialects in use, and are not provided at NHS dentists. Informal arrangements, such as relying on relatives to translate, can lead to a loss of privacy and dignity.[162,164]

> ***"My GP does not understand my problem. It is so frustrating as I can't speak English properly. I always need someone to translate for me at GP surgery."*** [164]

LOCAL SUPPORT

Blackburn with Darwen has three drop-in centres providing support for asylum seekers and refugees, at Darwen Asylum Refugee Enterprise (DARE), the ARC project, and Blackburn YMCA. In recognition of the welcome it offers to people in need of safety, it was granted 'City of Sanctuary' status in April 2018.[166]

* The Midlands and Lancashire CSU has also produced the useful *Guidance for considering the needs of Asylum Seekers and Refugees in commissioning health services*[165], with input from BwD.

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AGE WELL

ISSUES PARTICULARLY AFFECTING OLDER PEOPLE

TRIPS AND FALLS

Each year, around a third of over-65s will experience one or more falls, rising to 50% of over-80s. Falls in this age-group can result not only in pain and injury, but also loss of confidence and independence.[167] Hip fractures in particular severely impair the patient's prospects of being able to continue to live independently, and also carry a high mortality risk.[167,168] The fear of falling will often restrict the activities even of those who have *not* yet experienced a fall themselves.[169]

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Figure 86 - Ladies 'Strength and Balance' session organised by Baiter Sehat

Hospital admissions

After several years of persistently higher-than-average falls-related hospital admissions, Blackburn with Darwen is now similar to the England average, both among the 65-79 and the 80+ age-groups.[30]

Hip fractures

The overall rate of hip fracture for older people aged 65+ in Blackburn with Darwen has been close to average for several years. However, among the 80+ population (where most of these events occur), it is more erratic. The latest rate for this age-group was significantly above average, and one of the ten highest in England.[30]

Prevention and response

- Blackburn with Darwen's Falls Prevention Service offers targeted exercise programmes to improve the balance, strength and mobility of anybody over 65 who is at risk of falling.[170] The Chartered Society of Physiotherapists estimates that such programmes in Blackburn with Darwen can produce a return on investment of £3.85 per £1.[171]
- Home Assessment and Modification ('HAM') schemes aim to reduce falls risks by tackling issues such as loose mats, poor lighting and lack of handrails. They can produce a financial return on investment of £3.17 for every £1 spent, which rises to £7.34 per £1 when gains in Quality of Life are taken into account.[172,173,*]
- If an older person does fall, it is vital that help can be summoned quickly. Blackburn with Darwen now has over 2500 users of assistive technology, including falls pendants, alarms and bed occupancy sensors. Most are linked to the provider's monitoring and response centre, ensuring a prompt and appropriate response.[173,174]

FALLS PREVENTION IN THE ASIAN COMMUNITY

Concerned by the low attendance of South Asian heritage residents at falls prevention classes, Baiter Sehat ('Better Health') recently carried out a community engagement project on this topic with the borough's BME communities.

Focus group disussions confirmed that awareness of these services was low. However, when a special demonstration event was arranged for Asian ladies, it attracted nearly 50 enthusiastic participants. The report recommends that such sessions should be provided within community settings, for men and women separately. These should be promoted both verbally and in writing, in languages familiar to Asian elders. Two residents volunteered to become 'Falls Prevention Champions', who will help to spread the message.[175,176]

[*] *These returns were achieved when HAM schemes were delivered to people who had already been hospitalised by falls. They would probably be more modest for a lower-risk population.*[172]

DEMENTIA

What the papers say….

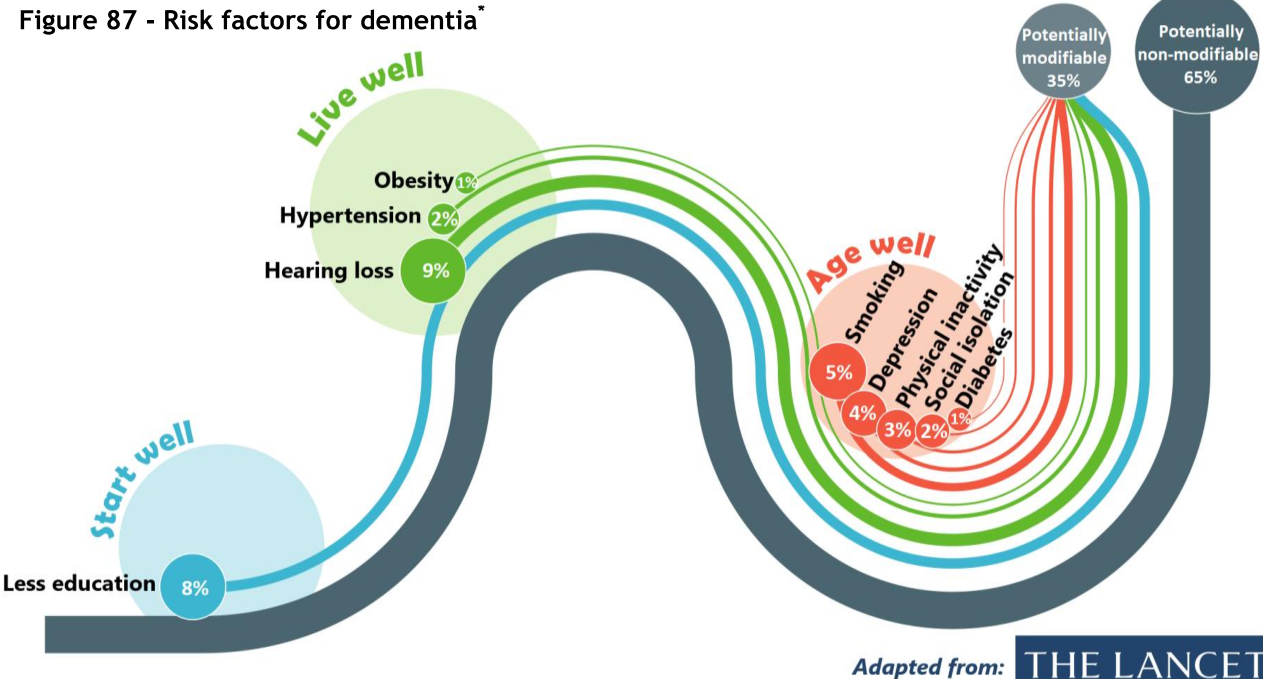
LOOKING AHEAD

Predicting the future burden of dementia is far from straightforward. Research at UCL and Liverpool University has concluded that: ***'The risk of developing dementia at any given age is going down over time, shifting dementia to later years in life. This decline is mainly because of improvements in healthcare and adopting healthier lifestyles.'*** [177] Even so, it predicts a 57% rise in the number of people *living* with dementia by 2040 in England and Wales, because of rising life expectancy.

'BE AMBITIOUS ABOUT PREVENTION' [181]

These predictions assume a continued decline in incidence rates, and would be higher still without it.[177] The study thus reinforces the key importance of public health measures aimed at dementia prevention.[178,179] Advice about how people can reduce their dementia risk now forms part of the NHS Health Check.[180]

Figure 87 - Risk factors for dementia*



Further new research, published in the Lancet, has quantified the proportion of new cases of dementia across the world that might theoretically be preventable.[181] As shown in Figure 87, modifiable risk factors are spread across the life-course, and together account for 35% of dementia incidence.*

Dementia in Blackburn with Darwen

As at August 2018, GP practices in Blackburn with Darwen had a total of 1133 patients aged 65 or over who had been formally diagnosed with dementia. It is estimated that the true number of people aged 65+ with the condition is likely to be nearer 1531, so this means that around 74% of those affected have received a diagnosis (England average 67.8%).[182] The latest age breakdown is for April 2018, when the total number of diagnosed patients aged 65+ was 1123 (Figure 88).

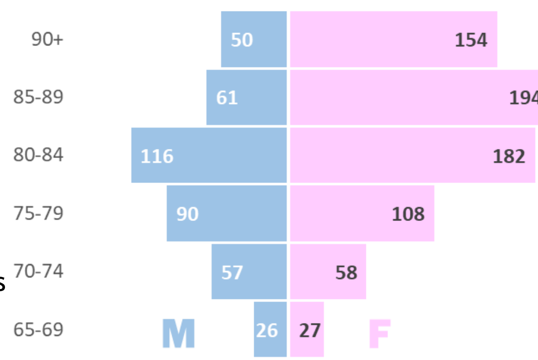


Figure 88 - Age/sex breakdown of Blackburn with Darwen patients aged 65+ diagnosed with dementia (as at April 2018)

BME COMMUNITIES

Previous work carried out by Baiter Sehat ('Better Health') has found low levels of dementia awareness within the local BME community, and a reluctance to come forward for diagnosis or accept help. There is significant stigma surrounding dementia, and no word for the condition in Urdu, Gujarati or Punjabi. However, these barriers are beginning to be overcome, and there is now an increased desire to learn about dementia and how it can be prevented, recognised and managed. With the support of schools, mosques and local businesses, a growing volunteer force of Dementia 'Friends' and 'Champions' are spreading the message in ways that recognise the language and cultural needs of the BME community, and have helped turn Whalley Range into the the borough's first 'Dementia Friendly Area'.[183,184]

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* *'Less education' means no secondary education. This is much less common in England than it is worldwide, so it may account for somewhat less than '8%' of the dementia risk in this country.*

See p44 for icon references

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QUALITY AND LENGTH OF LIFE

HEALTHY LIFE EXPECTANCY

Everything within the Public Health Outcomes Framework is geared towards achieving two 'overarching outcomes', one of which is **increased healthy life expectancy**. The importance accorded to this indicator reflects the philosophy that the public health system should be concerned not just with extending life, but with improving health and wellbeing across the life course. The calculation of Healthy Life Expectancy involves splitting total Life Expectancy into the portion spent in 'good' health and the remainder spent in 'not good' health, based on responses to a survey question such as: *"How is your health in general?"* (Figure 89):[185]

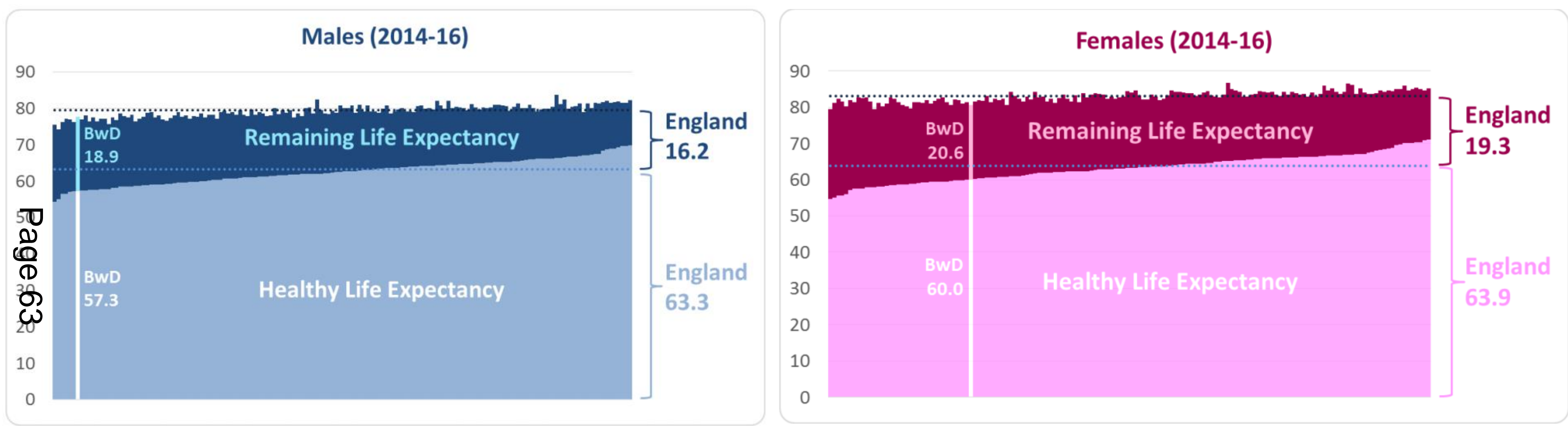


Figure 89 - Healthy Life Expectancy - Blackburn with Darwen compared with 150 upper-tier local authorities and England (2014-16)

It can be seen that Healthy Life Expectancy in Blackburn with Darwen is 57.3 years for males and 60.0 years for females, both of which are significantly lower than the England average. The borough's male Healthy Life Expectancy is the sixth equal lowest in England. When Healthy Life Expectancy is divided by total Life Expectancy, we find that males in Blackburn with Darwen can expect to spend 75.2% of their life in good health, and females 74.5%, which again is below average for both sexes.

If the 2014-16 results for Blackburn with Darwen are compared with 2011-13 (the most recent non-overlapping period), there has been no significant change. The same is true if we compare them with the earliest available set of results, for 2009-11.

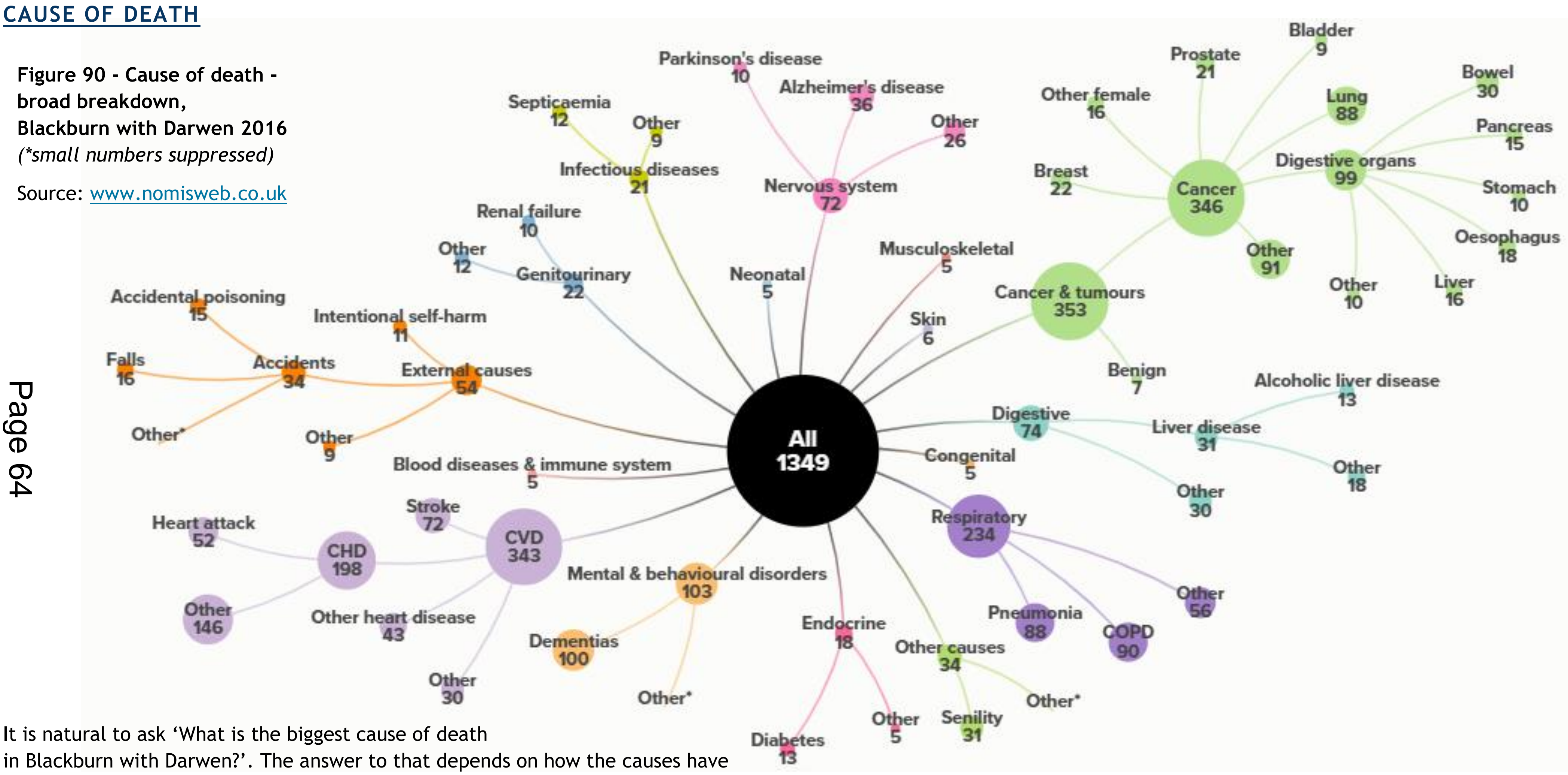
The Public Health Outcomes Framework acknowledges that Healthy Life Expectancy is the sort of measure which can take a long time to show any marked improvements, which is why the overarching outcomes are underpinned by a large collection of supporting indicators.[186]

END OF LIFE

CAUSE OF DEATH

Figure 90 - Cause of death - broad breakdown, Blackburn with Darwen 2016
*(*small numbers suppressed)*

Source: www.nomisweb.co.uk



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It is natural to ask ‘What is the biggest cause of death in Blackburn with Darwen?’. The answer to that depends on how the causes have been grouped together, but if we accept the very broad classification used here, the biggest category is ‘Cancer & tumours’ (with 353 deaths in 2016), followed by ‘CVD’ (343). This means that Cancer has overtaken CVD in Blackburn with Darwen since the previous Summary Review, as it had already done in England as a whole.

There is, however, no ‘right’ or ‘wrong’ way to split up the causes. The ONS prefers to combine the various forms of dementia, but split up CVD and cancers, which leads to the now-familiar headlines stating that Dementia and Alzheimer’s disease is the biggest cause of death in England and Wales.[187]

ICONS

Icons from the Noun Project (*thenounproject.com*):

- P23 – 'Weight Scale' icon by Semmel Zenko, 'Fruit' icon by Eucalypt
- P24 - 'Resting' icon by Luis Prado, 'Standing Posture' icon and 'Exercise' icon by Gan Khoon Lay
- P16. p24, p29, p32, p41 - 'Newspaper' icon by Loïc Poivet
- P31 – 'Heart Stroke' icon by Artem Kovyazin

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HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Dominic Harrison, Director of Public Health
DATE:	11th December 2018

SUBJECT:

Reducing deaths and ill health caused by poor air quality in Blackburn with Darwen and across Lancashire and Cumbria

1. PURPOSE

The purpose of this report is to:

- Provide an update on health related air quality both nationally and locally
- Provide information on recent work in Blackburn with Darwen and sub-regionally to improve air quality
- Outline next steps for action on air quality in both Blackburn with Darwen and sub-regionally

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

- Note the content of the report
- Consider what action the Health and Wellbeing Board and its constituent organisations may take to address and improve air quality.

3. BACKGROUND

As recently as the nineties it was felt that air pollution was no longer a major health issue in the UK. Priority had been given to tackling the biggest individual sources of air pollution and legislation had made the smogs of the fifties a thing of the past. As these major sources of emissions decreased, the relative contribution of smaller and more dispersed sources of air pollution has increased, which requires new types of action.

In more recent years evidence has emerged that small particles emitted to the air from various sources, such as road transport, industry, agriculture and domestic fires, are still having a considerable effect on health. Indeed, diesel engine exhaust, outdoor air pollution and particulate air pollution have been classified by the World Health Organization as carcinogenic. This type of air pollution is so small that it can't be seen by the naked eye, but can get into our respiratory system.

Air pollution reduces life expectancy by increasing deaths from heart disease, lung disease and circulatory problems and can have a short term impact over a single highly polluted day as well as long term impacts from low level exposure over a longer period of time. The majority of health problems result from long-term exposure to air pollution. Air pollution can also reduce lung development in children, which may increase symptoms in those young people who develop conditions like asthma.

The Impact of Air Pollution in Blackburn with Darwen:

Public Health England (PHE) estimate that poor air quality contributes to around 4% of all deaths across Lancashire and Cumbria. The figure for Blackburn with Darwen is 4.7% compared with Lancashire 4.4%; Blackpool 4.3%; and Cumbria 3.4% (PHOF, 2016). For Blackburn with Darwen this is equivalent to 62 deaths per annum however, air pollution is likely to contribute a small amount to the deaths of a larger number of exposed individuals rather than being solely responsible for the calculated figure of attributable deaths.

Air Pollution and Inequalities:

The most significant impacts of air pollution on health often fall on the most deprived communities and the most vulnerable individuals. There is a larger risk to health for young children and older adults, for whom air pollution causes more harm than passive smoking.

Local Action on Air Quality:

District and unitary councils have responsibility for monitoring air quality and reporting on the action being taken to improve areas of poor quality. Action to address the health impacts of air pollution on local populations can play a critical role in supporting other local priorities such as active travel and physical activity, health inequalities, sustainability and growth and regeneration.

Monitoring and modelling of air quality is undertaken in Blackburn with Darwen by Environmental Health staff to fulfil the requirements of the Local Air Quality Management regime, and to report on compliance with EU air quality targets. Air quality is monitored at 47 sites across the Borough and an automatic monitor at Accrington Road Community Centre. The outcome of this work is reported in an Annual Status Report, submitted to the Department for Environment, Food and Rural Affairs (Defra) each year which also outlines local action to improve air quality. For example;

- Initiatives to increase uptake in cycling and walking
- Travel planning information – identifying alternatives to car use
- New roads – bypasses and link roads
- Intelligent traffic light systems
- HGV bans on specific roads
- Camera systems providing information for transport/air quality action plans
- Electric vehicle charging points – on-street, at homes and at new commercial developments
- Cheaper parking for less polluting vehicles
- Bus and rail improvements
- Living green walls
- Planning guidance
- Targeting of vehicle fleets – e.g. increasing the number of low emission vehicles

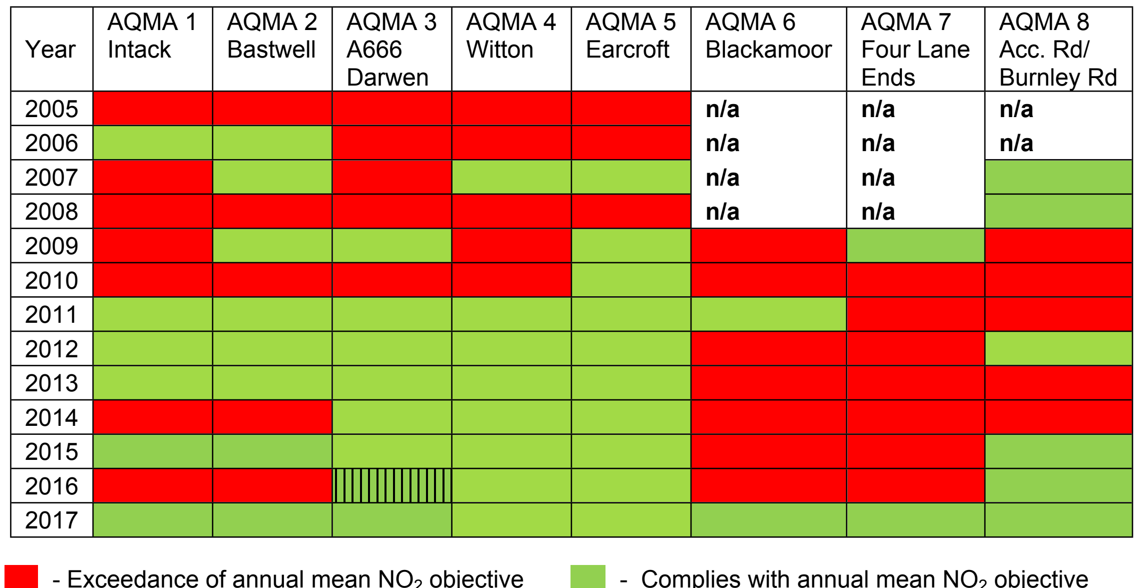
If a local authority finds any places where the national air quality objectives are not likely to be achieved, it must declare an Air Quality Management Area (AQMA). Where an AQMA is declared the local authority will put together a plan to improve the air quality. There are currently 7 AQMAs in the Borough, declared because of unacceptably high levels of nitrogen dioxides, mainly from road traffic.

- AQMA 1 - Intack, Blackburn (Junction of Whitebirk Rd and Accrington Rd)
- AQMA 2 - Bastwell, Blackburn (Junction of Whalley New Road and Whalley Range)
- AQMA 3 – Darwen Town Centre (A666 between Robert Street and Wraith Street, Darwen)
- AQMA 4 – Witton, Blackburn (Junction of Preston Old Road and Buncer Lane, Blackburn)
- AQMA 5 – Earcroft, Darwen (Junction of the A666 with M65 Link Road)
- AQMA 6 – Blackamoor (Junction of Stopes Brow, Blackamoor Road, Roman Road Blackburn)
- AQMA 7 – Four Lane Ends (Junction of Pleckgate Road, Revidge Road, Lammack Rd and Shear Brow)

An AQMA at the junction of Accrington Road / Burnley Road (AQMA 8) was revoked in 2017 due to improvements in the air quality as a result of Pennine Reach diverting traffic away from the affected area.

The table below shows how nitrogen dioxide levels have changed in the AQMAs over time. It can be seen that nitrogen dioxide in 2017 was below the level of concern in all AQMAs. Compared with previous years, there has been an improvement at almost all of the 46 monitoring locations. These improvements occurred across the Borough, so they can't be attributed to changes at individual junctions. The 2017 results are welcomed but should be treated with caution because some factors, like the weather, can cause short term changes in the build-up of pollution. The results of monitoring in the next few years will determine if 2017 was an anomaly or part of a lasting improvement.

Table 1: AQMA Trends Over Time



Year	AQMA 1 Intack	AQMA 2 Bastwell	AQMA 3 A666 Darwen	AQMA 4 Witton	AQMA 5 Earcroft	AQMA 6 Blackamoor	AQMA 7 Four Lane Ends	AQMA 8 Acc. Rd/ Burnley Rd
2005						**n/a**	**n/a**	**n/a**
2006						**n/a**	**n/a**	**n/a**
2007						**n/a**	**n/a**	
2008						**n/a**	**n/a**	
2009								
2010								
2011								
2012								
2013								
2014								
2015								
2016								
2017								

- Exceedance of annual mean NO_2 objective

- Complies with annual mean NO_2 objective

- Further monitoring ongoing to determine the existence or extent of any remaining pollution hotspot and whether it affects any residents in town centre flats.

AQMAs No.6 and No.7 present the most significant challenge. The action plan will be updated to include new measures to tackle problems at Four Lane Ends.

In order to achieve these improvements within Blackburn with Darwen a range of actions have been taken which can be split into 3 broad categories:

1. Physical changes – at junctions to address congestion and reduce emissions. The Pennine Reach rapid bus transport scheme was completed in April 2017 and has already brought about improvements in air quality at the Accrington Rd / Burnley Rd AQMA. Growth Deal 3 funding has been secured for local road projects including the Blackamoor Link Road. New intelligent traffic signals have been installed at Blackamoor.

2. Choices - giving people more choices about how they travel and making less polluting options more appealing. The Authority is backing cycling and walking, improving public transport, providing travel planning advice and raising awareness of the benefits that more sustainable and healthy options can provide. Major improvements in the quality of bus services have been delivered by Pennine Reach. In terms of cycling, there has been a 670% increase in leisure rides, the introduction of a new cycle pump track and the 26km Witton Wheel Cycling route. Walking and other active transport choices are being promoted by Public Health initiatives, such as the Eat Well, Move More, Shape Up Strategy 2017-2020, and the commitment to support physical activity, active travel, cycling and walking through the Pennine Lancashire Health and Social Care transformation plans.

It is recognised that there is a significant overlap between the need to address poor air quality and ill-health resulting from inactivity.

3. Managing Development - A new Air Quality Planning Advisory Note has been adopted for Blackburn with Darwen, which sets out how we intend to deal with site specific issues that need to be addressed and provides guidance which identifies how developers can take action that will reduce the health impact associated with development and transport emissions. For example, most new residential developments are required to include low emission gas boilers and electric vehicle charging points, and charging points are also being required at some commercial developments.

4. RATIONALE

Action on air quality across Lancashire and Cumbria:

Much of the action required to improve air quality will need to be taken by people without any specific statutory role to improve health and wellbeing. The impact of the individual household or business may be small, but the combined impact of actions taken by national and local government, large and small businesses and individuals can make a significant difference. As such, the Lancashire and Cumbria Directors of Public Health identified action on air quality as a sub-regional priority requiring a whole system approach and hosted a **Lancashire and Cumbria Air Quality Summit** on 28th February 2018 to explore ways to accelerate action.

The purpose of the summit was to;

- Improve understanding of air pollution, the health risks of air pollution and scale of the problem
- Improve understanding of what actions could be taken to reduce population exposure to air pollution with additional co-benefits to health, economy, sustainability
- Share good practice including national and local examples of air quality improvement work
- Strengthen participants understanding of their own and each other's' roles in tackling air pollution
- Consider ways of improving public awareness and engagement for action on air quality
- Define the agenda for collective action across Lancashire and Cumbria

The event was attended by Elected Members, Public Health, Planning and Transport and Environmental Health, special interest groups, citizen representatives and academics. The Programme was opened by Cllr Brian Taylor (Blackburn with Darwen Council) and included contributions from Public Health England, Prof Barbara Maher (Lancaster University) talking about emerging evidence of particulate matter in the brains of people with Alzheimer's disease, local authority representatives sharing local approaches and the importance of coordinated action and Prof John Whitelegg (Liverpool John Moores University) who challenged participants regarding further action to improve air quality in the region.

Attendees put forward ideas and suggested ways in which we can encourage and mobilise action on air quality, which were incorporated into a collective report of the Lancashire and Cumbria Directors of Public Health entitled Reducing deaths and ill-health caused by poor air quality in Lancashire and Cumbria. (attached as Appendix 1). The purpose of the report is to:

- Improve awareness and engagement for action on air quality and understanding of everyone's role in tackling air pollution, building on existing plans and strategies
- Start a conversation about the ways in which we can all work together and hold each other to account for action to improve air quality
- Outline areas for further action to reduce population exposure to air pollution, as identified at the Summit.

The report was launched on 21st June 2018 to coincide with Clean Air Day, which is a national drive to help people find out more about the issues surrounding air pollution and how they can make a difference.

5. KEY ISSUES

Air pollution doesn't just affect people living in AQMAs. It is evident that the Local Air Quality Management Regime and UK ambient air quality standards haven't adequately protected public health. For example no AQMAs have been declared in Lancashire and Cumbria because of particulate levels. Particulates are the tiny particles of soot produced when fuels are burnt. They are invisible to the naked eye but are able to pass deep into a person's lungs. Yet the fraction of mortality attributable to man-made particulates is significant. Action taken to reduce the impact of air pollution should not, therefore, be limited to measures designed to address problem in AQMAs only.

Bringing about change on a significant scale is not easy and requires a whole system and whole of society approach. Investment and growth has the potential to impact negatively on air pollution but is essential for the delivery of key objectives, such as employment and housing. As a consequence, there are conflicting priorities and this presents a challenge to us all.

Next Steps:

Blackburn with Darwen AQMA action priorities:

- Develop an action plan for Four Lane Ends junction AQMA.
- Assess the impact of the new road at Blackamoor AQMA once more information is known about the layout and anticipated traffic flows.
- Further monitoring to determine if some AQMAs can be revoked
- Close monitoring of the Moorgate Street/Livesey Branch Road and the Accrington Road Toll Bar Junctions because they hover below level at which new AQMAs may need to be declared.
- Delivering the DfT's Access Fund project "CONNECTING East Lancashire" working with businesses, educational establishments, residents and commuters to raise awareness of travel options and the choices available, in addition to delivering interventions that address specific barriers to active travel.
- Emissions from factories, domestic and commercial bonfires, and also from stoves and fireplaces in smoke control areas are regulated to minimise emissions.

Lancashire and Cumbria Air Quality Priorities:

The suggestions put forward at the Lancashire and Cumbria Air Quality Summit are captured in Appendix 2. This list is not intended to be exhaustive but will act as a guide for further discussion and local action. The Directors of Public Health are working with all stakeholders to turn these suggestions into appropriate action and understand how we might better mobilise the support of wider society in this challenge.

A sub-regional network of individuals from all sectors, including members of the community is being established in support of this and in Blackburn with Darwen we are establishing a local **community of interest** to support and sustain the agenda and our many and varied roles, responsibilities and interests in it. This will be both a real and virtual place for us to share information and good practice, bring local challenges and grow local solutions and a platform from which we can effectively engage in the wider sub-regional/regional/national activity.

6. POLICY IMPLICATIONS

There are no direct policy implications of this report..

7. FINANCIAL IMPLICATIONS

There are no direct financial implications of this report.

8. LEGAL IMPLICATIONS

The Environment Act 1995 requires local authorities to regularly assess the air quality in their area for the key pollutants designated in the National Air Quality Strategy.

The Council has a duty to review and assess local air quality, and to implement actions for improving local air quality. All district and unitary councils are required to submit an Air Quality Annual Status Report (ASR) to the Department for Environment, Food and Rural Affairs (Defra) each year giving an overview of air quality in their area and actions planned, in progress or completed to improve air quality.Where National Standards are not met Air Quality Management Areas must be declared and an Action Plan produced.

The proposals outlined in this report and appendices will assist the Local Authority in executing its responsibility to monitor emissions and reduce emissions in areas where minimum acceptable levels are exceeded.

The Council has a legal duty to write an annual progress report every 3 years, to update and screen assessments and, if required, produce detailed and further assessments.

9. RESOURCE IMPLICATIONS

There are no direct resource implications of this report.

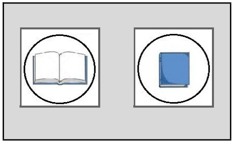
10. EQUALITY AND HEALTH IMPLICATIONS

The priorities set out in this paper are intended to improve health and wellbeing and reduce inequalities and all subsequent activity will be assessed in this regard.

11. CONSULTATIONS

The Lancashire and South Cumbria Air Quality Summit incorporated representatives of key stakeholder organisations and community representative groups. The points set out in this paper and the Lancashire and Cumbria report were presented to the Council's Executive Board for consideration on 11th October 2018.

VERSION:	**1**
CONTACT OFFICER:	Laura Wharton Denise Andrews
DATE:	20th November 2018
BACKGROUND PAPER:	Paper to Executive Board 11th October 2018



Air Quality and Public Health

Reducing deaths and ill-health caused by poor air quality in Lancashire and Cumbria

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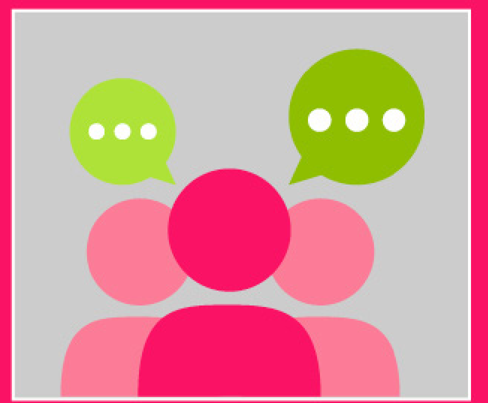

Talk the talk

Most people don't know how to protect themselves from air pollution. You can help them by sharing our REDUCE and AVOID tips.

Foreword from the Lancashire and Cumbria Directors of Public Health

Dear Colleagues,

Despite massive improvements over the past 50 years, poor air quality is still harming the health of residents of Lancashire and Cumbria. It is estimated that long term exposure to particulate matter alone has an effect equivalent to 29,000 deaths a year in the UK increasing the risk of illnesses such as heart disease, stroke, respiratory disease and cancers. Public Health England (PHE) estimates that the poor air quality contributes to around 4% of all deaths across Lancashire and Cumbria.

Action to address the causes and mitigate the consequences of avoidable air pollution needs to be taken at all levels of society from Government through to the individual. Reducing air pollution to the point that its effects on human health are zero is probably impossible. The creation of air pollution is a consequence of our mobile lifestyles, our chosen patterns of production and consumption of goods and of our need to provide some of the basics of life such as food and shelter. The challenge then is for us to decide how much pollution and consequent health harms are socially and morally acceptable and how much of it we want to stop.

Many of the ways in which we could reduce air pollution involve costs – to the economy, to the personal freedoms we enjoy, to consumer choice, to planning regulations and to the industries whose profits are maintained by not having to contain their pollution effects on surrounding populations. Air pollution is thus a 'wicked problem' – everyone wants it reduced but considerably fewer of us are prepared to take the actions necessary.

For such complex problems there are distinct advantages to taking a 'social movement for health' approach, which involves mobilising action across the whole of society including the public and private sectors, individuals and communities. This is the approach that the Lancashire and Cumbria Directors of Public Health are recommending. We began to explore this further with our partners at the Lancashire and Cumbria Air Quality Summit on 28th February 2018. The Summit brought together a cross section of those with some responsibility for air quality to better understand the ways in which we can accelerate improvement and make a collective difference.

This approach involves multiple agencies and individuals all working to a common goal across diverse communities, in different public, private and voluntary sector bodies, frequently without extra funding or centralised command and control project planning. We will explore the list of suggestions generated at the Summit (see page 16) and work together with all stakeholders to turn them into appropriate action. We will do as much of this work together with the public as possible and be as transparent as we can about what we are doing and what difference it is making.

To work through how we might better mobilise the support of wider society in this challenge we are working with the NHS Leadership Centre to explore how to better create public health leadership outside of the health sector. This will be a critical success factor if we are to make a difference.

Foreword from the Lancashire and Cumbria Directors of Public Health

We look forward to continuing the conversation about imroving air quality in Lancashire and Cumbria. You can join us at **#AirQualityLandSC**

This report is being launched to coincide with **Clean Air Day 2018**. For more information on Clean Air Day and the Action that people can take to reduce pollution and their exposure to pollution visit the Clean Air Day website at www.cleanairday.org.uk or follow **#CleanAirDay**

Lancashire and Cumbria Directors of Public Health :

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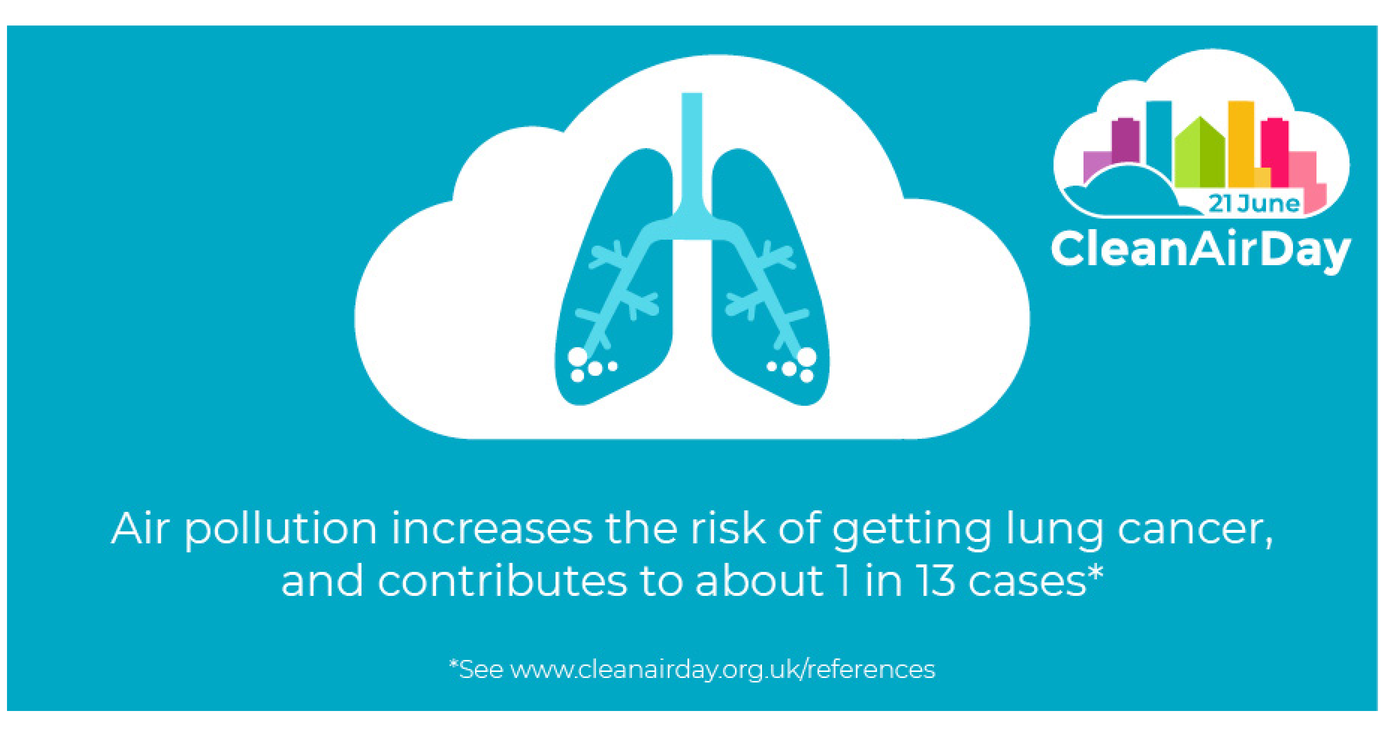
Dr Arif Rajpura, Blackpool Council



1 Purpose of the report

This is a collective report of the Lancashire and Cumbria Directors of Public Health highlighting air quality issues across the region and following on from the Lancashire and Cumbria Air Quality Summit held in February 2018. The purpose of the report is to;

- **Improve awareness and engagement for action on air quality and understanding of everyone's role in tackling air pollution, building on existing plans and strategies**
- **Start a conversation about the ways in which we can work together and hold each other to account for action to improve air quality**
- **Outline potential areas for further action to reduce population exposure to air pollution, as identified at the Summit.**

2 Understanding the problem

As recently as the nineties it was felt that air pollution was no longer a major health issue in the United Kingdom. Priority had been given to tackling the biggest individual sources of air pollution and legislation had made the great smogs of the fifties a thing of the past. As these major sources of emissions decreased, the relative contribution of smaller and more dispersed sources of air pollution has increased, which requires new types of action.

In more recent years evidence has emerged that small particles emitted to the air from various sources, such as road transport, industry, agriculture and domestic fires, are still having a considerable effect on health. This type of air pollution is so small that it can't be seen by the naked eye, but can get into our respiratory system.

The Department of Health's Committee on the Medical Effects of Air Pollutants (COMEAP) estimated the burden of particulate air pollution in the UK in 2008 to be equivalent to nearly 29,000 deaths and an associated loss of population life of 340,000 years by increasing the risk of diseases such as heart disease, stroke, respiratory disease and cancers. Indeed diesel engine exhaust, outdoor air pollution and particulate air pollution have been classified by the World Health Organization as carcinogenic.

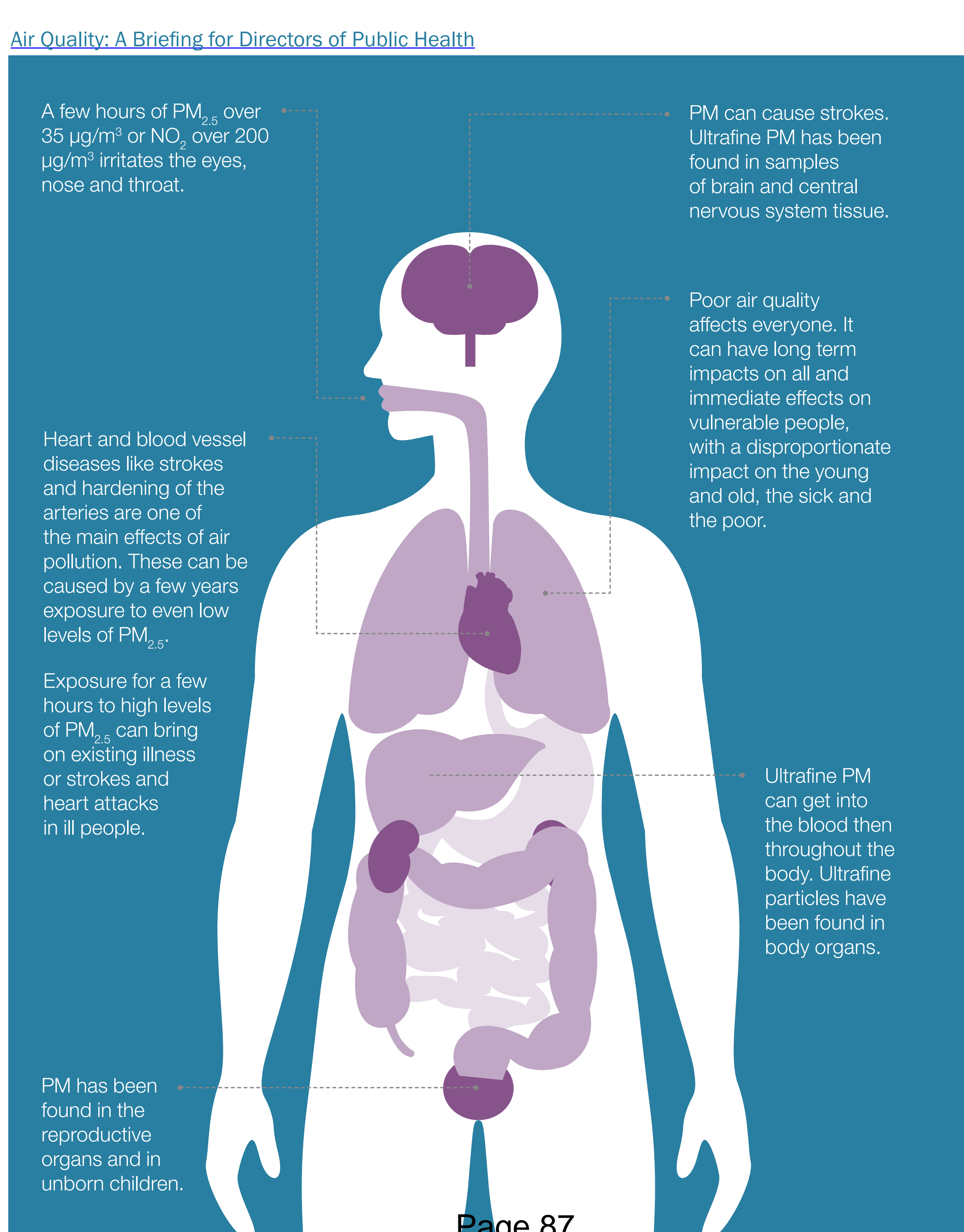
The Department for Environment, Food and Rural Affairs (Defra) has estimated the effects of nitrogen dioxide (NO_2) on mortality to be equivalent to 23,500 deaths in the UK annually, although this figure will include some overlap with the impact from exposure to other pollutants. It is difficult to reliably estimate the combined health burden of multiple pollutants from the same source, but a report by the Royal College of Physicians (RCP) in February 2017 estimates that all forms of air pollution account for around 40,000 deaths annually with an associated annual social cost of £22.6 billion.

Air pollution can have a short term impact over a single highly polluted day as well as long term impacts from low level exposure over a longer period of time. Evidence suggests that short-term exposure to air pollution increases the risk of death, but the numbers affected are thought to be lower than for long-term exposure. That's because most people will not be affected by short-term peaks in ambient air pollution but some, such as those with existing heart or lung conditions, may experience increased symptoms such as wheezing, coughing, and exacerbations of asthma and chronic bronchitis.

The majority of health problems result from long-term exposure to air pollution, which can cause breathing problems and other conditions mainly affecting the heart and lungs. In addition, air pollution can reduce lung development in children, which may increase symptoms in those young people who develop conditions like asthma.

Fig 1: Where air pollutants go in our bodies and what they do

Air Quality: A Briefing for Directors of Public Health



2 What is air pollution and where does it come from?

The graphic below highlights the most common sources of air pollution and where people are exposed:

Air pollution is a mixture of particles and gases than can have adverse effects on human health as described in the table below:

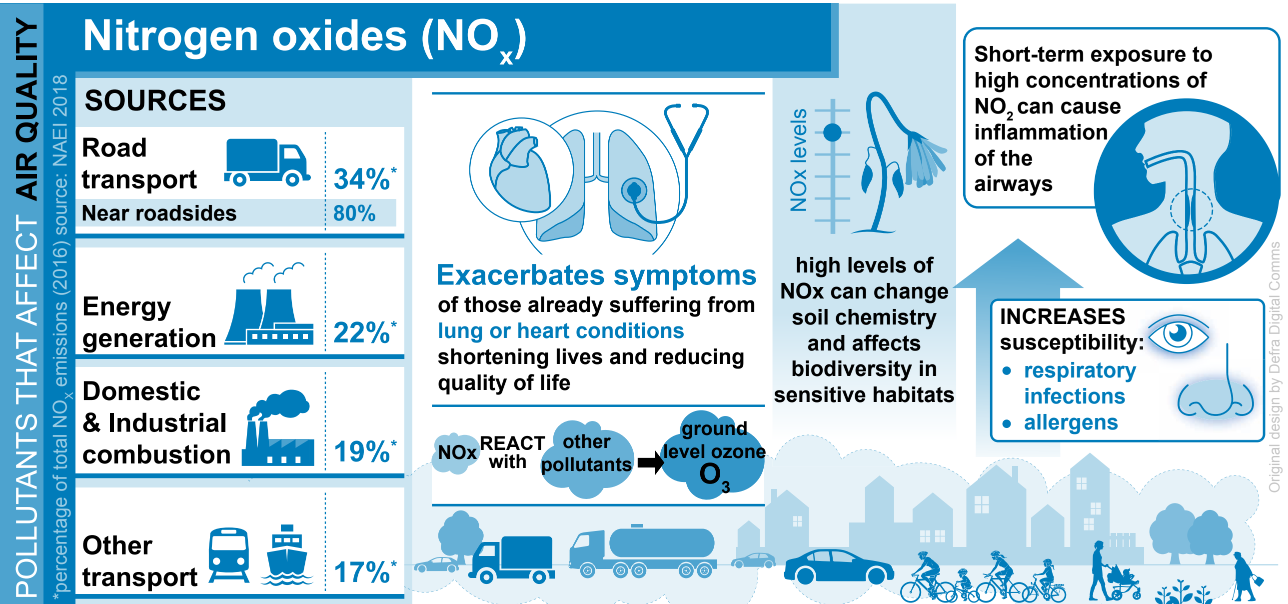
Oxides of nitrogen (NOX)	• A cover term for nitric oxide {NO) and nitrogen dioxide (NO_2) • A mixture of naturally occu ring and man-made gasses, often at a peak in rush hour traffic and strongly associated with diesel vehicles
Particulate matter (PM)	• A complex mix of substances wbich are mainly man-made • Can be coarse or very fine material and therefore possible to breathe into the lungs and pass into the bloodstream
Carbon dioxide (CO_2)	• A natural gas but considered a pollutant when man-made • Widely associated with climate change and global warming
Carbon monoxide (CO)	• Naturally present in the atmostphere but very harmful in enclosed environments • Man-made sources linked largely to combustion engines
Sulphur dioxide (SO_2)	• A gas which is present in the air mainly due to burning fossil fuels and oil. Power stations are a key source in the UK. • SO_2 emissions have successfully been reduced over previous decades

2 What is air pollution and where does it come from?

The most important types of pollution in terms of population health impacts are nitrogen dioxide (NO2) and particulate matter (PM), described below.

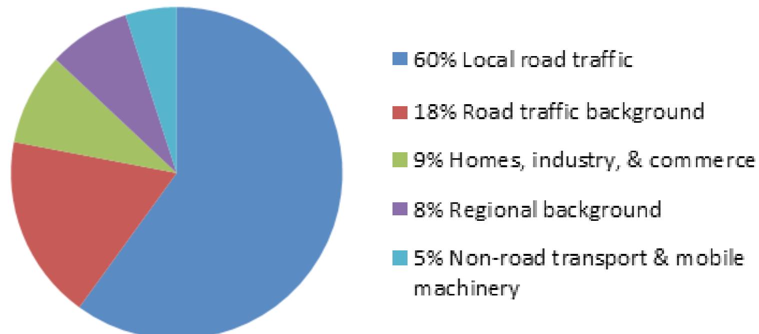
Nitrogen Dioxide (NO_2)

Nitrogen oxides (NOX) are a group of gases that are mainly formed during the combustion of fossil fuels. NO (nitrogen oxide) coverts to NO2 (nitrogen dioxide) very quickly and vice versa. It is therefore usual practice to refer to the two gases together as NOX. For reporting and measurement purposes, we report NOX as NO2. The figure below details its adverse effect on health.



The chart below shows the breakdown of roadside NO_2 sources across the UK but is representative of the sources in our Lancashire and Cumbria pollution hotspots.

Sources of Nitrogen Dioxide at Roadside Locations



These hotspots are locations where people are exposed to nitrogen dioxide levels in excess of the UK air quality standard of 40µg/m3 and where road vehicle emissions make a much more significant contribution to pollutions levels. Exposure is highest closest to the roadside.

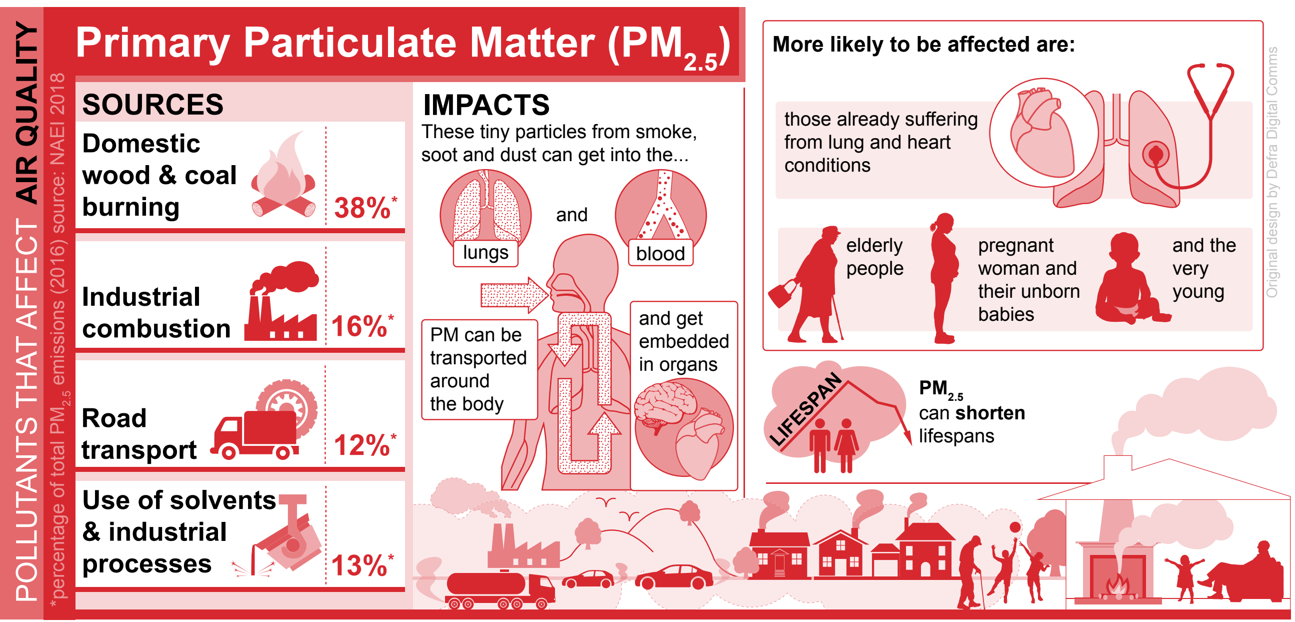
2 What is air pollution and where does it come from?

Particulate Matter (PM)

Particulate matter is everything in the air that isn't a gas. It is the suspended solids and liquids that come from natural sources such as pollen, sea spray and desert dust, and human made sources such as smoke from fires, emissions from vehicle exhausts, dust from tyres and brakes, as well as emissions from industry. Particulates are emitted directly from these sources, and can also be formed by chemical reactions in the atmosphere.

Additionally, the recent rise in the popularity of wood burning stoves and open fires is making a significant contribution to particulate matter. It is estimated by Defra that around 40% of particulate pollution comes from burning of domestic solid fuel.

Fine particulate matter (PM2.5), with a diameter of 2.5 µm or less (a µm is 1/1000th of a millimetre) has the strongest link to health outcomes. At this size the particles can be inhaled deep into the lungs. The figure below highlights the main sources and impacts of PM2.5.



2 Who is most at risk?

We are all affected by air pollution. However, the impact of air pollution on health is not distributed equally within a population, often falling on the most deprived communities and the most vulnerable individuals.

There is a larger risk to health for young children and older adults, for whom air pollution causes more harm than passive smoking. Air pollution reduces life expectancy by increasing deaths from heart disease, lung disease and circulatory problems. For example, the effect from long-term particulate matter exposure is greatest in those with heart disease, strokes or with lung cancer (COMEAP, 2010).

There is a disproportionate impact from poor air quality to those who live close to heavily, congested roads and other major sources of air pollution; factors which are more likely to affect people living in poorer communities.

Use your feet, take to the street

Walk, cycle, bus, tube, tram, boat, unicycle... However you like to travel, leave your car at home and take to the streets. As well as cutting down the amount of pollution you make, you can get some exercise, check out that new deli you've been meaning to pop into, or even meet a friend for a catch-up on the way home.

3 Air Quality in Lancashire and Cumbria

Local air quality can be quantified in terms of compliance with specific air quality objectives for key pollutants. Since December 1997 each local authority in the UK has been required to carry out a review and assessment of air quality in their area. This involves measuring air pollution and trying to predict how it will change in the next few years. The aim is to make sure that the national air quality objectives will be achieved throughout the UK. These objectives have been put in place to protect people's health and the environment.

Monitoring and modelling of air quality is undertaken across Lancashire and Cumbria to fulfil the requirements of the Local Air Quality Management regime, and to report on compliance with EU air quality targets. Local authorities report the outcome of this work in an Annual Status Report, which is usually published on each Local Authority website.

Air Pollutions Hotspots:

If a local authority finds any places where the national air quality objectives are not likely to be achieved, it must declare an Air Quality Management Area (AQMA). Where an AQMA is declared the local authority will put together a plan to improve the air quality - a Local Air Quality Action Plan.

Air Quality Management areas have been declared at 33 locations across Lancashire and Cumbria. They have all been declared as a consequence of raised levels of nitrogen dioxide.

Air Quality Management areas in Lancashire and Cumbria		
Authority	No. AQMAs	Air Quality Standard exceeded in AQMAs
Allerdale	0	
Barrow	0	
Blackburn	7	Nitrogen dioxide
Blackpool	1	Nitrogen dioxide
Burnley	0	
Carlisle	6	Nitrogen dioxide
Chorley	0	
Copeland	0	
Eden	0	
Fylde	0	
Hyndburn	0	
Lancaster	3	Nitrogen dioxide
Pendle	1	Nitrogen dioxide
Preston	5	Nitrogen dioxide
Ribble Valley	1	Nitrogen dioxide
Rossendale	2	Nitrogen dioxide
South Lakeland	1	Nitrogen dioxide
South Ribble	4	Nitrogen dioxide
West Lancs	1	Nitrogen dioxide
Wyre	1	Nitrogen dioxide
	33	

Correct as of June 2018

3 Air Quality in Lancashire and Cumbria

An interactive map of Air Quality Management Areas can be found here:

AQMAs interactive map - Defra, UK

The majority of the Lancashire and Cumbria AQMAs cover relatively small areas and are centred on one or two busy urban junctions where the dispersion of exhaust emissions from slow moving vehicles at congested junctions and/or adjoining roads is hindered by the proximity of nearby buildings. A few AQMAs cover larger areas in urban areas such as parts of Kendal, Lancaster, and Blackpool. It is important to bear in mind that AQMAs are 'hotspots' for air pollution but health impacts are not confined to these areas.

Nitrogen dioxide levels in the City of Lancaster AQMA are in the region of 60 to 66μg/m^3, whereas concentrations in the other AQMAs tend to be at or slightly above the objective threshold of 40μg/m^3.

Air Quality Elsewhere

Air pollution doesn't just affect people living in AQMAs. It is evident that the Local Air Quality Management Regime and UK ambient air quality standards haven't adequately protected public health . For example, no AQMAs have been declared in Lancashire and Cumbria because of particulate levels, yet the fraction of mortality attributable to man-made particulates is significant. Action taken to reduce the impact of air pollution should not be limited to measures designed to address problem in AQMAs.

The impact on health

The Public Health Outcomes Framework (PHOF), estimates the fraction of all-cause adult mortality attributable to man-made fine particulate (PM2.5) air pollution for the four local authorities as: Lancashire 4.4%; Blackburn with Darwen 4.7%; Blackpool 4.3%; and Cumbria 3.4% (PHOF, 2016: **3.01 - Fraction of mortality attributable to particulate air pollution**).

There are no local or national measures of NHS usage that can be directly attributed to air pollution. Whilst local information exists for conditions that poor air quality contributes to or exacerbates, such as asthma and COPD, it is difficult to make any direct links with air pollution. Indeed, the recently published draft Clean Air Strategy identifies the need to gather better information on where, when and how patients report and are treated for air quality related health conditions. We will continue to work to build a picture of the health impact on our communities in Lancashire and Cumbria.

4 Action on air pollution

Everyone has some responsibility for reducing air pollution and will need to do their bit if we are to significantly improve air quality. The impact of the individual household or business may be small, but the combined impact of actions taken by national and local government, large and small businesses and individuals will improve the air we breathe.

Much of the action required to make a difference in Lancashire and Cumbria will need to be taken by people without any specific statutory role to improve health and wellbeing. Creating a social movement for health is, therefore, an act of deliberative democracy – going as far as people are willing to support – either by personal behaviour change, changes to environments or changes to the legal frameworks.

Below is a summary of some of the key organisations and opportunities for action on air quality.

4.1 National Government

In the UK we have already adopted ambitious, legally-binding **international targets** to reduce emissions of the most damaging air pollutants by 2020 and 2030 and reduce the harm to human health by half.

The UK Government published its detailed **UK plan for tackling roadside nitrogen dioxide concentrations** in July 2017. The plan aims are to:

» Achieve statutory limit values for the whole of the UK within the shortest possible time

» Transform the UK's most polluted towns and cities into clean and healthy urban spaces, supporting those most directly affected

» Ensure that vehicle manufacturers play their part to improve the nation's air quality

Actions to reduce road transport emissions include those intended to:

» Reduce emissions from the current road vehicles in problem locations now, including through promoting public transport, cycling and walking; and

» Accelerate the turnover to cleaner vehicles to ensure that the problem remains addressed and does not move to other locations

The UK Government are now also proposing new goals to cut public exposure to particulate matter pollution and have very recently produced a **Draft Clean Air Strategy 2018** for consultation setting out the comprehensive action that is required from across all parts of government and society in order to achieve these including new powers to take action in areas where air pollution is a problem. The strategy sits alongside three other important UK government strategies: **the Industrial Strategy, Clean Growth Strategy** and **25 Year Environment Plan** and includes chapters covering:

- our understanding of the problem
- protecting the nation's health
- protecting the environment
- securing clean growth and innovation
- reducing emissions from transport
- reducing emissions at home
- reducing emissions from farming
- reducing emissions from industry
- international, national and local leadership

4.2 Public Health England

Public Health England (PHE) is an executive agency of the Department of Health and Social Care; a distinct organisation with operational autonomy. PHE provides local and national government, the NHS, industry and the public with evidence-based, professional, scientific expertise and support.

For air pollution the specific role of PHE is to act as expert advisors providing:

- The evidence base for interventions to reduce air pollution
- The evidence base for the impacts of air pollution
- The sources of air pollution in the environment

More specifically, PHE provides:

- Local support to stakeholders concerned with reducing air pollution
- Educational materials to highlight the effects of air pollution or raise awareness of its impacts
- Experts from the Centre for Radiation Chemicals and Environmental Hazards (CRCE) to facilitate developments in support of these aims
- National advocacy to identify the impacts of air pollution and the importance of effective remediation
- Support to central government in attaining European standards required for air quality
- Identification and sharing of best practice

4.3 Local Authorities

Local authorities have a central role in achieving improvements in air quality; their local knowledge and interaction with the communities that they serve mean that they know the issues on the ground in detail. They are well placed to decide local priorities and work with partners to implement the appropriate solutions in regards to local transport, smoke control, planning and public health. District and unitary councils have responsibilities around monitoring air quality and reporting on the action being taken to improve areas of poor quality.

All district and unitary councils are required to submit an Air Quality Annual Status Report (ASR) to Defra each year giving an overview of air quality in their area and actions planned, in progress or completed to improve air quality. Examples of these measures may include:

- Initiatives to increase uptake in cycling and walking
- Travel planning information – identifying alternatives to car use
- New roads – bypasses and link roads
- Intelligent traffic light systems
- HGV bans on specific roads
- Camera systems providing information for transport/air quality action plans
- Electric vehicle charging points – on-street, at homes and at new commercial developments
- Cheaper parking for less polluting vehicles
- Bus and rail improvements
- Living green walls
- Planning guidance – improving the assessment of air quality impact and identifying mitigation
- Targeting of vehicle fleets – e.g. increasing the number of low emission vehicles

There is a role for **Public Health in local government** in assessing the health impacts of poor air quality on the population, providing advice and guidance on appropriate policies and action, raising awareness and working with local authority air quality officers and other partners.

Action to address the health impacts of air pollution on local populations can play a critical role in supporting other public health priorities such as active travel and physical activity, health inequalities, sustainability, growth and regeneration and community engagement.

4 Action on air pollution

4.4 Businesses and industry

Clean growth means growing our income whilst tackling air pollution. Cleaner air leads to increased productivity through improvements in public health, leading to reduced sickness absence and through creation of an environment that is appealing to businesses and the public alike. Much of the action to generate clean growth is driven at a national level and is set out in the Governments Clean Growth Strategy but locally we can encourage business and industry to take steps to improve air quality for example by encouraging walking and cycling, minimising emissions from fleet vehicles and introducing flexible working polices that reduce the number of car journeys made by staff.

4.5 Individuals and communities

As citizens we can all help improve air quality, for example by learning more about and acting as advocates for air quality, trying alternatives to car travel or taking the active option (walking and cycling), asking local authorities and MPs to take action and aiming for greater energy efficiency in our homes.

5 About the Lancashire and Cumbria Air Quality Summit:

The Lancashire and Cumbria Directors of Public Health identified action on air quality as a sub-regional priority and hosted a Lancashire and Cumbria Air Quality Summit on 28 February 2018 to explore ways in which we can accelerate action and make a collective difference. The aims of the summit were to;

» Improve participants' understanding of air pollution, the health risks of air pollution and the scale of the problem
» Improve participants' understanding of what actions could be taken to reduce population exposure to air pollution with additional co-benefits to health, economy, sustainability
» Share good practice including national and local examples of air quality improvement work
» Strengthen participants' understanding of their own and each other's' roles in tackling air pollution
» Consider ways of improving public awareness and engagement for action on air quality
» Define the agenda for collective action to prevent air quality attributable deaths across Lancashire and Cumbria

The event was attended by over 60 people including Elected Members, Local Government Public Health, Planning and Transport and Environmental Health, Public Health England, special interest groups, citizen representatives and academics.

The Programme included an opening from Cllr Brian Taylor (Executive Member for Health and Adults, Blackburn with Darwen Council) and County Councillor Charlie Edwards (Lead Member for Health and Adult Services, Lancashire County Council). Further presentations included a UK overview from Public Health England and Prof Barbara Maher (Lancaster University Environment Centre) talking about emerging evidence of particulate matter in the brains of patients with Alzheimer's disease. Paul Cartmell from Lancaster City Council and Andrew Hewitson from Lancashire County Council went on to outline local approaches and Matthew Clark from Shropshire County Council talked about the importance of coordinated action. The final presentation was from Prof John Whitelegg (Liverpool John Moores University) who challenged participants regarding how much more we need to do to improve air quality in the region.

Attendees put forward ideas and suggestions of ways in which we can encourage and mobilise action on air quality as outlined in the following section.

6 Areas identified for potential action following the Summit

The suggestions put forward at the Summit are captured below under a number of key themes. This list is not intended to be exhaustive but will act as a guide for further discussion.

Theme	Suggested areas for future work on reducing air pollution across Lancashire and Cumbria,
Leadership at all levels:	Strengthen and improve local leadership for action on air quality including. Suggestions included; • Elected Member and officer Air Quality Champion roles • Inclusion and consolidation of air quality in strategic plans, such as Health and Wellbeing Strategies, Joint Strategic Needs Assessment, Walking and Cycling, Public Health, Transport and Economic plans. • Extension of professional networks to include wider partners and help facilitate sharing of best practice and knowledge.
Public Awareness and Engagement:	Encourage greater public transparency about local air quality and empower local people to understand how air pollution can affect their health, how they can reduce air pollution, protect themselves and understand the opportunities, tools and powers available in support of this including. Suggestions included; • Making information about local air quality more accessible to members of the public in a range of formats • Community Air Quality Champions • A simple but coordinated set of messages for different audiences and coordinated communications plan linked to Clear Air Day and beyond
Planning Policy:	Adopt a common set of principles/guidance for planning policy and ensure these are considered as part of (any) new application. A Supplementary Planning Document (SPD) is the strongest form of guidance needed to compete with other planning issues and priorities.
Green Infrastructure	Collaborate across Lancashire and Cumbria to understand and develop best practice in relation to green infrastructure / barriers, for example type of species and locations, and their potential to mitigate against air pollution National air quality grant funding could be accessed collectively to develop green barrier projects in suitable pollution hotspots.

6 Areas identified for potential action following the Summit

Theme	Suggested areas for future work on reducing air pollution across Lancashire and Cumbria,
Travel and Transport:	A number of suggestions were put forward at the summit for action on travel and transport including: • Helping people to be less reliant on their cars and change travel habits by giving them other options, such as reliable public transport and introducing more walking and cycling routes.School and business Travel Plans – working with large employers • Making it easier for people to drive in the most efficient, least polluting way by providing them with information and training. • No idling zones, around schools, hospitals for example • Facilitating the uptake of elective vehicles and other clean alternatives to petrol and diesel vehicles • Improving vehicle emission standards for taxis and private hire vehicles consistent with neighbouring authorities • Reducing emissions from public transport and improving the public transport experience. • Action on these areas is underway at a local level through air quality actions plans, however, some interventions could be more effective when considered on a Lancashire and Cumbria footprint, such as facilitating EV infrastructure, for example.
Non transport pollution sources	The focus is often on emissions from vehicles, however there are a number of other pollution sources often overlooked, in particular from activities around the home such as wood burning stoves, open fires and cleaning with certain solvents. It is important to clarify and communicate the health messages and advice available to inform choice and behaviour to reduce personal exposure. Other non-transport pollution sources include farming and industry, such as from commercial biomass boilers, the impact and health messages need to be communicated.
Growing the evidence base and evaluation of actions	Interventions should be based on the evidence of what works and be evaluated before and after to ensure fully considered action plans are in place, including the cumulative impacts of pollution sources, and anticipated reductions are realised. Currently many actions are not fully evaluated or monitored so we have little information on their impact and whether actual improvements are achieved. There are opportunities to work across Lancashire and Cumbria to assess and evaluate actions that are best delivered large-scale such as on the highway network, for example the use of intelligent traffic systems and real time monitoring could be explored.

7 Next Steps

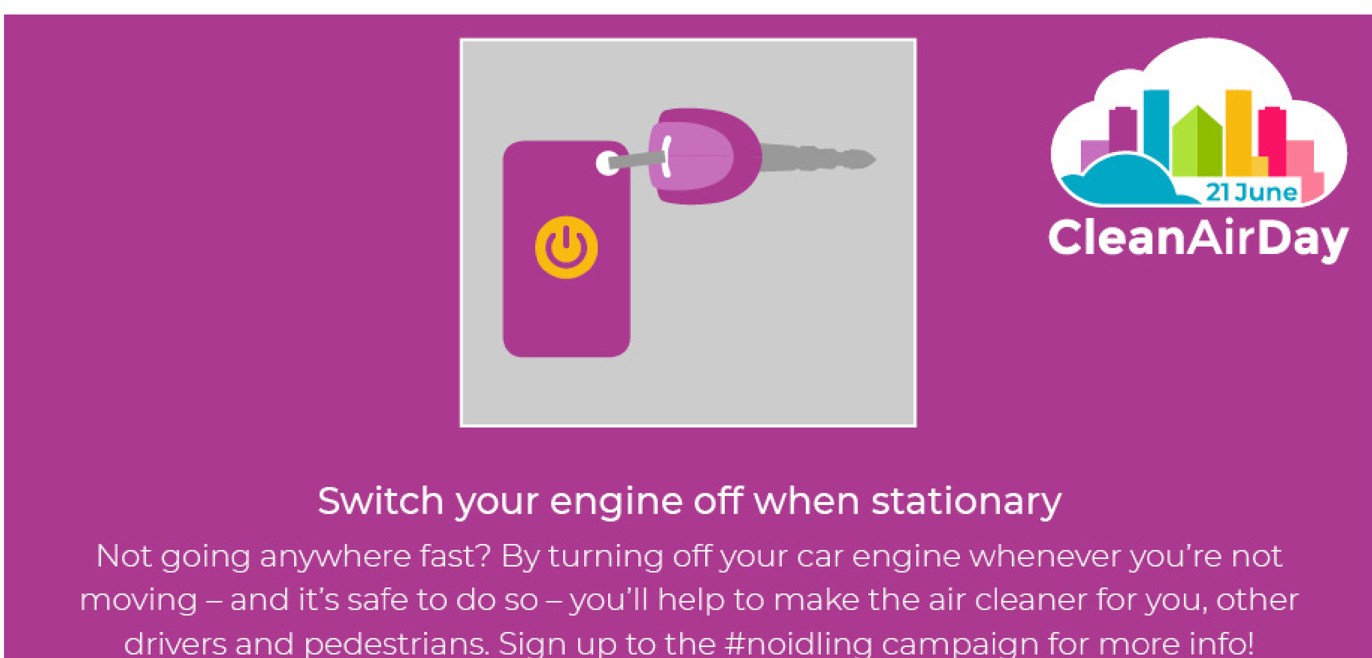
This report is intended help start a wider conversation about the action we need to take collectively to improve air quality.

We will further explore the list of suggestions generated at the Summit and work with all stakeholders to turn them into appropriate actions. We will do as much of this work in collaboration with the public as possible and be as transparent as we can about what we are doing and what difference it is making.

To work through how we might better mobilise the support of wider society in this challenge will work with the NHS leadership Centre to explore how to better create public health leadership outside of the health sector. This will be a critical success factor if we are to make a difference.

This report is being launched to coincide with Clean Air Day 2018. For more information on Clean Air Day and the Action that people can take to reduce pollution and their exposure to pollution visit the Clean Air Day website at www.cleanairday.org.uk or follow **#CleanAirDay**

We look forward to continuing the conversation about imroving air quality in Lancashire and Cumbria.
You can join us at **#AirQualityLandSC**



Cleaning up our air on the longest day of the year

Reduce air pollution today by
walking or cycling instead of taking your car.

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Appendix 2 : Key Recommendations of the Lancashire and Cumbria Air Quality Summit

Theme	Suggested areas for further work across Lancashire and Cumbria
Leadership at all levels:	Strengthen and improve local leadership for action on air quality including; • Elected Member and officer Air Quality Champion roles • Inclusion and consolidation of air quality in strategic plans, such as Health and Wellbeing Strategies, Joint Strategic Needs Assessment, Walking and Cycling, Public Health, Transport and Economic plans. • Extension of professional networks to include wider partners and help facilitate sharing of best practice and knowledge.
Public Awareness and Engagement	Encourage greater transparency about local air quality and empower local people to understand how air pollution can affect their health, how they can reduce air pollution, protect themselves and understand the opportunities, tools and powers available in support of this. For example: • Making information about local air quality more accessible to members of the public in a range of formats • Community Air Quality Champions • A simple but coordinated set of messages for different audiences and coordinated communications plan
Planning Policy:	• Adopt a common set of principles/guidance for planning policy and ensure these are considered as part of (any) new application. A Supplementary Planning Document (SPD) is the strongest form of guidance needed to compete with other planning issues and priorities.
Green Infrastructure	• Collaborate across Lancashire and Cumbria to understand and develop best practice in relation to green infrastructure, for example type of species and locations, and their potential to mitigate against air pollution. National grant funding could be accessed collectively.
Travel and Transport	Action on these areas is underway at a local level, however, some interventions could be more effective when considered on a wider footprint. • Help people to be less reliant on their cars and change travel habits by providing alternatives e.g. public transport, walking and cycling routes. • School and business travel plans – working with large employers • Making it easier for people to drive in the most efficient, least polluting way by providing them with information and training. • No idling zones, around schools, hospitals for example • Facilitating the uptake of elective vehicles and other clean alternatives to petrol and diesel vehicles • Improving vehicle emission standards for taxis and private hire vehicles consistent with neighbouring authorities • Reducing emissions from public transport and improving the public transport experience.
Non transport pollution sources	• Clarify and communicate the health messages and advice available to inform choice and behaviour to reduce personal exposure to non-transport pollution sources from activities around the home such as wood burning stoves, open fires and cleaning with certain solvents. Other non-transport pollution sources include farming and industry, such as from commercial biomass boilers.
Growing the evidence base and evaluation of actions	• Interventions should be based on the evidence of what works and be evaluated before and after. There are opportunities to work across Lancashire and Cumbria to assess and evaluate actions that are best delivered large-scale such as on the highway network, for example the use of intelligent traffic systems and real time monitoring could be explored.

Health for Wealth

Building a Healthier Northern Powerhouse for UK Productivity

Foreword

The vision for the Northern Powerhouse was built in the knowledge that if we harnessed the potential of the great cities of the North we would be increasing the economic strength of the United Kingdom. The North's cities and towns led the Industrial Revolution and their decline has seen a marked shift downwards into lower wages compared to the South, with lower productivity.

Henri Murison, Director of the Northern Powerhouse Partnership

Linking up Liverpool, Manchester, Sheffield, Leeds, Hull and Newcastle with high-speed, integrated transport systems and cutting-edge digital connectivity would allow those cities to collaborate and contribute more than the sum of their parts, creating a single market. Only with this joined-up approach could the sluggish productivity of the Northern Powerhouse be stimulated and allow our businesses to thrive.

Transport is a vital component of the Northern Powerhouse, with Northern Powerhouse Rail (NPR) promising the world-class transport network our commuters, families and businesses deserve. Reducing journey times, enhancing capacity and increasing frequency are all compelling reasons to build the network, but potentially more important is the opportunity for economic growth NPR would create. Reversing decades of stagnation takes time, but opening up new labour markets and opportunities for our young people would have a transformational effect.

In addition, our businesses need access to the skilled workforce they need to embrace the digital revolution, embedding emerging technology such as robotics, AI, 3D printing and VR into everything they do.

Our education system requires major interventions, as set out in our Educating the North report, particularly tackling entrenched disadvantage leading to our children falling behind their peers in other parts of the country.

Until now health has not had the profile it should have in the Northern Powerhouse, despite its undoubted importance.

Life expectancy is on average two years lower in the North than the South, and there is a productivity gap between the Northern Powerhouse and the rest of England of £4 per-person-per-hour. In this report, led by the Northern Health Science Alliance (NHSA), the link between the two is set out across the North for the first time.

People in the North are more likely to leave work due to sickness than those in the South, and when they leave they are less likely than those in the South to go back into work. This report, put together by leading academics from six Northern universities, shows that ill health in the North accounts for over 30% of the productivity gap with the rest of England. What's more, the report's findings show that the NHS allocated budgets explain over 18% of this productivity gap.

Importantly, improving health in the North could reduce the existing gap in GVA of £4 per-person-per-hour between the Northern Powerhouse and the rest of England by up to £1.20. Improving health in the North increases the whole country's productivity.

To tackle the poor health and increase productivity in the Northern Powerhouse we need proportional interventions to the scale of the opportunity from those who can drive it forward: industry, central and local government.

The Mayor, Andy Burnham, a former Labour Health Secretary, will now be able to fully integrate health and social care utilising health devolution. Newcastle University was funded to create the National Centre for Ageing which can have an impact across the North, and in Leeds the presence of NHS Digital and a major cluster of health data businesses is of global significance.

From Liverpool to the new Mayor of the North of Tyne to be elected in May, health should be the next major transfer of power which government offers pro-actively, and without it, unlocking productivity and our economic potential will be held back.

The economic arguments for the Northern Powerhouse are ignored at the United Kingdom's risk. We need to strengthen our country's economic performance in every way we can, particularly when we leave the European Union.

The businesses of the Northern Powerhouse require a healthy, productive workforce. Addressing ill health would support a workforce which is fit and able, and – allied with improved connectivity, education and skills – could create the right conditions for a thriving Northern Powerhouse.

Government, as it looks to allocate additional NHS spending, here has the evidence needed for how that investment can also be financed sustainably through increased productivity in the Northern Powerhouse. Spending more on health here, through more efficient devolved arrangements will close the gap in fiscal terms of what the North contributes to the UK economy, generating increased revenues for the Treasury to make the NHS in the long term more financially sustainable nationally for decades to come.

Executive Summary

60 Second Summary

There is a well-known productivity gap between the Northern Powerhouse and the rest of England of £4 per-person-per-hour. There is also a substantial health gap between the Northern Powerhouse and the rest of England, with average life expectancy 2 years lower in the North. Given that both health and productivity are lower in the Northern Powerhouse, the NHSA commissioned this report from six of its eight university members (Newcastle, Manchester, Lancaster, Liverpool, Sheffield and York) to understand the impact of poor health on productivity and to explore the opportunities for improving UK productivity by unlocking inclusive, green, regional growth through health improvement. Our report shows the importance of health and the NHS for productivity in the Northern Powerhouse. So, as it develops its post-Brexit industrial strategy, central government should pay particular attention to the importance of improving health in the Northern Powerhouse as a route to increased wealth.

Key findings

- Productivity is lower in the North
- **A key reason is that health is also worse in the North**
- Long-term health conditions lead to economic inactivity
- **Spells of ill health increase the risk of job loss and lead to lower wages when people return to work**
- Improving health in the North would lead to substantial economic gains
- **Improving health would reduce the £4 gap in productivity per-person per-hour between the Northern Powerhouse and the rest of England by 30% or £1.20 per-person per-hour, generating an additional £13.2 billion in UK GVA**

A key reason is that health is also worse in the North

Long-term health conditions lead to economic inactivity

Spells of ill health increase the risk of job loss and lead to lower wages when people return to work

Improving health in the North would lead to substantial economic gains

30% of the £4 per person per hour gap in productivity (or £1.20 per hour) between the Northern Powerhouse and the rest of England is due to ill-health. Reducing this health gap would generate an additional

in UK GVA

Summary of Detailed Findings

- Health is important for productivity: improving health could reduce the £4 gap in productivity between the Northern Powerhouse and the rest of England by 30% or £1.20 per-person per-hour, generating an additional £13.2 billion in UK GVA
- **Reducing the number of working age people with limiting long-term health conditions by 10% would decrease rates of economic inactivity by 3 percentage points in the Northern Powerhouse**
- Increasing the NHS budget by 10% in the Northern Powerhouse will decrease economic inactivity rates by 3 percentage points
- **If they experience a spell of ill health, working people in the Northern Powerhouse are 39% more likely to lose their job compared to their counterparts in the rest of England. If they subsequently get back into work, then their wages are 66% lower than a similar individual in the rest of England.**
- Decreasing rates of ill health by 1.2% and decreasing mortality rates by 0.7% would reduce the gap in gross value added (GVA) per-head between the Northern Powerhouse and the rest of England by 10%.
- **Increasing the proportion of people in good health in the Northern Powerhouse by 3.5% would reduce the employment gap between the Northern Powerhouse and the rest of England by 10%**
- So, given the relationship between health, health care and productivity in the Northern Powerhouse, then in order to improve UK productivity, we need to improve health in the North.

Increasing the NHS budget by

10%

in the Northern Powerhouse will decrease economic inactivity rates by 3 percentage points

If they experience a spell of ill health, working people in the Northern Powerhouse are

39%

more likely to lose their job compared to their counterparts in the rest of England. If they subsequently get back into work, then their wages are 66% lower than a similar individual in the rest of England.

Challenges

Although these findings demonstrate the scale of the health and economic challenges facing the Northern Powerhouse, they also provide a blueprint to overcome the problem: in order to improve UK productivity, we need to improve health in the North. However, there are challenges which need to be addressed:

- Expenditure on public health and prevention services has always lagged behind spend on the treatment of existing conditions. In 2017/18 in England, £3.4 billion was spent by local authorities on public health. This was dwarfed by Department of Health and Social Care spend of over £124 billion, the vast majority of which went on hospital-based treatment services. Public health budgets are estimated to experience real-term cuts averaging 3.9 per cent each year between 2016/17 and 2020/21.
- **Austerity presents a real challenge for Northern agencies to implement approaches to improving health. Local authorities have faced disproportionally larger cuts and reductions in social welfare since 2010 have also had more of an impact in the Northern Powerhouse.**
- Exiting the European Union is a challenge for the NHS in terms of the supply of highly skilled workers. Uncertainties over post-Brexit NHS and local authority public health budget settlements are also a challenge for planning prevention and health and social care services particularly in the Northern Powerhouse.
- **Health research funding in the UK is heavily concentrated in the so-called 'golden triangle': London, the South East and the East of England receive over 60% of funding. This is exacerbated by the fact that the Northern Powerhouse's strengths are in applied health research, for which there is high need in the region but much less funding available nationally and regionally.**
- Uncertainty around the effectiveness of public health interventions means that more applied research is needed to develop, pilot and evaluate and scale-up interventions to improve health – particularly in areas of high need such as the Northern Powerhouse.
- **Green and Inclusive Growth is required given the well-documented threats posed by climate change. It cannot be the case of 'business as usual' for an industrial strategy to increase productivity in the North, innovation is required to ensure carbon-free growth. Growth in the North also needs to be socially inclusive - reaching all places in the region and people from all social backgrounds.**

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of funding. This is exacerbated by the fact that the Northern Powerhouse's strengths are in applied health research, for which there is high need in the region but much less funding available nationally and regionally.

Recommendations to Central Government

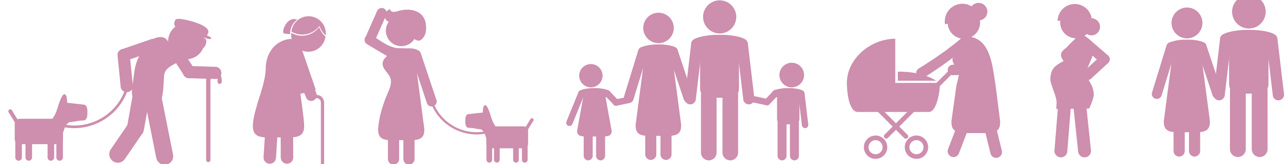
As it develops its post-Brexit industrial strategy, central government should pay particular attention to the importance of health for productivity in the Northern Powerhouse. Specifically, we make four key proposals to central government:

1) To improve health in the North by increasing investment in place-based public health in Northern Powerhouse local authorities.

2) To improve labour market participation and job retention amongst people with a health condition in the Northern Powerhouse.

3) To increase NHS funding in the Northern Powerhouse – to be spent on prevention services and health science research.

4) To reduce economic inequality between the North and the rest of England by implementing an inclusive, green industrial strategy.



Recommendations to Northern Powerhouse Local and Regional Stakeholders

We make four key proposals to Northern Powerhouse local and regional stakeholders:

1) Health and Wellbeing boards and the emerging NHS integrated care systems should commission more health promotion, condition management and prevention services.

2) Local enterprise partnerships, local authorities and devolved Northern regions should develop locally tailored 'health-first' programmes in partnership with the local NHS and third sector providers.

3) Local enterprise partnerships, local authorities and devolved Northern regions should scale-up their place-based public health programmes across the life course: 'starting well', 'living well' and 'ageing well'.

4) Local businesses should support job retention and health promotion interventions across the Northern Powerhouse workforce and Northern city regions and Northern NHS integrated care systems should lead by example.

Figure 1.4: An English Journey – life expectancy for men along the East Coast, Great Western and West Coast Mainlines

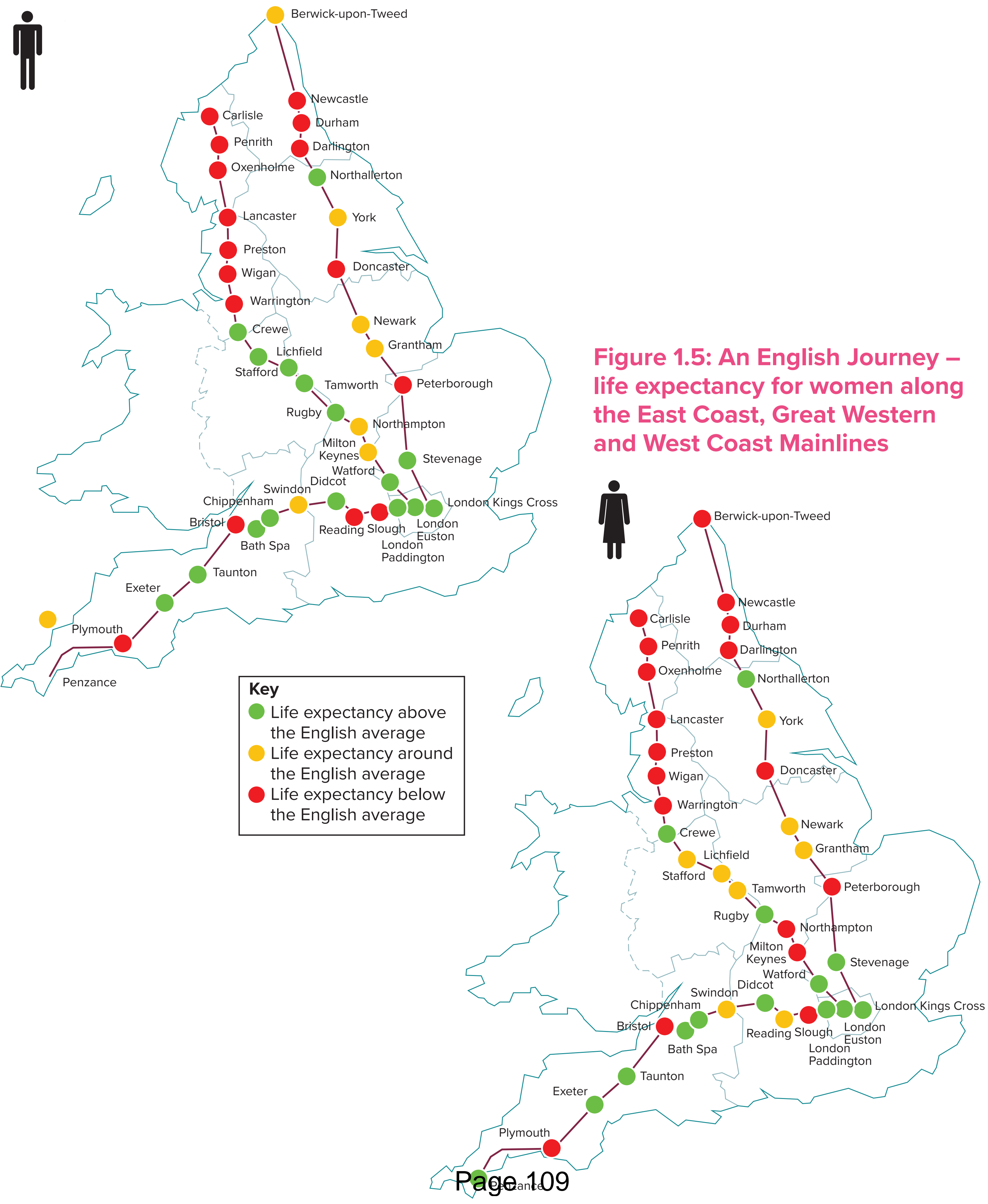


Figure 1.5: An English Journey – life expectancy for women along the East Coast, Great Western and West Coast Mainlines

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