Public Document Pack

Health & Wellbeing Board

Wednesday, 4th December, 2019
5.30 pm

AGENDA

1. Welcome and Apologies

To welcome those present to the meeting and to receive any apologies for absence

2. Minutes of the meeting held on 4th September 2019

To approve as a correct record and to sign the minutes of the meeting held on 4th September 2019.

Minutes of the meeting held on 4th September 2019 **3 - 8**

3. Actions from the Previous Meeting

To consider any actions arising from the previous meeting.

4. Update on the Pan Lancashire Health and Wellbeing Proposals

To receive an update from the Director of Public Health.

5. Start Well Update

To receive an update from the Director of Children's Services.

6. Healthy Weight Declaration

To receive a report of the Director of Public Health

Blackburn with Darwen joint Local Authority Declaration on Healthy Weight 3 years on **9 - 108**
Appendix A LADHW committments update Oct 2019
Appendix B HWD Evaluation Report 2019 FINAL
Eat Well Move More Shape Up 2017_2020 Final Strategy

7. Better Care Fund

To receive an update on the Better Care Fund.

8. Vulnerable Person Strategy

To receive a report on the Vulnerable Person Strategy.

Vulnerable People Strategy	**109 - 126**
Vulnerable People Strategy appendix	

9. Child Death Overview Panel Annual Report

To receive a report of the Panel

Child Death Overview Panel Annual Report 2018 19	**127 - 132**

10. General Updates From Board Members

To receive updates from Members of the Board.

11. Date of the next meeting

To Note that the next meeting of the board is scheduled to take place on 4th March 2020.

Date Published 26th November 2019
Denise Park, Chief Executive

Health & Wellbeing Board

Start well | Live well | Age well

BLACKBURN WITH DARWEN HEALTH AND WELLBEING BOARD
MINUTES OF A MEETING HELD ON TUESDAY, 4th SEPTEMBER 2019

PRESENT:

Councillors	Mohammed Khan (Chair)
	Maureen Bateson
	Julie Slater Mustafa Desai
Clinical Commissioning Group (CCG)	Roger Parr Dr Penny Morris
Voluntary Sector	Vicky Shepherd
Council	Gifford Kerr
	Prof. Dominic Harrison
	Jo Siddle
	Sayyed Osman
	Laura Wharton
	Paul Conlon

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were received on behalf of Angela Allen and Jayne Ivory. The Chair informed the committee that Joe Slater had resigned from the Board as a lay member. The chair paid tribute to the long and dedicated service given by Joe both as a previous member of the Primary Care Trust, the CCG and the Health and Wellbeing Board. Members of the board joined with the chair in thanking Joe for his dedicated service.

2. Minutes of the meeting held on 18th June 2019

RESOLVED – That the minutes of the meeting held on 18th June 2019 be agreed as a correct record and signed by the Chair.

3. Declarations of Interest

There were no declarations received.

4. Public Questions

The Chair informed the Board that no public questions had been received.

5. Joint Commissioning and Better Care Fund

The Committee received an update on the Better Care Fund performance and delivery for quarter 4 of 2018/19 and quarter 1 2019/20.
The board were informed of the implications of the new Better Care Fund Planning Framework 2019/20 which had been published in July 2019 and outlined requirements to:-

1. Refresh BCF plan to measure progress and develop future plans and schemes in line with national metrics and national conditions for 2019/20
2. To refresh and agree joint pooled funding arrangements as part of the BCF plan under section 75 of the NHS act 2006 incorporating the increase in annual uplift of 5.3% for the 2019/20 budget.
3. Submit a new BCF Planning Template 2019/20 which incorporates iBCF and Winter Pressures grants by 27th September 2019.

The Blackburn with Darwen BCF had been reviewed and updated in August and due to the timescales approved by the Chair of the Board to enable submission to meet the national deadline. The final BCF Plan and Section 75 Agreement would be submitted to the Board for formal approval at the meeting on 4th December 2019.

RESOLVED –
1. That the Better Care Fund quarter 4 2018/19 and quarter 1 2019/20 summary of the better care fund performance and delivery be noted.
2. That the Better Care Fund and iBetter Care Fund finance position at the end of quarter 4 2018/19 and quarter 1 2019/20 be noted
3. That the overview of the new National Better Care Fund Planning Requirements for 2019/20 with details of the refresh of the local Better Care Fund plan and timescales be noted.

5. Live Well Update

The Director of Adults and Prevention, Sayyed Osman, gave an update on the Live Well Steering Group.

The Board were reminded of the key aims of the strategy which were to-

- work with the most complex adults currently living in HMOs / rough sleeping, who are 'stuck' in the revolving door of services
- consult with key stakeholders and service users to re-design support and interventions to the strategic principles and developments of 'Transforming Lives; Strengthening Communities
- evaluate the local approach and share learning to inform both local and national developments
- consider the Health and Wellbeing Strategy and the overarching ambitions for integration to reduce inequalities by providing intervention and support for people at the earliest possible opportunity to achieve better outcomes for individuals and families
- Increase resilience in local communities by developing community capacity and coordinate service delivery across agencies to reduce duplication and improve effectiveness

The Board were informed that the consultation with Stakeholders (including those with lived experience) had put forward the following views-

- Continue to align Making Every Adult Matter approaches within the context of 'Transforming Lives', Neighbourhood Models of Care/LICP developments.

- Consider sign up to a series of MEAM Pledges.
- Ensure a 'One Workforce' approach to include skilled MEAM champions and MEAM approaches to support people with multiple disadvantage and complex needs.
- Improve governance and ownership with strategic alignment to the Live Well Board.

The Board were informed that the next steps were to develop the Local Integrated Care Partnership building trust and collaboration at the Neighbourhood Partnership level. Investigations were ongoing as to what can be done strategically to mitigate and manage the challenges we are facing on Homelessness, street begging and vulnerability and the new Vulnerable People Strategy will contain recommendations on this basis for further integration. Support would be given to deliver strategic objectives of Making Every Adult Matter. Links between UC and the strategy to support vulnerable people ensuring BwD residents are a priority and the membership of the Live Well Board to reflect the new priority within the VP Strategy for BwD would be undertaken.

A number of cross cutting themes were to be undertaken. These included taking steps to avoid introducing a 'poverty premium' around access to public services or in paying for public services. The aim was to design services which were available to all, but deliver increasing benefits to those at greater levels of need, to achieve a 'levelling up' effect. Policies and practice would be scrutinised to ensure that they do not introduce or exacerbate barriers and stigma for those at risk of or experiencing poverty and opportunities would be sought to engage local communities and/or service users in the development of actions and services which address child poverty. Opportunities to explore basic awareness-raising on the causes and consequences of child poverty with all frontline staff that were likely to come into contact with families at risk of or experiencing poverty would be taken.

The Board were reminded of the work that was being undertaken including-

- Big White Wall – website where residents can access an online support network for low level mental health problems.
- Time to change Hub – we are working with Lancashire Mind and local partners to raise awareness of the stigma of mental health problems using local Champions.
- Prevention Concordat for better mental health – Currently writing up our application form to sign up the Authority to the Public Health England Concordat, pledging Blackburn with Darwen Council to take a preventative and evidence based approach to mental wellbeing.

The Board looked at the steps that were being taken to improve Mental Health in the borough, these included-

- Blackburn with Darwen Public Health were looking to recommission our community mental wellbeing offer.
- A new model with align our service with partner organisations to encourage a system-wide approach to better public mental health.
- A new model will be in place for April 2020

The Committee were informed of the challenges and the next steps for the Live Well Steering Group

RESOLVED - That the Director of Adults and Prevention, Sayyed Osman, be thanked for his presentation

6. <u>Local Area SEND Update</u>

The Jo Siddle, gave an update on the SEND inspection Briefing. The inspection took place in June and reviewed progress against the implementation of the SEND reforms and outcomes for children and young people a series of meetings/visits will take place.

The meetings and visits timetable involved:

- Staff from adult and children's social care, health and education
- Children and young people aged 0-25 with SEND and their parents/carers
- Early years providers, including children's centres
- Schools
- Pupil Referral Units and alternative providers
- Colleges
- Respite/short-break providers
- Health providers
- Parent Carer Forum

Key lines of enquiry were determined by the lead inspector, informed by information gathered from the local area's Annual Peer Review Self Evaluation Report, the parent/carer webinar and other sources of information.

The Inspection Key findings included-

- Provision for SEND is a key priority for all partners
- There is a real enthusiasm, and can do attitude, to work closely together to make sure children and young people get the best support
- Since 2014 the local area has made considerable progress in implementing the reforms and recent changes to leadership and governance has accelerated this
- Families feel listened to and the majority feel their children receive the help and support they need
- Local area demonstrates a clear capacity for improvement
- Leaders have an in-depth knowledge of the local area and have made considerable progress in addressing issues
- Local area's coproduced SEND Strategy
- Quality, coproduced Local Offer website
- Leaders' and managers' accurate knowledge of the local area is not fully reflected in improvement plans and Improvement planning is too process, rather than outcomes, focussed
- Better use of data is required to inform/evaluate commissioning and strategic planning
- Provision for young people when they leave school is not sufficiently well developed
- Parents have concerns about their child's transition into adulthood and feel anxious about their future
- Parents tell us they are not listened to when their children's needs are less obviously visible which can lead to delays in accurate identification of needs
- Demand for psychological services for those with lower-level mental health needs is exceeding capacity
- Lack of clear targets in EHC plans reduces the ability to measure, monitor and evaluate improved outcomes

The Board were informed of the next steps that would include-

- Areas that have been identified for further improvement would form the basis of the revised SEND Strategy Action Plan for the local area
- This plan will be coproduced with stakeholders and co-owned between Blackburn with Darwen Council and Blackburn with Darwen Clinical Commissioning Group (CCG)

- Outcomes based planning framework is to be adopted to support SEND improvement planning, performance monitoring and accountability, to ensure effort remains impact focussed

RESOLVED- 1. That the Jo be thanks for her presentation and the congratulations be forwarded to all those who assisted in achieving the successful outcome.
2. That further reports be submitted to the Health and Wellbeing Board where necessary.

9. Suicide and Self Harm Prevention Strategy 2016-19 Review.

The Board received an update on progress made and the key achievements from the Blackburn with Darwen partnership Suicide and Self Harm Prevention Strategy (2016/19), providing an overview of the Lancashire and South Cumbria Integrated strategic approach to suicide prevention, together with an outline of the refreshed local priorities for the Suicide Prevention action plan.

RESOLVED- 1. That the progress made and achievements resulting from the Blackburn with Darwen Partnership Suicide and Self-Harm Prevention Strategy 2016-19.be noted.

2. That the refreshed priorities and support the local strategy group to develop, monitor and implement the local suicide prevention action plan be approved.

3. That the support of Board members to attend the Blackburn Town Centre campaign event to demonstrate support for World Suicide Prevention Day on 10th September 2019 be noted

10. Updates from Members of the Board

The Public Health Specialist, Laura Wharton, gave an update on the PAN Lancashire Health and Wellbeing Board. It was noted that there was concern regarding the Integrating Care Partnership and moving forward with the Health and Wellbeing Board.

An update would be brought to the next Health and Well Being Board meeting.

RESOLVED - That the Director of Public Health to present an update report to the next Health and Wellbeing Board meeting

11Blackburn with Darwen collaboration including leisure, PH, adults & prevention, VCFS & CCG colleagues to populate the Pathfinder plan templates informed by local insight, data, priorities and ideas shared from the engagement events.

- Support development of Place based approach in Blackburn Central ward alongside Social Integration programme

RESOLVED – That the Health and Wellbeing Board noted and endorsed the content of the report

Signed……..

Chair of the meeting at which the Minutes were signed

Date……

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Director of Public Health and Wellbeing
DATE:	4th December 2019

SUBJECT: Blackburn with Darwen's Joint Local Authority Declaration on Healthy Weight – 3 years on

1. PURPOSE

To inform the Health and Wellbeing Board about progress to date on the joint Local Authority Declaration on Healthy Weight.

To update the Health and Wellbeing Board on the key learning from the recently completed independent evaluation.

To highlight key issues affecting the effective implementation of the joint Local Authority Declaration on Healthy Weight.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

That the Health and Wellbeing Board:

- Note the contents of the report.
- Note that unhealthy weight remains a significant public health issue requiring ongoing senior level leadership and commitment to increasing physical activity levels, improving access to healthy and sustainable food and encouraging self-care from council, partners and stakeholders.
- Note the progress made to date and the key issues affecting the effective implementation of the joint Local Authority Declaration on Healthy Weight.
- Support a review and refresh of the local commitments in 2020.

3. BACKGROUND

Physical inactivity and unhealthy weight are major public health problems due to their association with serious chronic diseases and the costs to both the individuals and society as a whole.

The economic cost of unhealthy weight is significant and with the increasing pressure on the health and social care system, prevention must be a priority. Obesity is a complex, but largely preventable condition, which has serious, far-reaching physical, psychological and social consequences that affects virtually all age and socioeconomic groups although some groups are affected more than others. Obesity impairs a person's wellbeing, quality of life and ability to earn.

The joint Local Authority Declaration on Healthy Weight (Declaration)

- enables local authorities to review their policies and consider how these may impact on healthy weight
- draws attention to the problems caused by unhealthy weight
- helps the council both to take leadership and to challenge partner organisations to play their own role in addressing healthy weight

Developed by Food Active, the Declaration is a means for local government to take a 'whole systems' policy based approach to tackling unhealthy weight and to date 20 local authorities have signed the Declaration. The Declaration was launched as part of the Eat Well, Move More Shape Up strategy which provides a framework for action to increase the number of people with a healthy weight, to increase physical activity levels and ultimately increase healthy life expectancy. In April 2017 Blackburn with Darwen Borough Council and Clinical Commissioning Group signed the country's first joint Declaration signifying a joined up approach and formal commitment to tackling unhealthy weight in Blackburn with Darwen. East Lancashire Hospitals Trust signing their Declaration then followed this in 2018.

To assess the impact of the Declaration to date and identify recommendations for future action Blackburn with Darwen's Public Health commissioned Food Active to conduct an independent evaluation earlier this year.

4. RATIONALE.

Key Progress To Date

Progress against the commitments in the Declaration continues, as can be seen in the full review in Appendix A but with the acknowledgement that there is still much to do to have a significant impact on the population.

Headline achievements are:

- Blackburn with Darwen Food Alliance and Food Poverty Action plan development.
- Blackburn with Darwen was designated a Breastfeeding Friendly Borough in November 2017.
- Borough's first Healthy Weight Summit held at Ewood Park in March 2019 with a subsequent follow up in October 2019.
- Commissioned an independent evaluation with key learning to develop on.

There are two other significant success on a Pennine Lancashire footprint which the Declaration has supported since signing in 2017

- Sport England Local Delivery Pilot – Blackburn with Darwen led the successful bid to become one of 12 Sport England funded sites to test new ways of working with those who are hardest to reach
- Childhood Obesity Trailblazer Programme – Blackburn with Darwen led the success to become one of five national Trailblazers to test the limits of existing powers of local government in tackling childhood obesity and developing solutions to local obstacles aiming to enable ambitious local action and to achieve change at scale.

Evaluation and Key Learning

Ten participants were interviewed for the evaluation holding a wide range of positions and roles, which provided the opportunity to understand views on both healthy weight in Blackburn with Darwen and the Declaration from a variety of perspectives.

- Obesity is considered an issue in Blackburn with Darwen
- All participants felt that they had a role to play in addressing unhealthy weight in Blackburn with Darwen

- Overall participants were very positive about the impact and the opportunities generated from the Declaration
- Participants felt it was key to ensure momentum continued
- Utilising Elected Members to drive the healthy weight agenda forwards was seen as important
- Working with communities was flagged as important is driving the Declaration forwards
- Participants felt it was important to use the Declaration to continually revisit and review policies and practice
- It was seen as important to ensure impact was continually monitored and evaluated

Opportunities

Following the Declaration evaluation, it is timely to review and refresh the local commitments. Strategically led by the Shape Up sub group and following consultation with the Healthy Weight summit attendees a number of possibilities for inclusion have been identified for further consultation with stakeholders, partners and the public next year including:

- Support partners to sign the partner pledge.
- Closer partnership working with Clinical Commissioning Group and connection to wider Pennine Lancashire Transformation work including connection to districts through the Trailblazer and Sport England programmes.
- Whole System Review using the route map developed by Public Health England to provide a consistent approach partners from policy development to frontline delivery. Unhealthy weight remains everybody's business and requires a coordinated and sustained effort to ensure that the whole system is working together to create a step change in tackling unhealthy weight.
- Sport England Together an Active Future programme in Blackburn with Darwen – increasing physical activity levels in the most inactive by doing things differently. Also ensure that healthy weight is considered in all activity connected with the programme by partners and stakeholders.
- Childhood Obesity Trailblazer – developing system leaders to champion healthy weight, challenging the planning system, supporting businesses to provide a healthier offer and mobilising the community to demand healthier food.

5. KEY ISSUES

Tackling obesity requires a whole systems approach from all partners and stakeholders. Taking a population approach through policy change and development will have the greatest impact on obesity rather than focussing on service delivery to a targeted group. Ongoing engagement with key partners and ensuring key contacts are maintained within services to maintain momentum in tackling unhealthy weight.

The year on year cut in funding from central government to the Council and Clinical Commissioning Group has led to reduced capacity to support the Declaration commitments. Whilst there remains widespread support for the Declaration from senior leaders within both organisations, full engagement in supporting the Eat Well Move More Shape Up strategy steering group where the Declaration is managed continues to be low priority.

Lack of understanding of the wider determinants affecting unhealthy weight can lead to a tendency

to focus on one issue as the root cause e.g. hot food takeaways, rather than looking at the whole system and mechanisms involved e.g. poverty. This intention to tackle unhealthy weight will require further awareness of the complexities of unhealthy weight and how some of these issues can be tackled locally. Further work is now planned to raise awareness of the Declaration and the need for a whole systems approach to tackling healthy weight for both elected members and senior managers across the statutory organisations to address this.

6. POLICY IMPLICATIONS

The Declaration has been aligned to both local and national recommendations and guidelines for improving access to healthy and sustainable food, increasing physical activity levels and achieving a healthy weight and Blackburn with Darwen's refreshed Health and Wellbeing strategy. The commitments were developed in line with national policies and guidelines and local priorities as derived from the extensive consultation work undertaken.

The Declaration takes into account the strategies, frameworks and policies listed below:

- Public Health Outcomes Framework 2014-15 (Department of Health, 2014)
- Blackburn with Darwen Joint Health and Wellbeing Strategy 2018-21
- BwD Planning for Health Supplementary Planning Document
- BwD Integrated Strategic Needs Assessment
- Prevention Is Better Than Cure - including Childhood Obesity Plan Chapter 3 (DHSC, 2018)
- Childhood Obesity Plan Chapters 1 (2017) & 2 (2018)
- The NHS Long Term Plan (NHS, 2019)

7. FINANCIAL IMPLICATIONS

There are no financial implications. The Declaration commitments will be supported within existing partner agency budgets and the Department of Health Public Health Prevention grant. Significant funding was secured from Sport England between now and 2025 to develop the Together an Active Future programme focussing on system change in physical activity. A smaller level of funding from the Department of Health and Social Care has been awarded to develop and deliver the Childhood Obesity Trailblazer plan objectives.

8. LEGAL IMPLICATIONS

Transfer of public health from the NHS to local government and Public Health England has introduced a significant extension of local government powers and duties and represents an opportunity to change focus from treating sickness to actively promoting health and wellbeing. Section 12 of the Health and Social Care Act inserts a new section 2B into the NHS Act 2006 to give each relevant local authority a new duty to take such steps as it considers appropriate to improve the health of the people in its area. This section also gives the Secretary of State a power to take steps to improve the health of the people of England and it gives examples of health improvement steps that either local authorities or the Secretary of State could take, including giving information, providing services or facilities to promote healthy living and providing incentives to live more healthily.

Local authorities have considerable discretion in how they choose to invest their grant to improve their population's health, although they have to have regard to the Public Health Outcomes Framework and should consider the extant evidence regarding public health measures.

9. RESOURCE IMPLICATIONS

Activities relating to the Declaration will be delivered by strategic health and wellbeing board partners, with the council's Public Health and Wellbeing team providing a leadership and co-ordination role.

10. EQUALITY AND HEALTH IMPLICATIONS

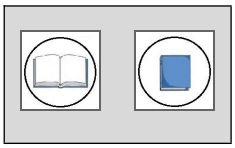
The Health Impact Assessment associated with the strategy and Declaration has been reviewed and remains valid. Declaration is a population health tool to promote healthy weight across the Borough. Maintaining a healthy weight has positive health implications. The Declaration advocates for policies, strategies and activities, which will positively impact on the most vulnerable and at risk in the Borough.

11. CONSULTATIONS

Initial consultation at the Healthy Weight Summit and subsequent follow up event.
Healthy Weight Declaration Evaluation including comment from a number of Council officers and Elected Members.
Further consultation to inform the refresh of the Declaration is planned for next year.

VERSION:	**1.0**

CONTACT OFFICER:	Beth Wolfenden
DATE:	13th November 2019
BACKGROUND PAPER:	LADHW Commitments Update October 2019 (Appendix A) Blackburn with Darwen's Local Government Healthy Weight Declaration - An Evaluation (Appendix B) Blackburn with Darwen Local Authority Declaration on Healthy Weight Eat Well Move More Shape Up Strategy 2017-2020



Review Date July 2019 – end of Year 2

Progress against Local Authority Declaration on Healthy Weight commitments – LA/CCG

		By Who	Time-scale	RAG Rating	Comment / Update on Progress
1.	**Commitments:**				
1.1	**Protecting residents from the commercial pressures and vested interests of the food and drink industry supplying high fat, salt and sugar products.**	LA - Comms PH&WB			The council's advertising policy was reviewed in 2017 and PH commented on and made recommendations for HFSS food and drinks to be included in 400m hot food takeaway restriction around schools. No changes were made to the policy at that time. **Recommendation/Action:** to review of Advertising Policy to support the Childhood Obesity Trailblazer work and address this commitment in LADHW
1.2	**Consider how commercial partnerships with the food and drink industry may impact on messages communicated around healthy weight to the local community.**	LA – Comms PH&WB/ Strategic Partners			Piece of work required to develop to map out potential conflicts of interest with the HFSS in funding/commercial partnerships with partners. This should include wider PH messages around alcohol, gambling and climate change conflicts. Acknowledge issues around loss of funding when raising this. The Council have supported the rejection of both the Coca Cola Christmas Truck and Premier League Trophy Tour Bus from coming to BwD **Recommendation/Action**: Work with relevant partners such as Healthy Stadia to develop action plan to support this commitment Continue to support the lobbying against Coca Cola coming to the Borough if approached.
1.3	**Review provision in all our public buildings, facilities and providers to make healthy foods and drinks more convenient and affordable and limit access to high-calorie, low-nutrient foods and drinks (to include all public institutions**	LA/ - PH&WB Procurement CCG			ELHT have implemented changes to vending as part of the CQUIN to increase the access to healthier options. Learning from this can be shared with and used by LA and CCG. CCG Fusion House vending machine is owned by St Modwen – after a consultation with staff they asked that it remain in situ. Range of catering contracts via LA – contracts require review with Public Health support **Recommendation/Action**: Undertake a full review of vending machines in all council owned/controlled buildings Request CCG support a review of CCG and Health Centre vending offer

		By Who	Time-scale	RAG Rating	Comment / Update on Progress
	such as schools, hospitals, care homes, leisure facilities).				Develop a staff consultation to support the review across LA/ CCG/Health Centres Review LA catering contracts
1.4	**Increase public access to fresh drinking water on local authority controlled sites.**	LA – Environement PH&WB/ CCG			Water available via fountains in gyms for facility users but not in other building for public Opportunity to support single use plastic agenda and Council's Climate Emergency Declaration by promoting www.refill.org.uk and re-useable bottles Possible opportunity to provide access to water in parks via application to Heritage Fund **Recommendation/Action:** Promote Refill.org.uk with BwD businesses and organisation Source funding for water fountains in town centres Engage with United Utilities to explore water availability
1.5	**Consider supplementary guidance for hot food takeaways, specifically in areas around schools, parks and where access to healthier alternatives are limited.**	LA – Planning PH&WB			Planning for Health SPD adopted in 2016 with some success. A5 applications had reduced however A3s have increased. PL has recently been chosen as a Childhood Obesity Trailblazer area and this will give some capacity to review and strengthen the PfHSPD and support other districts to adopt their own SPD. A range of planning regulatory tools will be explored to determine best fit which will be supported by an enhanced Recipe 4 Health programme **Recommendation/Action**: Review and strengthen PfHSPD
1.6	**Advocate plans with partners including the NHS and all agencies represented on the Health and Wellbeing Board, healthy cities, academic institutions and local communities to address the causes and impacts of obesity.**	LA/CCG/ Pennine Leaders Forum			Regular update to CCG Governing Body on EWMMSU strategy and Declaration commitments. Quarterly Shape Up sub groups meetings and EWMMSU Strategy steering group and annual report which are shared with HWBB. Healthy Weight Summit held in March 2019 with planned 6/12 follow ups. **Recommendation/Action:** Work more closely with emerging PCNs on healthy weight agenda to be supported by Sport England programme work Support Elected Members to be advocates for healthy weight in their communities and member duties

		By Who	Time-scale	RAG Rating	Comment / Update on Progress
1.7	**Strive to protect our children from inappropriate marketing by the food and drink industry**	LA/HPHF Programme			Links to 1.1 Opportunity to be part of the Outsmart Advertising scheme (meeting Aug 2019 to discuss) Raise awareness of advertising and marketing techniques in communities via Trailblazer 'Great Big Junk Food Debate' campaign **Recommendation/Actions:** Ensure advertising/marketing techniques included in the campaign Explore Outsmart Advertising opportunity Support the Bite Back 2030 campaign
1.8	**Support the government in taking action at national level to help local authorities reduce obesity prevalence and health inequalities in our communities**	LA – PH&WB			DPH lobbies national Government via ADPHs nationally to reduce inequalities. Support Food Active in consultation responses particularly around the Childhood Obesity Plan Submit expressions of interest for national programmes impacting on childhood obesity which include ambitious plans to tackle unhealthy weight locally. Recent success with Childhood Obesity Trailblazer and Sport England Local Delivery Pilot both with which have the potential to impact on national policy and strategy Continue to share good practice regionally and nationally where invited to do so e.g. PHE Spatial Planning Conference 2019, Westminster Food and Nutrition Forum 2019 **Recommendation/Actions:** Continue to support activity as described above
1.9	**Ensure food and provided at public events includes healthy provisions, supporting food retailers to deliver this offer.**				Little progress to date. Relevant relationships need to be built to work on food offer at events which have Council control. National Festival of Making is an opportunity to showcase healthy street food and local food businesses however this years had little healthy food/drink – opportunity to influence food/drink offer and develop cooking opportunity during the Festival. Support to partner events to be offered via Be Well Together **Recommendation/Action:** Discuss approach to support event catering/food at Food Alliance meeting

		By Who	Time-scale	RAG Rating	Comment / Update on Progress
					National Festival of Making – link with organisers to plan a healthier food/drink offer Seek examples of good practice from other LAs around public event food offers
1.10	**Support the health and well-being of local authority staff and increase knowledge and understanding of overweight and obesity to create a culture and ethos that de-normalises unhealthy weight.**	LA – PH&WB HR			Wellbeing Week held in October for the last two years – moving to a Wellbeing Month in 2019. Focus across all areas of wellbeing. Access to Wellbeing Service and reduced price gym membership – not all will/want to access. Network of Workplace Health Champions to pass on wellbeing information to teams – not all areas are covered by WHC. Workplace health programme places large focus on Mental Health - more emphasis required on de normalising unhealthy weight. Addressing embedded workplace food culture around rewards, fundraising etc **Recommendation/action:** Workplace GULP campaign to be piloted Identify WHC gaps and recruit. Review all HR policies to ensure healthy weight is embedded. Consult with HR team to begin to address food culture across the council
1.11	**Consider how strategies, plans and infrastructures for regeneration and town planning positively impact on physical activity.**	LA – PH&WB Planning Transport			BwD Local plan review has commenced 2019 – Public Health have commented. Health Impact Assessments should be reviewed for all major applications – currently PH do not see these **Recommendation/action:** To work closely with Strategic Planners to ensure the PfHSPD is embedded in the Plan and physical activity is embedded in other relevant strategies Work with Transport Planner to promote active travel and increase walking and cycling Embed a process for PH to review major applications
1.12	**Monitor the progress of the plan against commitments and publish the results**	LA – PH&WB			Independent evaluation being completed Sept 2019 with report to Exec Board, CCG Governing Body and HWBB with recommendations to follow. Progress monitored via EWMMSU Steering Group **Recommendation/Action:** Reports to Boards as above on completion of

		By Who	Time-scale	RAG Rating	Comment / Update on Progress
					evaluation
2.	**Local Commitments:**				
2.1	**Support the introduction of 'Mile a Day' and 'Couch to 5k' in primary and secondary schools respectively**				Training for primary schools promoted and provided by BwD SGO, BRFC Trust and Active Lancashire. Training will continue to be provided as required. Mapping exercise continues but difficult to keep accurate log of schools who participate. Couch to 5K more difficult to develop due to run leaders being required to be over 18. Youth Sport Trust have been running programmes in school to support them to embed PA as a part of the school day – Pleckgate case study on whole school approach to physical activity. **Recommendation/action:** DfE Healthy Schools Rating released July 2019 and to be used to engage HTs in embedding Daily Mile or similar in school day. PH to visit HT forums to promote
2.2	**Support Early Years settings to enable a structured physical activity offer and healthy food policy**	LA – PH&WB EYS team			EYS food and physical activity guide developed in 2018 and made available for all EYS providers. PH have been trying to evaluate uptake and usefulness of the tool – no significant response yet Annual review complete 2019 Further work to support fundamental movement skills (FMS) to be explored via Sport England programme to aid school readiness and support lifelong physical activity habit **Recommendation/action:** Evaluation required to assess effectiveness of the Guide – support require from LA EYS team. Develop pilot FMS programme through Sport England LDP
2.3	**Develop a Food Poverty Network to reduce food poverty and tackle malnutrition in all settings**	BwD Food Alliance			BwD Food Alliance now 'live' and managing the BwD Good Food Plan to tackle food insecurity and sustainability. This is being managed via quarterly meetings – senior leadership now required to gain and maintain momentum. The Alliance acknowledges that funding is required to ensure the plan is able to be delivered effectively. **Recommendation/action**: Identify senior leader to Chair meetings Identify funding sources to support the delivery of the Good Food Plan

		By Who	Time-scale	RAG Rating	Comment / Update on Progress
2.4	**Support the introduction of school food policies including lunchbox policies**	LA-PH&WB Education			Primary school food policy developed in November 2017 for school to adopt. Evaluation of this is now required – support from Education services requested. Secondary school food guide is being co-developed with young people, BwD Healthwatch and UCLAN and will consider the whole school approach to food. Schools currently being identified to support this work. **Recommendation/action**: Evaluation of primary food policy to complete. Begin work on secondary food guide
2.5	**To be a designated Sugar Smart Town**	LA – PH&WB HPHF team			Work to be included in Childhood Obesity Trailblazer programme. Aiming for adoption in Sugar Smart September but due to work on the Trailblazer this will now be postponed until April 2020 to coincide with a celebration of 3 years of the strategy. Engage partners to make the pledge as part of the launch. **Recommendation/action:** Sugar Smart Town adoption to be put on Exec Board forward planner for April 2020. Develop action plan in conjunction with Trailblazer work
2.6	**Develop a Food Charter for the Borough to promote healthy and sustainable food in a local economy**	BwD Food Alliance			Developed as part of the Good Food Plan. Also developed a Pledge to support the plan. This will be managed via the BwD Food Alliance. **Recommendation/action:** Links to ICS sustainable food strategy to be made.
2.7	**Promote Active Travel and use Rights of Way across the Borough to increase physical activity, for social and employment opportunities and minimise air pollution**	LA – PH&WB BwD Connect			BwD Connect programme developed a range of activities and interventions to promote active travel and cycling activities for beginners to advanced cyclists. Funding ends this year – risk to continuation of programme Further work to promote RoW to be developed – walking is a priority within the BwD Sport England Pathfinder business case. The HW Declaration supports the Council's Climate Emergency Declaration **Recommendation/action:** make clear link to the HWDec and EWMMSU strategy within Climate Emergency action plan to support multiple agendas Develop walking and cycling as a priority in Sport England development.
2.8	**Support 'Street Play' initiatives through exploring the implementation of periodic temporary**	LA – PH&WB			To be explored via Sport England funding. To include alley and street play along with other 'non-standard' play areas that do not include closing streets. Explore examples of good practice across the country. Work with Keep Blackburn/Darwen Tidy to develop opportunities. **Recommendation/action:** Develop pilot via Sport England programme Engage KBT/KDT to develop a programme to support environmental agenda

		By Who	Time-scale	RAG Rating	Comment / Update on Progress
	street closure orders and other innovative sites for play				alongside increasing physical activity
2.9	**To be a designated Breastfeeding Friendly Town**	LA – PH&WB Children's Services ELHT LCFT			Status achieved in November 2018. ELHT Baby Friendly Team lead on action plan. Six 'permanent' billboards across the town with images of mums feeding their babies in local places. Initiation rate now at 80%. BF Team Gold Award holders for sustainability with a successful reaccreditation of Health Visiting and Children's Centres. Network of volunteers to support BF mums and very active Facebook support group 'Breast Intentions' Further work now required within the Council to embed aims and objectives of a Breastfeeding Friendly Town **Recommendation/action:** Review of Breastfeeding policy. Review of staff training around supporting BF
2.10	**To achieve Sustainable Food Town status**	BwD Food Alliance			Links to 2.3 and 2.6 Aim to achieve by end of 2020

FOOD ACT!VE

BLACKBURN.GOV.UK
Blackburn with Darwen Borough Council

NHS
Blackburn with Darwen
Clinical Commissioning Group

BLACKBURN WITH DARWEN'S LOCAL GOVERNMENT HEALTHY WEIGHT DECLARATION:

An Evaluation

October 2019

FOOD ACT!VE

CONTENTS

FOOD ACT!VE

1.0 SUMMARY

The Local Government Declaration on Healthy Weight (Declaration) enables local authorities to review their policies and consider how these may impact on healthy weight; it draws attention to the problems caused by overweight and obesity; it helps the council both to take leadership but also to challenge partner organisations to play their own role in addressing healthy weight.

The Declaration was originally designed by the North West based healthy weight campaign, Food Active in consultation with expert stakeholder, including Directors of Public Health, local authority officers, academics and partner organisations.

This evaluation report of the Blackburn with Darwen Declaration was requested in order to assess progress. It contains a background to the Declaration and the steps Blackburn with Darwen Council and Clinical Commissioning Group (CCG) took for it to be adopted. Ten senior council officers and members were interviewed for their insight and comments.

The report is authored by Alex Holt of Food Active.

2.0 INTRODUCTION

Food Active is a regional healthy weight campaign commissioned by local authorities in the North West including Blackburn with Darwen Council. The programme was initiated in 2012 as a collaborative commitment by Directors of Public Health to address obesity, following the launch of the Government White Paper 'Healthy Weight Healthy Lives'. The Food Active brand was launched in November 2013 using a website, e-bulletin and social media and is now well known both nationally and internationally.

Food Active has proposed the development of a Local Government Declaration on Healthy Weight as a means for local government to take a 'whole systems' policy-based to addressing obesity. Blackpool Council was the first to adopt such a Declaration in January 2016 with three other North West councils following in the next twelve months (St Helens, Knowsley and Lancashire). Blackburn with Darwen were the first council to jointly sign with their CCG (13th April 2017). To date (October 2019) 19 councils have signed the Declaration.

FOOD ACT!VE

3.0 BACKGROUND TO THE FOOD ACTIVE LOCAL GOVERNMENT DECLARATION ON HEALTHY WEIGHT

Food Active aims to add value locally by tackling obesity through a collaborative approach, with a specific focus on population level policies that will help reduce excess weight. In August 2014, Food Active organised and hosted a meeting with expert stakeholders to initiate discussions on the principles of drafting a local authority commitment to address obesity. The rationale for developing such a document is based on the Local Authority Declaration on Tobacco Control. The event informed initial discussions on the focus, priorities for action and overarching vision for the policy tool, to consider engagement and support within local authorities and a process for its development and possible timescale. Further workshops were then delivered across the region with key stakeholders in three local authorities. The objectives were to consider the proposed content and local variation in relation to priorities and issues affecting policy development and decision making, engagement with key council members and national and local endorsement. These events resulted in the development of a draft declaration in 2015.

Street in Blackburn depicting the unhealthy food environment

4.0 THE BLACKBURN WITH DARWEN COUNCIL AND CLINICAL COMMISSIONING GROUP DECLARATION ON HEALTHY WEIGHT

The Declaration was launched as part of the Eat Well, Move More, Shape Up Strategy to provide strategic leadership to the healthy weight agenda. Overweight and obesity levels in Blackburn with Darwen (as of 2017/18 results) are:

Overweight (including obesity): 23.6% in reception, 34.6% in year 6 and 61.9% for adults. The reception and year 6 figures for Blackburn with Darwen are higher than the England average (22.4% for reception; 34.3% for year 6), but lower than the North West average (23.9% for reception; 35.5% for year 6). The figure for adults in Blackburn with Darwen is very slightly lower than both the England (62.0%) and North West average (64.3%).

Blackburn with Darwen's Eat Well, Move More, Shape Up Strategy is structured around access to affordable, healthy and good quality food; increasing opportunities to be physically active; and health promoting environments, the aims include:

Eat Well Aims

- Promote healthy and sustainable food choices for all
- Tackle food poverty and diet related ill-health across the life course
- Build community food knowledge, skills and resources
- Promote a vibrant diverse local food economy
- Transform catering and food procurement
- Reduce waste and the ecological footprint of the food system

Move More Aims

- Active society: creating a social movement where physical activity is a priority for everyone
- Moving professionals: activating networks to create active healthy workplaces and make every contact count to promote physical activity
- Active environments: creating the right spaces for safe and enjoyable physical activity
- Moving at scale: maximising the potential of the existing assets and build on existing evidence base on what works to make us active

FOOD ACT!VE

Shape Up Aims

- Transforming the environment we live in
- Making healthier choices easier by educating and empowering individuals and communities
- Giving all children the best start and tackling the generational issue of healthy weight in families
- Ensuring holistic and integrated evidence-based support for individuals with weight related conditions – either under or overweight

Children eating lunch, St. Gabriel's Primary School

The Blackburn with Darwen Declaration includes two sections. The first is a series of 14 generic statements developed by Food Active, and in consultation with the steering group, concerning the impact of overweight and obesity and includes commitments to protect the well-being of staff and citizens. The second part includes 10 commitments agreed by Blackburn with Darwen Council to meet its local needs. This is the same approach taken by the majority of the councils who have adopted similar Declarations in England. The text of Blackburn with Darwen's local commitments is contained in full in Appendix 2.

Signing the Declaration on Healthy Weight in Blackburn with Darwen meant the council made a formal and public commitment to support employees and the residents of Blackburn with Darwen to tackle the issue of obesity by encouraging individuals to make healthy choices. It was signed formally by Cllr Mohammed Khan M.B.E., Leader of the Council; Cllr Mustafa Desai, Executive Member for Health and Adult Social Care; Dominic Harrison, Director of Public Health.

Signatories of Blackburn with Darwen's Healthy Weight Declaration.

FOOD ACT!VE

5.0 METHODS OF EVALUATION

In addition to having access to both internal and publicly available Blackburn with Darwen Council briefing documents and presentations, interviews were carried out with ten key respondents in senior roles within Blackburn with Darwen Council including four Elected Members. They were asked the same seven questions (see Appendix 3) and asked if there was anything that they wanted to add at the conclusion of the interview.

The interviews were either recorded on an audio device and notes taken as back up or completed electronically by the participant, if an interview was not possible. A transcribed version of each interview was sent to the participant for verification. The respondents can all be identified (see Appendix 1) but given it is the roles they play in relation to the Declaration that are important, they are referred to below as follows:

DPH	Director of Public Health
PHDM	Public Health Development Manager
CCG	CCG Clinical Lead
CPH	Consultant in Public Health
EMCYP	Executive Member for Children, Young People and Education
EMDCS	Executive Member for Digital and Customer Services
EMCL	Leader of the Council
EMAHW	Assistant Executive Member for Health and Wellbeing
PSDM	Planning Strategy and Development Manager
STP	Senior Transport Planner

FOOD ACT!VE

6.0 FINDINGS

The transcribed quotes have been themed under each of the question headings. Quotes from all ten of the participants appear in the findings below, some have more quotes than others due to the level of detail in the interview. Please note not all issues raised by interviewees have been included in this report, some text has been issued for reasons of brevity.

6.1 OBESITY IN BLACKBURN WITH DARWEN

All saw obesity as an important issue and were clear that obesity needed to be addressed.

CCG: "Yes, as a GP I see lots of patients with weight problems, and this directly and indirectly contributes to a lot of ill health".

STP: "With recent figures indicating that one in four adults in Blackburn with Darwen are classified as obese and with 1.5% classified as severely obese I would, yes feel that obesity is a problem within the Borough"

CPH: "Yes for me absolutely, obesity is a local problem for us"

Links between obesity and deprivation/poverty.

EMCL: "Yes, it is a problem, particularly amongst the more deprived".

EMDCS: "Obesity is a problem, we have known for a number of years, in terms of where the town sits in the terms of demographics, in terms of poverty, it is a constant problem that we are trying to address

PHDM: "Both adult and childhood obesity levels in Blackburn with Darwen are similar to the national average. However, the main issue in Blackburn with Darwen is the Level of obesity within our most deprived wards. Our most deprived wards also see an increase in poor dental health, disproportionate numbers of hot food takeaways and poor access to green space".

There was acknowledgement that underweight is an issue in Blackburn with Darwen.

EMCYP: "I think healthy weight overall is a problem. It is both a problem in terms of overweight and obesity but also underweight.

DPH: "We are not surprising amongst the very worst in the country [for obesity] given our level of poverty and given that obesity is linked to poverty. I think one of the reasons for that, for us, is that we have 30% south Asian population who certainly in the younger years tend to weigh less, in fact we have a related but opposite problem which is relatively high percentage of low weight children. Of course, those things can be related, but in our case, we think some of it is related to ethnicity."

FOOD ACT!VE

6.2 ROLES IN PROMOTING HEALTHY WEIGHT IN BLACKBURN WITH DARWEN

Ensuring healthy weight is discussed and taken seriously:

CPH: "My role is trying to explain that it is not just about taking a population approach, it's not just what services we commission and care pathways we have for treating weight issues, it is about a whole system change…it is partnership working and raising awareness that slight changes to policies and practice in various sectors could influence overall outcomes of obesity prevalence".

Making sure change happens:

EMCL: "I am responsible as leader of the council for the action plan, to make sure we are monitoring the whole process, to make sure the strategy is implemented in our polices and practice in the local authority"

DPH: "As a Director of Public Health of course, my role is to make sure the system is working to produce the maximum number of the population in the healthiest weight possible…I think one of the things we are increasingly realising is that we cannot screen, case-find or treat our way out of obesity, because the percentage of the population with that problem is getting bigger every year".

PHDM: "I support the council, CCG and other settings in ensuring healthy weight is a priority in all policies and daily practice".

Understanding all council services have a role to play in addressing unhealthy weight:

STP: "I see my role as more of a supportive role in promoting healthy weight in Blackburn with Darwen through the Connecting East Lancashire Programme (CEL). CEL encourages people to be more active through walking and cycling schemes.

PSDM: "My role is to ensure Blackburn with Darwen's strategic framework supports and highlights the promotion of healthy weight wherever possible".

It is about promoting prevention as key:

CCG: "As a GP I am a still a strong supporter of family medicine and influencing families to make the right choices…but I also work with the CCG in a more strategic direction trying to get patients away from medical care and looking at self-management, self-care, and promoting healthy weight and healthy lifestyles".

Understanding the role of elected members:

EMDCS: "I feel every elected member has a role to play in terms of the uptake and belief around the strategy and actually delivering the messages to inform local residents and the local population on the importance of healthy weight".

EMCYP: "In my role supporting children and families, it is about the right start for children".

Dr Penny Morris, Medical Director, BwD CCG presenting at the Healthy Weight Summit, March 19.

6.3 ROLES IN SUPPORTING BLACKBURN WITH DARWEN COUNCIL TO ADOPT THE DECLARATION

Role of public health to drive this agenda forward:

PHDM: "I successfully advocated for the adoption of the declaration with senior leaders from both the council and the CCG".

DPH: "My role as DPH and our role as a public health department was to lead our key stakeholders in signing up – those stakeholders being the CCG and the local authority".

Communication was key:

EMCL: "I was to make sure the departments within the council were fully on board to implement this policy and to make sure that all elected members are very much aware of what work we are trying to do, and then they can raise awareness in their own local area.

CPH: "I ensured the agenda continued, that we continued to have regular strategic meetings, continuing to ensure the whole council recognised that they had a role to play".

System leader support:

EMAHW: "As an elected member I had to support the officer's recommendations (or not), which I did whole-heartedly.

EMDCS: "I inputted into the debate and actually supported the executive member and the offices who were bringing this forward".

6.4 HAS THE DECLARATION HELPED TO ADDRESS UNHEALTHY WEIGHT?

It has helped to generate opportunities:

EMAHW: "It has helped to influence the things we are working on now…Recipe for Health, Obesity Trailblazer, food poverty, working with public and private sector".

DPH: "I think one of the areas where I could say it has been particularly helpful is that we are now, on the basis of the work done on the declaration and our wider strategic work we have put in bids for, and have been successful in a being a child obesity trailblazer in a recent national programme".

CPH: "We are committed, we have a strategy, we have a declaration and I think that really strengthens our funding applications, so when funders look at us, we do look like we have actually done the leg work, this project is more likely to succeed because we have got those strong partnerships".

Demonstrates a real commitment:

STP: "It is valuable in having such a supporting document that shows commitment to improving health and wellbeing of the local population…this in turn completely supports the work we are delivering through the CEL project".

EMDCS: "Having [a declaration] there reminds us that yes we have the issue and we have a duty of care to deliver our strategies to address the issues that we set out to do".

Ensures policies and practice support healthy weight:

PSDM: "It's helped to raise awareness of the issue when assessing planning applications for developments which may affect eating behaviours of residents".

PHDM: "I think people genuinely do not have healthy weight on their radar or consider it an issue when considering policy, service development and embedded daily practice and the Declaration can help to start those sometimes difficult conversations".

EMCYP "Policies we have adopted around advertising, what we do what we don't do. Trying to get businesses to think more healthily".

FOOD ACT!VE

6.5 HAS ADOPTING THE DECLARATION CAUSED ANY DIFFICULTIES?

The general consensus was that the declaration has not caused difficulties for respondents in their roles:

DPH: "No, we see it very much as an asset and as a very useful tool in mobilising political and organisational support for a set of objectives which should be self-evident but often aren't".

EMAHW: "Not at all. It is encouraging more than putting obstacles in our way".

CPH: "We have had some interesting conversations but I would say it was good to have those conversations, so they were actually opportunities".

But there was reference to the fact there were challenges

EMDCS: "It is not an easy issue to resolve overnight, it is a long game, it is not easy to change people's behaviour, it has challenges and we are working extremely hard to tackle those challenges".

EMCYP: "For a lot people, they think that we don't understand the pressures of life for them, so where we have got parents who have to work because of the system, it is easier to buy a take away meal or a pre-cooked meal from a supermarket than make it from scratch, because people are busy and they take the simple option which is not always the healthy option".

PHDM: "There is also a challenge around 'health vs wealth' where economic regeneration and the pressure on the Council to create revenue from advertising and high-profile events such as the Festival of Making. There is no easy answer to this and will be an ongoing piece of work".

CPH: "We also had a discussion about workplace health which has been quite challenging, so I think we are sometimes seem as the 'food police' or the 'health police'".

FOOD ACT!VE

And maintaining momentum was seen as key:

EMCL: "The only difficulty I have found was raising the awareness and maintaining momentum".
PHDM: "The difficulty has been maintaining momentum and raising awareness of the Declaration and its commitments".

Healthy weight is everybody's business:

CPH: "Raising awareness of what it means to sign up to the healthy weight declaration, means that everybody has to understand it is about health promoting environments, health promoting settings, and it feeds into workplace health as well, so people need to think before promoting their event, or activity that it does fit, it is a consistent message that we are promoting".

6.6 WHAT STEPS CAN BE TAKEN TO ADDRESS UNHEALTHY WEIGHT IN BLACKBURN WITH DARWEN

Working with communities, with elected members:

EMCL: "Engaging with the community, engaging with elected members….changing behaviour and attitude and culture of the community and individual".
PHDM: "Engaging all elected members in the healthy weight discussion and support them to advocate for healthy weight in their communities".
DPH: "One of our biggest underutilised capacities is the commitment, enthusiasm and continued engagement of our elected members. I think signing the healthy weight declaration is a key strategy to enabling elected members to become engaged at a political level in some of the challenges involved in reducing obesogenic environments".
DPH: "Create a social movement for health".

Around education:
EMDCS: "Education – helping people to understand the effect of a choice they are making".

Early intervention:

EMCYP: "For me it is about starting as early as possible".
CPH: "Recognising children and young people, so staring at a very early age, or even pre-conception with a focus on population health and wellbeing but actually so we don't lose the focus on the family approach and we don't lose the focus and just think about adults and treatment of obesity, we do think about primary prevention as a key policy and strategy".

Review current practice:

PHDM: "Review all policies and ensure healthy weight features in every policy".
PHDM: "Review all communication and marketing activity from the council to ensure consistent messages which affect healthy weight are given out to council staff and residents".
CPH: "Workplace health and staff culture change [within the Council].
CPH: "Look at policies and strategies to ensure we are creating health promoting environments, not contradicting".
DPH: "To be constantly vigilant about what opportunities there are through existing powers of inspection, of regulation, and of planning to control the proliferation of unhealthy hot food outlets in places".
CCG: "With the reconfiguration of services around networks and working more as integrated teams, I think both council and health services, although we have a brilliant connection already, it could be better".

Work as a whole system:

STP: "To ensure the approach to tacking obesity is a whole system approach across all council departments, ensuring everyone understands the importance and the role they have to play".

Physical activity at Blackburn Central High School

FOOD ACT!VE

6.7 HOW SHOULD THE DECLARATION BE TAKEN FORWARD?

To a certain extent this has been covered previously, keeping momentum going is key, as is engaging with Elected Members and all council departments.

Also using it to look for further opportunities:

EMAHW: "I think the obesity trailblazer is a big, big thing for us and I think it will help us to identify what will work and what isn't working".

Ensuring everyone is aware of the role they have to play:

SPT: "In my opinion it is vitally important that as a council we all understand what the healthy weight declaration is, the role that we play with the work that we do and how we work together to tackle the obesity issue".

Consistent messages:

CCG: "A joint push…so we are all singing from the same hymn sheet, just get this message out that there are ways of getting to a healthier weight, that there is help out there, not just for residents, but for practitioners, for workers, for social workers, for doctors and nurses to make better use of existing resources so we are all sending the right message out, sometimes the message isn't always clear and sometimes it is a little bit confused".

EMCL: "Reviewing our communication system and marketing strategy, and to send a consistent message to residents and staff members of the council".

Seema Kennedy MP and Leader of the Council, Cllr Mohammed Chan OBE visiting a hot food take-away, to celebrate Pennine Lancashire being selected as a childhood obesity trailblazer.

Continually monitor and review:

EMDCS: "We have to continually monitor ourselves and assess the impact of the strategies we have implemented – are they really having an impact on people's weight, on childhood obesity? It is about making those decisions, implementing them, reviewing effectiveness and continually tweaking to improve, then we will end up with a robust strategy to improve people's lives".

DPH: "We need the whole system to sign up, and that means national government and national government departments who create policy and provide the context for healthy or unhealthy food supplies".

CPH: "In Blackburn we do have the joint declaration and I think that was a really great move to link with the CCG and the local authority, so place-based prevention. So, to take it on to the next steps we need to think about our other strategic partners in our patch".

PHDM: "We will also maintain the engagement from partners and stakeholders who attended the Healthy Weight Summit in March to 'grow' the healthy weight movement into communities and settings across Blackburn with Darwen".

PHDM: "Review and refresh the local commitments beyond 2020".

Cllr Brian Turner hosting the Healthy Weight Summit, March 2019. Bringing partners together to strengthen action on healthy weight in the borough.

FOOD ACT!VE

7.0 SUMMARY AND KEY LEARNING

Ten participants were interviewed for this evaluation exercise. Participants held a wide range of positions and roles, which provided the opportunity to understand views on both healthy weight in Blackburn with Darwen and the Declaration from a variety of perspectives.

- Obesity is considered an issue in Blackburn with Darwen
- All participants felt that they had a role to play in addressing unhealthy weight in Blackburn with Darwen
- Overall participants were very positive about the impact and the opportunities generated from the Declaration
- Participants felt it was key to ensure momentum continued to impact on healthy weight
- Participants felt a system-wide approach was very important
- Utilising Elected Members to drive the healthy weight agenda forwards was seen as important, and useful in engaging communities
- Partnerships were viewed as important – it was suggested that they need to think about other strategic partners across the patch
- Working with communities was flagged as important is driving the Declaration forwards
- Participants felt it was important to use the Declaration to continually revisit and review policies and practice
- It was seen as important to ensure that impact was continually monitored and evaluated
- Consistent messages were viewed as important
- It was suggested that a review and refresh the local commitments beyond 2020 should be considered

8.0 ACKNOWLEDGEMENTS

Thank you to the officers and members of Blackburn with Darwen Council who supported and participated in this evaluation. Thank you to Beth Wolfenden for coordinating the participants.

Thanks to Robin Ireland and Nicola Calder at the Health Equalities Group who led the development of the Local Government Declaration on Healthy Weight.

Thank you to Beth Bradshaw at the Health Equalities Group for her support with the interviews and compiling the report.

9.0 APPENDICIES

APPENDIX 1: INTERVIEWEES FOR EVALUATION REPORT

DPH	Professor Dominic Harrison	Director of Public Health
PHDM	Beth Wolfenden	Public Health Development Manager
CCG	Dr John Randall	CCG Clinical Lead
CPH	Shirley Goodhew	Consultant in Public Health
EMCYP	Cllr Maureen Bateson	Executive Member for Children, Young People and Education
EMDCS	Cllr Quesir Mahmood	Exec Member for Digital and Customer Services
EMCL	Cllr Mohammed Khan OBE	Leader of the Council
EMAHW	Cllr Brian Taylor	Assistant Exexutive Member for Health and Wellbeing
PSDM	Helen Holland	Planning Strategy and Development Manager
STP	Melanie Taylor	Senior Transport Planner

APPENDIX 2: LOCAL COMMITMENTS FROM BLACKBURN WITH DARWEN'S DECLARATION, AS ADPOTED IN MARCH 2017

> Support the introduction of 'Mile a Day' and 'Couch to 5k' in primary and secondary schools respectively

> Support Early Years settings to enable a structured physical activity offer and healthy food policy

> Develop a Food Poverty Network to reduce food poverty and tackle malnutrition in all settings

> Support the introduction of school food policies including lunchbox policies

> To be a designated Sugar Smart Town

> Develop a Food Charter for the Borough to promote healthy and sustainable food in a local economy

> Promote Active Travel and use of Rights of Way across the Borough to increase physical activity, for social and employment opportunities and minimise air pollution

> Support 'Street Play' initiatives through exploring the implementation of periodic temporary street closure orders and other innovative sites for play

> To be a designated Breastfeeding Friendly Town

> To achieve Sustainable Food Town status

APPENDIX 3: QUESTIONS USED FOR THIS EVALUATION

Q1: Do you feel obesity is a particular problem in Blackburn with Darwen?
Q2: How do you see your role in promoting healthy weight in Blackburn with Darwen?
Q3: What role (if any) did you play in the adoption of the Local Authority Declaration on Healthy Weight by Blackburn with Darwen Council?
Q4: Has the Declaration helped you (and/or the Council) to address healthy weight in Blackburn with Darwen? If so, what influence do you feel it has had?
Q5: Has adopting the Declaration caused any difficulties either for you in your role or for the Council?
Q6: Can you identify what you feel may be the three most important steps that the Council may be able to take in tackling obesity in Blackburn with Darwen?
Q7: What do you think may be the best way of taking the Local Authority Declaration on Healthy Weight forward?
That concludes my questions. Is there anything else about the Local Authority Declaration that you would like to add?

This support pack has been prepared by:

Alex Holt
Food and Nutrition Lead
Food Active

Beth Bradshaw
Project Officer
Food Active

Contact:

151 DALE STREET, LIVERPOOL, L2 2JH

INFO@FOODACTIVE.ORG.UK

FOODACTIVE.ORG.UK

@FOOD_ACTIVE

0151 237 2686

FOOD ACT!VE

Produced in November 2019

Eat Well Move More Shape Up

Blackburn with Darwen's Food Physical Activity and Healthy Weight Strategy

2017 – 2020

BLACKBURN with DARWEN BOROUGH COUNCIL

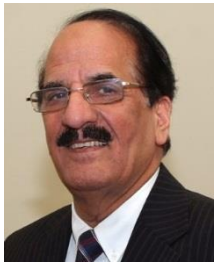
Contents

Foreword

The food we eat and the how physically active we are, is influenced by many complex factors, and not simply our lifestyle choices or genetics. The environment in which we live, grow, learn, work, play and age directly affects our food choices and, our levels of activity. For most of us, our attitudes, behaviours and lifestyle choices are affected by how much money we have or, what is available locally. Society influencers such as the media, education, peer pressure or culture have powerful effects on our individual, and family, choices. In addition, local, national and global policies can positively or negatively contribute to our individual health and wellbeing.

The impact of a continued unbalanced diet and inactive lifestyle over the life course has many negative health and wellbeing consequences, such as obesity, diabetes, cardiovascular disease, some cancers, and poor mental health and wellbeing. Not only does this affect our life style directly, but the cost of treating these health conditions is now beyond what we can afford. Therefore, we need to increase the focus on primary prevention and early intervention, to support and empower individuals and communities by making the healthier choices easier, and to enable us to keep happy, healthy and well and most importantly to prevent such diseases from developing. This 'Eat Well, Move More and Shape Up' strategy is the first comprehensive local strategy of its kind to encompass the three strategic aims around (i) food and nutrition, (ii) physical activity and (iii) healthy weight. This cross cutting strategy provides a call to action not just to our usual health and wellbeing partners, but to local businesses small, medium and large, who have a key role to play in developing the choice architecture available to both customers and their employees. We know that if we have a healthy workforce, then we have a more productive workforce.

We fully endorse and recommend this strategy to **ALL** of our partners, as these aims can only be achieved by the combined efforts of many. We encourage each partner to take a leadership role in creating this change within their sphere of influence. As individuals, we need to lead by example and create a new healthier 'norm', and engage local residents to create a more active and healthier environment to live, work and play.



Cllr Mohammed Khan M.B.E.
Leader of the Council

Cllr Mustafa Desai
Executive Member for Health and Adult Social Care

Dominic Harrison
Director of Public Health

Executive Summary

Our Vision:

'For everyone in Blackburn with Darwen to move more, eat well and maintain a healthy weight'

There is a growing body of evidence about the negative effects of obesity, physical inactivity and poor diet on the physical and mental health and wellbeing of individuals along with the economic costs to society. Some might argue that eating healthily and being physically active is a choice which is taken by the individual and cannot be influenced by an external force. However, we know that due to the inequalities which exist in society and many other factors including the power of junk food marketing, increasing mechanisation and the austerity measures put in place by the current UK Government, those choices are being taken away.

With the majority of the population currently overweight or obese, social norms are shifting. Challenging this 'new norm' will require national action with support from local government, greater awareness in recognising the fragility of the health care system and community education to generate a social movement for a health and self-care.

Blackburn with Darwen is one of the most deprived Boroughs in the country and with that comes huge challenges in health and wellbeing. Around 75,000 adults in the borough are overweight or obese and the rate of obesity more than doubles from 9.4% at 4-5 year old to 22.1% at 10-11 year old. Over 50,000 adults in Blackburn with Darwen are not active enough to benefit their health with the cost of physical inactivity to the Borough being over £3 million. Dental health in the Borough is also very poor with 3 year olds have almost double the national average dental decay and 5 year olds have the worst dental health in the country.

Drawing on the recommendations from national insight work and physical activity, obesity and food strategies and extensive local consultation, a detailed action plan which takes a life course approach will support this strategy. Whilst it is acknowledged that services and interventions are important in tackling the issues identified in the strategy, there must be a focus on coordinated, strategic action ensuring health in all policies and strong, local authority and health leadership.

Working together to tackle health inequalities in Blackburn with Darwen is a focus of this strategy. To support some of the most vulnerable groups in our communities, even in these times of financial pressure, we will be taking a whole systems approach to tackling obesity and physical inactivity. It is in engaging with all partners and stakeholders, including council and health leaders, Community, Voluntary and Faith sector organisations, the wider public sector, private business and local communities themselves; the strategy demonstrates a joint commitment to work together to have prevention as a priority in all that we do that we can make a significant difference to the health and wellbeing of the residents of Blackburn with Darwen.

Overall Strategy Mission

- Support an environment that empowers people to make physical activity and healthy eating the easy choice for everyone throughout the course of their lives
- Encourage positive lifestyle changes that enable the people of Blackburn with Darwen to improve their health and wellbeing and to be a healthy weight
- Empower the most vulnerable and at risk of poor health in our community to make positive behaviour changes
- Building community capacity and mobilising the workforce of Blackburn with Darwen to make every contact count

Introduction

Eat Well

For Blackburn with Darwen to be a place:

- Where everyone can access healthy, affordable, good quality food and enjoy a healthy diet
- Where the food in the borough is produced and sourced locally which in-turn supports the local economy and helps sustain the environment
- Where food is used to bring the community together celebrating different food cultures and promoting cohesion through food.

Eat Well Aims

1 Promote healthy and sustainable food choices for all

2 Tackle food poverty and diet related ill-health across the life course

3 Build community food knowledge, skills and resources

4 Promote a vibrant diverse local food economy

5 Transform catering and food procurement

6 Reduce waste and the ecological footprint of the food system

Move More

To increase the levels of physical activity across the life course for all residents in Blackburn with Darwen through greater partnership and collaborative working:

Move More Aims

1. Active society: creating a social movement where physical activity is a priority for everyone
2. Moving professionals: activating networks to create active healthy workplaces and make every contact count to promote physical activity
3. Active environments: creating the right spaces for safe and enjoyable physical activity
4. Moving at scale: maximising the potential of the existing assets and build on existing evidence base on what works to make us active

Shape Up

Promote an environment which positively encourages residents to achieve a healthy weight through making healthy lifestyle choices by:

Shape Up Aims

1. Transforming the environment we live in
2. Making healthier choices easier by educating and empowering individuals and communities
3. Giving all children the best start and tackling the generational issue of healthy weight in families
4. Ensuring holistic and integrated evidence based support for individuals with weight related conditions – either under or overweight

Key Drivers

NHS 5 Year Forward View 2014

Get Well Soon – Place Based Health 2016

Healthier Lancashire Programme

Cumbria & Lancashire Sport & Physical Activity Strategy

Lancashire Walking & Cycling Strategy

Everybody Active Every Day

Childhood Obesity: A Plan for Action

Sporting Futures

Towards an Active Nation

UK Active's Blueprint for an Active Nation

Governance

The Eat Well, Move More, Shape Up strategy will be accountable to the Blackburn with Darwen Health & Well Being Board and will be the responsibility pf the Eat Well, Shape Up, Move More steering group which is chaired by a representative from Public Health to ensure the development of the strategy. As the strategy develops, members of the groups will engage and liaise with their organisation, community and peers to ensure wide cascade and ownership of the action points within the strategy. Membership of this group comprises key partners and stakeholders, as outlined in appendix i.

The strategy will:

- raise the profile of physical activity opportunities and the benefits of increased participation amongst the population
- identify a number of key principles to increasing participation in physical activity
- coordinate, inform and influence the way in which individuals and organisations work
- Strategically influence the development of intervention programmes to increase physical activity levels, reduce obesity levels and encourage and promote healthy food choice within key target groups to address health inequalities

2. Food

Food is essential for life and can have an impact that is both positive and/or negative, depending on the type of food we eat. Food helps meet our physical needs by providing us with energy and nutrients but for many people it can also meet social, cultural and emotional needs. However, increasingly, we see the food system being challenged both domestically and globally.

A healthy diet is defined by the World Health Organisation as achieving energy balance, limiting energy intake from total fats, free sugars and salt and increasing consumption of fruits and vegetables, legumes, whole grains and nuts. Evidence shows that the environments in which people develop their dietary behaviour and make their food choices significantly influence what they purchase and, in turn, what they eat. [1]

Furthermore, significant differences in nutritional knowledge have been linked to different socioeconomic groups, with knowledge declining with lower socioeconomic status. For example, children who live in the most deprived areas are at an increased risk of adult cardiovascular disease, partly reflecting lower exposure to healthy foods. This learned behaviour can then reinforce adult food preferences for less healthy foods.

A recent review on interventions to promote healthy eating[2] found that lower socioeconomic position is associated with a higher intake of energy dense, nutrient poor foods high in saturated fat and sugar, and with lower intake of fruit, vegetables and whole grains. Food selection is not only a behavioural choice but can also be influenced by factors such as cost, access and knowledge.

2.1 Health and Wellbeing

Recent data shows that diet has overtaken tobacco in having the greatest impact on health in the UK[3]. Unhealthy diets are attributed to a number of health conditions which in-turn have a massive burden on health and social care institutions.

Insight from the findings of the National Diet and Nutrition Survey provides an indication of the diet, nutritional intake and the nutritional status of the general population in the UK. The key findings of the survey from 2008/2009 – 2011/2012 shows that the UK population is consuming too much saturated fat, added sugars and salt, and not enough fruit, vegetables, fibre and oily fish.[4]

Nationally, the government's '5 a Day' programme has continually highlighted the importance of including fruit and vegetables in the diet. A preventative strategy; it is aimed at improving diet and nutrition in the general population. Current guidelines recommend that adults and children should aim to eat at least five portions of a variety of fruit and vegetables each day. Fruit and vegetables may also play a key role in weight management when combined with a reduction in fat intake, may reduce the risk of developing Type 2 diabetes and impaired cognitive function.

The 2013 Health Survey for England found that higher consumption was also associated with higher income, and vice versa. 30% of men and 35% of women in the highest income quintile had consumed five or more portions on the previous day compared with only 19% of men and 23% of women in the lowest quintile. This same pattern is repeated for children.[5]

As a nation we are eating too much sugar and it is bad for our health. Consuming too many foods and drinks high in sugar can lead to weight gain[6] and health related problems,[7] as well as tooth decay.[8] Sugar intake of all population groups are above the recommendations contributing to around 12 to 15% of energy intake.[4] Consumption of sugar and sugar sweetened drinks is particularly high in school age children and it also tends to be highest among the most deprived communities who also experience a higher prevalence of tooth decay and obesity and its health consequences.[9] [10]

The World Health Organisation[1] attributes unhealthy diets and physical inactivity to the significant rise in obesity and one of the leading causes of non-communicable diseases including cardiovascular disease, type 2 diabetes and certain cancers. Consuming a healthy diet is essential to help prevent the aforementioned long term conditions.

2.2 Breastfeeding

Earlier this year new research was published in the Lancet confirming that breastfeeding saves lives, improves health and cuts healthcare costs in every country, including the UK. [11] Yet despite the overwhelming evidence, the UK has some of the lowest breastfeeding rates in the world with initiation rates in England of 74.3% (Figure 1).[12] There are social, cultural and economic barriers which mean that many women are unable to breastfeed successfully despite genuine efforts to do so. This can lead to women experiencing feelings of pain, guilt and anger.

The evidence is well-established, for both the benefits to mother and baby of breastfeeding, and the significant risks of not breastfeeding. Breastfeeding has some of the most wide-reaching and long lasting effects on your baby's health and development.

Babies who breastfeed at a lower risk of [11 13 14]

- Gastroenteritis
- Respiratory infections
- Sudden infant death syndrome
- Obesity
- Type 1 & 2 diabetes
- Allergies (e.g. asthma, lactose intolerance)

Breastfeeding is associated with a higher IQ, translating into improved academic performance, as well as increased long-term earnings and productivity. Emerging evidence suggests that breastfeeding has a positive impact on mother-baby relationships: breastfeeding releases certain hormones which promote maternal feelings and behaviour. Strong early relationships and a stable and loving environment are all conducive to babies' healthy emotional, social and physical development, through production of the hormone oxytocin. Oxytocin acts like a fertiliser for the brain, promoting the growth of neurons (brain cells) and the connections between them, enabling babies to grow into secure, happy children. [15 16]

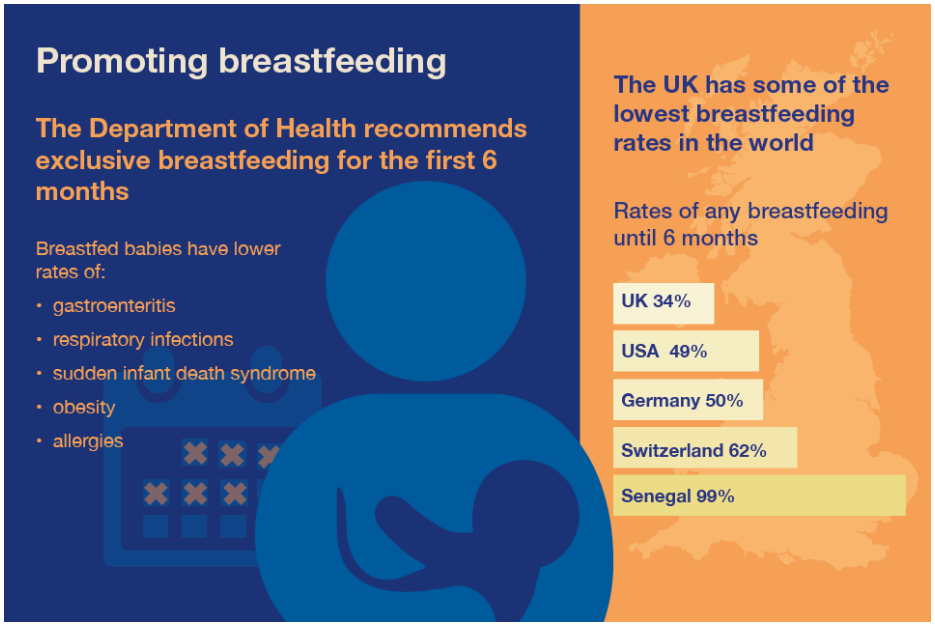


Figure 1. Health matters: giving every child the best start in life - promoting breatfeeding. (Public Health England, 2016).

2.3 Food Sustainability, the Environment and Food Waste

The Food and Agriculture Organisation[17] describes a sustainable diet as

> '..those diets with low environmental impacts which contribute to food and nutrition security and to a healthy lifestyle for future generations. Sustainable diets are protective and respectful of biodiversity and ecosystems, culturally acceptable, accessible, economically fair and affordable, nutritionally adequate, safe and healthy; while optimising natural and human resources' (FAO, 2012)

According to the Sustain website[18] their definition of what equates to 'good food' is that it should be produced, processed, distributed and disposed of in ways that:

- *'Contribute to thriving local economies and sustainable livelihoods - both in the UK and, in the case of imported products, in producer countries;'*
- *'Protect the diversity of both plants and animals and the welfare of farmed and wild species'*
- *'Avoid damaging or wasting natural resources or contributing to climate change;'*
- *'Provide social benefits, such as good quality food, safe and healthy products, and educational opportunities'.*

More than 70% of the population lives in urban areas in Europe, a number that is likely to increase in the forthcoming years.[19] It is taken for granted that everyday food will arrive at restaurants, shops, supermarkets, schools, etc. across our towns and cities – enough to meet the health and diverse cultural needs of the population. However, there is evidence to suggest that our food system is vulnerable which could lead to reduced access and availability of food.

Dependence of the food system on fossil fuels is one of many examples of negative environmental impact of our diets. From production to consumption; our food system emissions contribute to 30% of global greenhouse gas emissions.[20] The UK imports approximately 47% of total food products which adversely contribute to carbon emissions associated with food transportation, refrigeration and packaging.[21]

Alongside climate change, biodiversity, depletion of natural resources, food waste, and food packaging all have considerable impact on the environmental. According to the 'Love Food, Hate Waste' website, approximately 7 million tonnes of food and drink is thrown away from our homes; the majority of which could have been eaten. This equates to £12.5bn a year at an average cost of £470 a year per household, rising to approximately £700 for a family with children. Reducing this unnecessary food waste can have a positive impact on the environment and would be the equivalent of taking 1 in 4 cars off the road.

Food waste is further exacerbated by lack of understanding of food labels. Whilst foods that have passed their 'use by' date should never be eaten, 'best

before' dates refer to quality rather than food safety and are therefore are usually safe to eat. Limitations and lack of understanding of food labelling, may be leading to some shoppers disposing of food that is still fit for consumption.

2.4 Food Poverty

In recent years, food poverty has been highlighted as a growing problem which has "all the signs of a public health emergency that could go unrecognised until it's too late to take preventative action".[22] Use of emergency food aid in the UK, particularly in the form of food banks, has dramatically increased over the last decade.[23]

The Department of Health recognises food poverty as "the inability to afford, or to have access to, food to make up a healthy diet.[24] In November 2014, the Church of England, Oxfam UK, Child Poverty Action Group and the Trussell Trust published a report on understanding and reducing the use of food banks in the UK – 'Emergency Use Only'.[25] Participants in the research reported that food bank use was primarily in response to a financial crisis which had resulted in no money for food.

It is widely reported that individuals and families who experience food poverty are more likely to eat a diet which is unhealthy; characterised by food that is higher in saturated fat, salt and sugar. Furthermore, they are more likely to eat processed foods which are both cheap and energy dense.

The UK Faculty of Public Health response to the All Party Parliamentary Inquiry into Hunger and Food Poverty in Britain[26] acknowledged that the reasons for inequalities in the UK are complex and many individuals and families in the UK are living in poverty which in turn impacts their ability to afford a nutritious diet.

Food prices in the UK have risen by 12% in real terms since 2007.[21] Yet, in the same period, UK workers have suffered a 7.6% fall in real wages.[27] The recent 'Brexit' referendum may bring additional volatility to the food market with examples of suppliers increasing food prices further exacerbating the issue of food poverty. With low wages and the high cost of food, many vulnerable individuals and families will find it increasingly difficult to afford food to meet their most basic nutritional needs.

2.5 Accessibility and Availability of Affordable Food

The following groups are people are at increased risk of experiencing food poverty:[28]

- people living on low incomes or who are unemployed
- households with dependent children
- older people
- people with disabilities
- members of black and minority ethnic communities

Poor accessibility to affordable healthy foods, linked to a number of factors makes people already vulnerable more susceptible to experiencing food poverty. Factors such as closure of shops in deprived areas, out-of-town supermarket developments, poor transport links etc. all contribute to poor access and affordability of healthy food.

Food supply and access to food are highlighted as two key factors which ensure food security.[29] Figure 2 below includes the various determinant of food security.

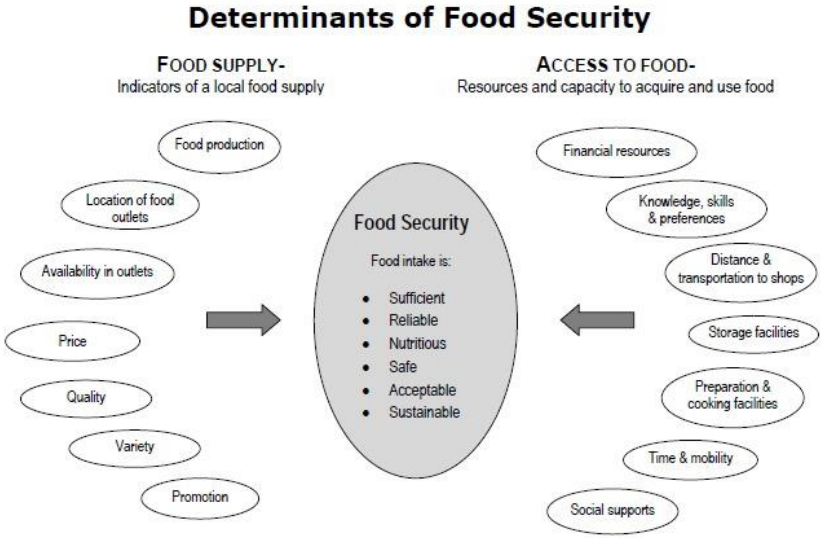


Figure 2 Determinants of Food Security. (Adapted from Rychetnik 2003)

All components in the food system are required to ensure community food security. A whole system approach with the right amount of resources and capacity are required to ensure a good quality food supply.[30]

2.6 Food Procurement

The public sector spends about £2.4bn per annum procuring food and catering services. This represents approximately 5.5% of UK food service sector sales. Schools, hospitals, armed forces, central and local government, government agencies, prisons and courts to name a few, are recipients of these monies. Food procured for these institutions can significantly affect the health, wellbeing and eating habits of the people using them making it vitally important that food procurement for the public sector is not only value for money, but also helps in making wider impacts.[31] The 2015-2020 Sustain Better food Better farming Better lives Strategy[32] details the need for strengthening public sector standards for food and to ensure public money is invested in wider social, economic and environmental benefits, ensuring that all public sector settings are serving healthy, sustainable diets.

The DEFRA report written by Dr Peter Bonfield[31] highlights how effective public procurement can deliver a range of benefits. It can support a thriving local economy and also supply quality nutritious food for its customers. It can also help in:

- *Supporting farmers and food producers and rightly rewarding them for operating to high animal welfare and production standards;*
- *Building training opportunities into contracts, to ensure a well-skilled food and farming sector for the future;*
- *Tackling health issues by enabling people to eat well across the public sector, including in our hospitals, and contributing to wider societal wellbeing;*

• *Helping our school children to value their food by knowing where their food comes from, and how to cook healthy meals.*

2.7 Food culture, education and skills

In the UK we have lived through a food revolution in recent years. Cooking features heavily on prime time television and chefs have become celebrities with some able to influence and improve food policy. Our shops and supermarkets offer a much wider range of products than ever before and reflect a demand for ingredients to meet a much more developed sense of taste and interest in a range of cuisines. We have moved on from the austere times of post war food rationing and food lacking in flavour and enjoyment and more people want to understand where their food comes from, how it was produced and who produced it. However for many, food that would have been made from scratch has been replaced with a ready meal or fast food. Still too many children do not know where their food comes from and lack the basic cooking skills required to create a meal from scratch. Where once families ate together many do not even have a dining table whilst in most workplaces, the lunch break has been replaced by a rushed sandwich sat at the desk with food being used for fuel and not being enjoyed.

The food system across Lancashire offers an array of opportunities for creating jobs, increasing economic prosperity and improving the wellbeing of the entire community that reside and work within the County and promote food sustainability. Boosting local food production and local food networks will bring food growers and suppliers closer to the communities they serve and potentially reap sustainable economic and environmental benefits for all residents. Connecting urban consumers with the local farmers in and around Blackburn with Darwen will help develop a deeper understanding of the value of food and its relationship to our health and the environment. Reducing 'food miles' by developing more localised food networks will also help reduce the greenhouse gas emissions and in the long-term improve air quality and the impact on the environment and our health.

2.8 What is a Healthy Diet?

A healthy, balanced diet consists of a variety of foods. This includes at least five portions of fruit and vegetables a day; starchy foods, in particular wholegrains, such as bread, pasta and rice; protein-rich foods such as meat, fish, eggs and lentils, dairy foods and limited amounts of food containing high fat, salt and sugar. A diet full of variety of foods is important but so is portion control. Eating the right amount in relation to the level of physical activity a person does each day can help control weight and subsequently reduce the risk of diet related diseases.

Figure 3 Eat Well Guide (Public Health England, 2016)

The components of a healthy diet are best shown by the 'Eatwell Guide' (Figure 3). The Eatwell Guide is described by Public Health England as a resource that:

'….shows the proportions in which different types of foods are needed to have a well-balanced and healthy diet.'

This includes everything that is eaten throughout the day and applies to different sub-groups of the population taking into consideration everyone (except under 2 year olds due to their differing nutritional needs) and acknowledging people eat different diets due to religious, cultural reasons and/or lifestyles. Dietary requirements also change or are advised to be modified dependant on life-stage from preconception and pregnancy through to older people.

2.9 Key Documents

Better food. Better farming. Better lives. Sustain Strategy 2015-2020, 2015

Sustainable Development Commission, 2011

The Green Food Project Conclusions; Defra, July 2012

Sustainable Consumption Report: Follow-up to the Green Food Project; Defra, July 2013

The Foresight report 'Tackling Obesities: Future Choices', 2007

'Healthy Lives, Healthy People', Public Health White paper, 2010

'Healthy Lives, Healthy People: A call to action on obesity in England', 2011

A Plan for Public Procurement, Defra, 2014

3. Physical Activity

3.1 Introduction

'Physical inactivity is described as doing no or very little physical activity at work, at home, for transport or during discretionary time and not reaching physical activity guidelines deemed necessary to benefit public health'[33]

Physical inactivity is known to be the fourth leading cause of global mortality. Many of the leading causes of ill health in society today such as coronary heart disease, cancer and type 2 diabetes, could be prevented if more inactive people were to become active.[34] Physical inactivity is one of the leading causes of death in developed countries, responsible for an estimated 22-23% cases of coronary heart disease, 16-17% of colon cancer, 15% of diabetes, 12-13% of strokes and 11% of breast cancer cases.[35] Evidence also continues to mount that the best way to prevent dementia is to follow the general guidelines for a healthy lifestyle.[36] A study at Cambridge University[37] has concluded that around 30% of cases of Alzheimer's disease may be attributable to seven risk factors including a healthy diet but both papers agree that the most important factor is physical activity. Alongside reducing premature death and the incidence of disease, being physically active has benefits for mental health, quality of life and wellbeing and maintaining independent living in older age. Being active plays a key role in brain development in early childhood[38] [39]and is also good for longer-term educational attainment.[40] Increased energy levels boost workplace productivity and reduce sickness absence. An active population can even reduce levels of crime and antisocial behaviour.[41]

Figure 4 Physical activity as a drug (Sport England)

Physical activity can help to play a role in reducing health and social inequalities[42] and as a result of its wide reaching impact has been described as the 'best buy' in public health.[43] An analysis of the Global Burden of Diseases, Injuries and Risk Factors Study[44] found physical inactivity and low physical activity to be among the ten most important risk factors in England. Physical inactivity places a significant burden on the healthcare system and

the economy and in 2013/14 physical inactivity was found to cost the NHS Clinical Commissioning Groups £455million.[45] Furthermore, ill-health of working age individuals (aged 16-64) can cost the government between £62 and £72 billion and have a total economic impact of £103 to £129 billion each year.[46] In 2010 the CMO for England called for a doubling of walking and an eight-fold increase in cycling.[47] A study by public health economists found that within 20 years this increase would lead to savings of roughly £17 billion (in 2010 prices) for the NHS in England and Wales.[48]

Despite the well reported health and economic benefits of physical activity, levels of participation in the UK are currently very low in both children and adults with 66% of men and 54% of women in the UK claiming to meet the recommended guidelines and 21% and 16% of girls aged 5-15 in England take the physical activity they need for good development (Figure 5).[49] As a population we are 24% less active than in 1961 and if current trends continue, we will be 35% less active by 2030.[50]

Physical activity levels decline rapidly with increasing age. 11% of men in the age 25-34 age group are classified as physically inactive and this figured quadruples to 46% in the 75+ age group. There is a similar picture for women are inactive where levels of physical inactivity treble in the 75+ age group. In the North West region numbers meeting recommended guidelines are lower than the national avenue at 59% for men and 48% for women. There are also stark differences in inactivity levels between the highest and lowest income quintiles with almost double the number of inactive women (34%) and treble the number of inactive men (29%) from the lowest income quintile.[49]

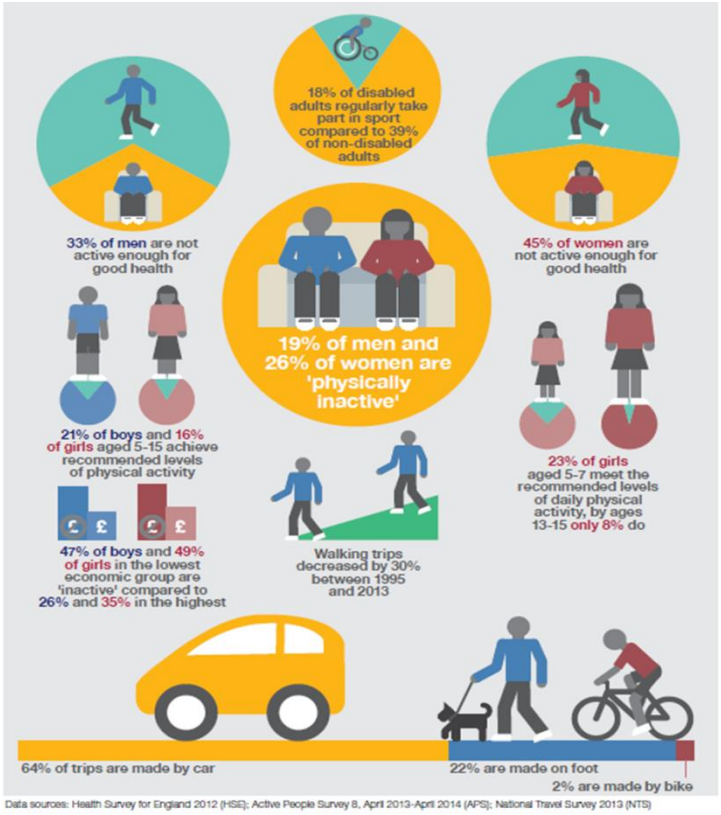


Figure 5 Physical Inactivity Infographic (Data source: Active People Survey 2013-2014, National Travel Survey 2013, Health Survey for England, 2012)

A number of studies have shown low levels of physical activity among minority ethnic groups in the UK. This is particularly true for South Asian populations[51] where markedly lower levels of physical activity compared to the White population have been found to remain significant even after

controlling for age, sex, education, adiposity and self-reported health variations.[52] Further analysis of separate South Asian groups suggests that people from the Bangladeshi community have markedly lower levels of physical activity than other South Asian groups.[53] More recent statistics from the BHF showed only 26% of Bangladeshi men and 11% of Bangladeshi women meet the recommended levels.[54]

'Sedentary behaviour is not defined simply as a lack of physical activity. It is a group of behaviours that occur whilst sitting or lying down and that require very low energy expenditure. The low energy requirements distinguish sedentary behaviours from other activities that also occur while sitting down, but which require greater effort' [55]

There is a growing body of evidence linking sedentary behaviour with chronic disease morbidity and mortality in adults[56 57 58 59 60 61] and early evidence to suggest sedentary behaviour may also be a health risk in children and young people.[62 63 64]Sedentary behaviour damages health because of the way it affects circulation and fails to use muscles and bones. Guidelines now recommend that people of all ages should avoid prolonged periods of sedentary behaviour and break up periods of sitting.[65] Sedentary behaviour is on the increase in the UK with more adults inactive on weekend days than week days with this pattern even more evident in children and more than 40% of women and 35% of men spend more than six hours a day desk-bound or sitting still and applies across the life course.[66] Sedentary behaviour is more prevalent with increasing age, with evidence of a marked increase from approximately 60 years of age onwards.[67] Children who tend to be more sedentary have a good chance of continuing to be sedentary as adolescents. This suggests sedentary habits developed early in life tend to be relatively unchanging over time. Even individuals who meet current physical activity guidelines may be at risk of the adverse effects associated with prolonged periods of sedentary behaviour[68] therefore there are key messages that need to be communicated even to those who meet the minimum physical activity guidelines.

3.2 Physical Activity and Obesity

The risks to health with weight gain are the same as being physically inactive, weight gain during adulthood can also increase the risk of heart disease, diabetes, and other chronic conditions. Since it's so hard for people to lose weight and keep it off, it's better to prevent weight gain in the first place. Encouragingly, there's strong evidence that staying active can help people slow down or stave off "middle-age spread".[69] The more active people are, the more likely they are to keep their weight steady;[70 71] the more sedentary, the more likely they are to gain weight over time.[72]

3.3 How Does Activity Prevent Obesity?

Researchers believe that physical activity prevents obesity in multiple ways:[73]

- Physical activity increases people's total energy expenditure, which can help them stay in energy balance or even lose weight, as long as they don't eat more to compensate for the extra calories they burn.

- Physical activity decreases fat around the waist and total body fat, slowing the development of abdominal obesity.
- Weight lifting, push-ups, and other muscle-strengthening activities build muscle mass, increasing the energy that the body burns throughout the day—even when it's at rest—and making it easier to control weight.
- Physical activity reduces depression and anxiety,[74] and this mood boost may motivate people to stick with their exercise regimens over time.

Exercise can help promote weight loss, but it seems to work best when combined with a lower calorie eating plan.[75] If people don't curb their calories, however, they likely need to exercise for long periods of time—or at a high intensity—to lose weight.[76] [77]

Weight loss is best achieved by combining changes in eating habits with increased amounts of physical activity. Physical activity is thought to be more effective in the prevention of overweight and obesity than in its treatment. Yet, results from a European survey suggest that people perceive food to be far more important in preventing weight gain than physical activity. Similarly, when asked about the most important influences on health, nutrition ranked much higher than physical activity.[78]

It is important to keep in mind that staying active is not purely an individual choice: The so-called "built environment"—buildings, neighborhoods, transportation systems, and other human-made elements of the landscape—can influence how active people are.[79] People are more prone to be active if they live near parks or playgrounds, near open spaces and in areas with good links to cycle paths and safe pavements, or close enough to work, school, or shopping to safely travel by bicycle or on foot.[80]

There is a correlation between being overweight or obese and being physically inactive. The HSE report published in 2008[81] show self-reported activity levels by BMI category. Both men and women who were overweight or obese were less likely to meet the recommendations compared with men and women who were not overweight or obese. Given these findings, it is not surprising that obese men and women had the highest rates of low activity (36 per cent and 46 per cent respectively). Those who were not overweight or obese spent fewer minutes on average in sedentary time (591 minutes for men, 577 minutes for women) than those who were obese (612 minutes for men, 585 minutes for women). Young people who are overweight or obese tend to have lower participation sport and physical activity[82] and if we are to tackle the obesity epidemic and prevent it escalating further there needs to be consideration in changing attitudes to physical activity and making it an enjoyable and social experience for young and old alike.

3.4 What is physical activity?

'Physical activity is described as any body movement produced by the skeletal muscles that results in a substantial increase over resting energy expenditure'[83]

This strategy is focusing on physical activity in its broadest sense; and how we can embed physical activity into our everyday lives to make more people across the life course physically active. There are many definitions of physical activity which encompasses sport, active living and active recreation:

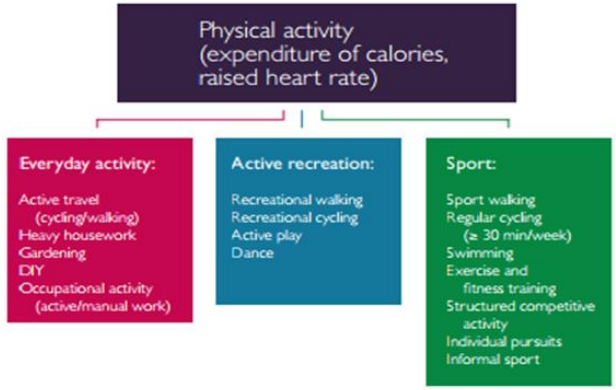


Figure 6 Definition of Physical Activity (Department of Health, 2011)

Physical activity does not need to be strenuous to be effective. Thirty minutes a day of moderate aerobic activity can be a brisk walk, a swim, or even a spell of gardening. Each ten-minute bout that gets the heart rate up has a health benefit. Although sport can be part of the picture, activity can also be more informal. Fitness does not have to be a 'regime' and everyday activity such as walking or cycling to the shops or to work can be a great way to reach the minimum recommended physical activity levels. The key to achieving and maintaining the recommended physical activity levels is to build it into everyday life and when choosing leisure based activity to ensure it is enjoyable for the individual. In doing this the physical activity can become habitual and embedded in daily routines.

3.5 What is Sedentary Behaviour?

A sedentary individual is different from someone who is considered inactive. Inactive can be used to describe those who are active but not sufficiently to meet the physical activity guidelines. For instance an adult who completes the recommended 150 minutes per week of moderate physical activity can still be considered sedentary if they spend a large amount of time seated, for example, at their desk at work and a child who accumulates at least 60 minutes per day of moderate physical activity can still be considered sedentary if they spend a great deal of their time sitting or lying down, e.g., playing video games or sitting in a car or buggy.

3.6 So How Much is Enough?

Start Active Stay Active[65] details the Chief Medical Officers of the UK's guidelines for physical activity from cradle to grave which allow for greater flexibility for achieving the recommended levels of physical activity and also includes new guidelines on sedentary behaviour.

Physical activity guidelines for the under fives

- Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.
- Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 hours), spread throughout the day.
- All under-fives should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).

Physical activity guidelines for children and young people (Figure 7)

- All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.
- Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week.
- All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods.

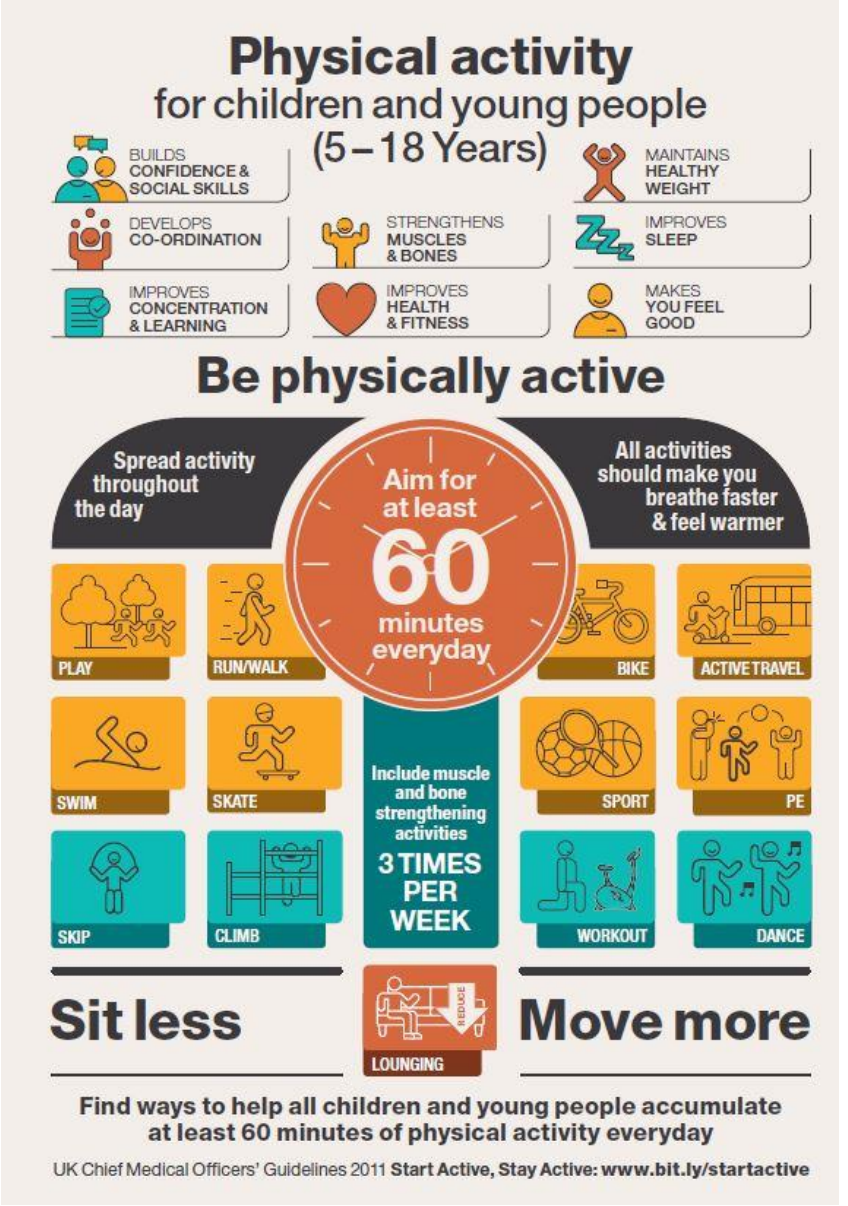


Figure 7 Children and Young People's Physical Activity Infographic (Department of Health, 2016)

Physical activity guidelines for adults (Figure 8)

- Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
- Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.
- Adults should also undertake physical activity to improve muscle strength on at least two days a week.
- All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Physical activity guidelines for older adults (Figure 8)

- Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.
- Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
- For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.
- Older adults should also undertake physical activity to improve muscle strength on at least two days a week.
- Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
- All older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Figure 8 Physical activity guidelines for adults and older adults (Department of Health, 2016)

3.7 Active Travel

Promoting active travel can impact significantly on public health in terms of increasing physical activity, reducing obesity, reducing pollution and road traffic accidents and reducing social isolation.

Building walking or cycling into daily routines is the most effective ways to increase physical activity and short car trips (under 5 miles) are a prime area for switching to active travel and public transport. Volume and speed of motorised traffic can reduce opportunities for positive contacts with other residents and can contribute to social isolation.[84] Disadvantaged areas tend to have a higher density of main roads, leading to poorer air quality, higher noise levels and higher collision rates.[85] The obesogenic environment impacts most on our most disadvantaged groups which discourages walking and cycling and further exacerbates health inequalities[86]

In 2014 2,082 children aged 0-15 were killed or seriously injured on Britain's roads[87] Children in the 10% most deprived wards are 4 times more likely to be hit by a car than those in the 10% least deprived .[88] Concern about road traffic injury is a major contributor to physical inactivity as parents can be reluctant to allow children out of the home without constant adult supervision. Improving access to safe and appropriate play spaces, including green space, is vital to enable more children to play outdoors.[89] Some areas have experimented with 'street play' time where streets have been closed for set periods on a regular basis to encourage children to play actively,

independently and safely near their own front door building resilience, confidence and self-esteem.[90]

A key challenge is to enable children to walk or cycle to and from school safely and actions to assist this can include developing a school travel plan, providing training and practical support to promote safe cycling, developing walking buses and other partnership work between schools, parents and carers, communities and the local authority. [91] There is growing evidence of the benefits of 20mph speed limits to reduce road danger, pollution and congestion [92] and repeated national surveys show strong public support for 20mph in residential streets[93] [94] and many towns and cities in England have implemented or are committed to 20mph speed limits across much of their road networks.[95]

Transport systems and the wider built environment play a crucial role in either promoting or hindering physical activity. People who cycle for travel purposes rather than for leisure are four times more likely to meet physical activity guidelines than those who do not.[96] It is not surprising therefore that those countries with the highest levels of active travel generally have the lowest obesity rates.[97]

The overall costs to society from road transport are substantial. It has been estimated that half of the UK's £10bn cost per annum of air pollution comes from road transport.[98] In terms of health care savings it has been estimated that £17bn over a 20 year period could be saved with the largest cost saving through the expected reduction in the number of cases of Type 2 diabetes[99] Investment in walking and cycling infrastructure or behaviour change programmes can be expected to deliver low cost, high-value dividends for individual health, the NHS, the transport system and the economy as a whole.[100]Any strategy must address the motivational and behavioural aspects to support people to become more physically active and one aspect is how we design, build and connect our neighbourhoods, towns and cities and the transport systems which support these.[80]

For older adults with low mobility and people with disabilities the built environment is key to maintaining independence and mobility [101] and consultations with these groups has highlighted the importance of adequate road crossings, pavements, toilets, and public seating when planning the urban design.[102] For those with dementia, having crossings with increased crossing times and audible and visual cues are necessary to help people with dementia cross the road safely.[103]

Access to green spaces influences physical activity across the life course with research suggesting that access to the natural environment increases physical activity and reduces obesity.[104][105] The use of green space declines with increasing distance from it. Research suggests that people living closest to formal parks are more likely to achieve recommended levels of physical activity and are less likely to be overweight or obese.[106] [107]Despite living in

rural communities people may find it as hard to be physically active as those who live in towns and cities due to being able to safely accessing services by walking and cycling with a lack of pavements or cycle ways and public transport can discourage use of the modes of transport even when moving between towns that may not be too far apart. It is a challenge for planners to consider how access can be improved and the needs of walkers and cyclists can be met in the design and planning of the rural road network.

3.8 Sport and Health

Public Health England and Sport England have been developing their relationship to bring together 'sport' and 'physical activity' and this has led to Sport England developing their new five year strategy Towards an Active Nation[108] which is focusing much more on tackling inactivity than it ever has done. In the past Sport England has funded projects that do not recognise activities such as walking, dance and utility cycling which can be extremely effective in reaching inactive people who might not consider themselves as 'sporty' however the next round of funding will address this.

The new strategy is calling for customer focused, behaviour change driven interventions which will tackle physical inactivity, particularly in children and young people and the under-represented groups, and will encourage strong and robust collaboration between partners who can deliver outcomes thus recognising the need to change ways of working in order to make a real difference.

The recent cross government strategy Sporting Future[109] details the change in measuring physical activity via the Active Lives survey rather than the traditional Active People survey to more accurately capture physical activity data again reflecting the move from sport to all physical activity in measuring national activity levels. Sport England will begin to work with organisations it has not traditionally worked with and bring together partnerships to deliver the objectives in the strategy and to build capacity across all sectors involved in increasing physical activity such as those involved in outdoor recreation.

While the Department of Culture Media and Sport (DCMS) who authored the strategy has a strong interest in getting people active in all settings, including outdoor recreation, they recognise that the Department for Environment, Food and Rural Affairs (Defra) has policy responsibility in England for the 'fabric' of the natural landscape, including rights of way, the England coastal path and National Parks. Given the joint interest in this area, DCMS and Defra will continue to work together to ensure the potential of our natural capital (including rights of way, canal and river paths, National Parks and Areas of Outstanding Natural Beauty, accessible forests and open spaces) to meet physical activity needs is met. Other departments also have a role in encouraging outdoor activity, for example the Department for Transport in delivering walking and cycling infrastructure or the Department for Communities and Local Government

in relation to urban green spaces and parks. These departments will also be linked in to this work.

3.9 Key Documents

Cumbria & Lancashire Sport & Physical Activity Strategy

Everybody Active Every Day

PH8 Physical Activity and the Environment

PH13 Physical Activity in the Workplace

PH17 Physical Activity for Children & Young People

PH41 Cycling & Walking

PH54 Exercise Referral Schemes

Sport England: Towards an Active Nation

Sporting Future: A New Strategy for an Active Nation

Lancashire Cycling & Walking Strategy

Working Together to Promote Active Travel: A briefing for local authorities

Healthy Weight

Obesity is a major public health problem due to its association with serious chronic diseases and the costs to both the individuals and society as a whole. The rapid increase in the number of obese people in the UK is a major challenge with analysis by the government's Foresight programme showing that over half of the UK adult population could be obese by 2050.[110] The economic implications are substantial with the NHS costs attributable to overweight and obesity projected to double to £10 billion per year by 2050 with the wider costs to society and business estimated to reach £49.9 billion per year.[111]

Obesity is a complex, but largely preventable condition which has serious, far reaching physical, psychological and social consequences that affects virtually all age and socioeconomic groups although some groups are affected more greatly than others. Obesity impairs a person's wellbeing, quality of life and ability to earn. Society has radically altered over the last five decades with major changes in work patterns, transport, food production and food sales. The pace of the technological revolution is outstripping human evolution[112] [113] [114] [115] [116] [117] [118] and for an increasing number of people weight gain is inevitable and largely involuntary and could be described as a consequence of a modern lifestyle.

4.1 How Do We Define Overweight and Obesity?

Overweight and obesity are defined as abnormal or excessive fat accumulation that may affect health. Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in metres (kg/m^2).

The WHO definition is:

- a BMI greater than or equal to 25 is overweight
- a BMI greater than or equal to 30 is obesity.

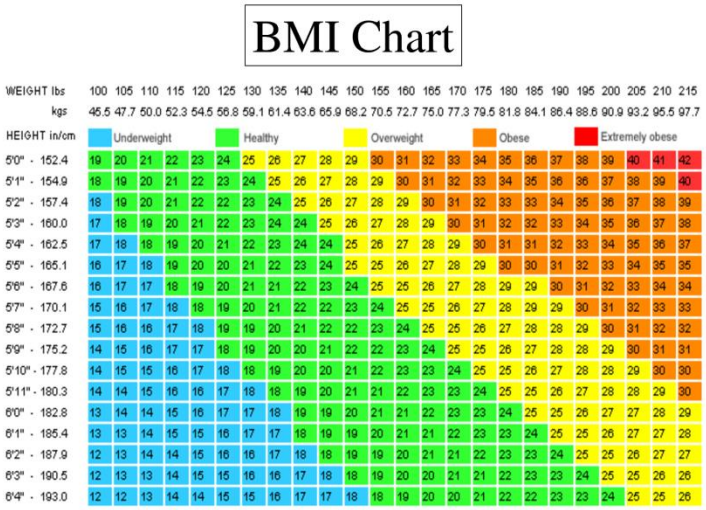


Figure 9 BMI Chart

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults. The clinical limitations of BMI should be considered. BMI is a surrogate measure of body fatness because it is a measure of excess weight rather than excess body fat. Factors such as age, sex, ethnicity, and muscle mass can influence the relationship between BMI and body fat.[119] Also, BMI does not distinguish between excess fat, muscle, or bone mass, nor does it provide any indication of the distribution of fat among individuals.

The following are some examples of how certain variables can influence the interpretation of BMI:

• On average, older adults tend to have more body fat than younger adults for an equivalent BMI.

• On average, women have greater amounts of total body fat than men with an equivalent BMI.

• Muscular individuals, or highly-trained athletes, may have a high BMI because of increased muscle mass.

Because no single body fat measure clearly distinguishes health from disease or risk of disease, BMI should serve as the initial screening of overweight and obesity for adults. It should be recognised that other factors, such as fat distribution, genetics, and fitness level, contribute to an individual's assessment of disease risk. However, BMI is a reasonable indicator of body fat for both adults and children. Because BMI does not measure body fat

directly, it should not be used as a diagnostic tool. Instead, BMI should be used as a measure to track weight status in populations and as a screening tool to identify potential weight problems in individuals.

BMI for Children and Young People

The concerns associated with using BMI for adults also apply to children and adolescents. Other factors, including height and level of sexual maturation, influence the relationship between BMI and body fat among children as well. For children and teens age 2-19, BMI is age and sex-specific and is often referred to as BMI-for-age - example for boys shown in Figure 10. A child's weight status is determined using an age and sex-specific percentile for BMI rather than the BMI categories used for adults. This is because children's body composition varies as they age and varies between boys and girls. Therefore, BMI levels among children and teens need to be expressed relative to other children of the same age and sex as in NCMP data.

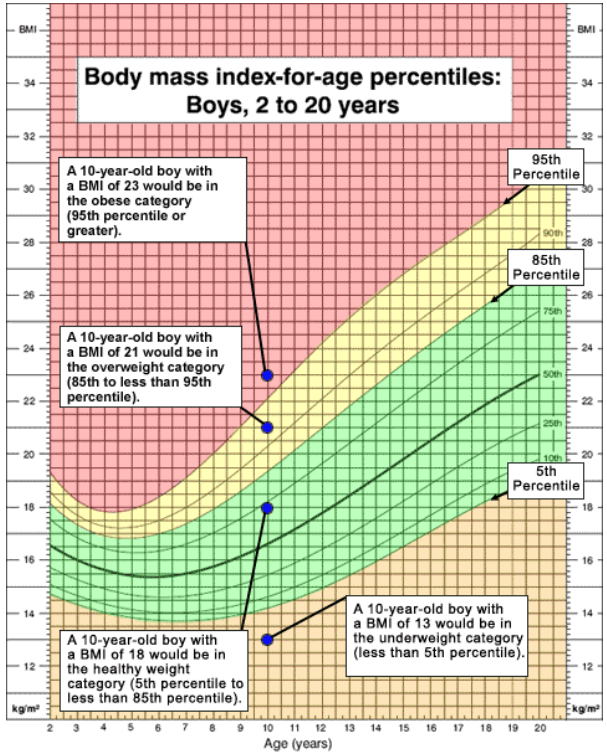


Figure 10 BMI-for-age Boys (Centre for Disease Control)

Weight Status Category	Percentile Range
Underweight	Less than the 5th percentile
Normal or Healthy Weight	5th percentile to less than the 85th percentile
Overweight	85th to less than the 95th percentile
Obese	95th percentile or greater

Figure 11 Obesity as a complex issue. (Source: Adult obesity:applying All Our Health, Public Health England, 2015)

4.2 What causes obesity?

Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the accumulation of excess body fat.

The 2007 government-commissioned Foresight Report [7] describes obesity as a complex system where there are many causes and no single cause dominates (Figure 11).

The technological revolution during the 20th century has left an obesogenic environment which is exposing the biological vulnerability of humans.

However this alone cannot explain the rapid increase in the prevalence of obesity in the population over the last three decades. Changes in the external environment have revealed the underlying tendency to gain weight and obesity is linked to social developments and shifts in values such as changes in work/home lifestyle patterns, motorised transport, changes in food production and marketing.

Much unhealthy behaviour that is common today are the 'easy' option for instance many children who are driven to school could in fact could walk or cycle however parental fears about potentially dangerous roads, long travel distances and the need for convenience prevent this from happening, therefore removing an opportunity to be physically active. This so called 'passive obesity' makes healthy behaviours an inherent challenge. Attitudes and responses are key drivers of obesity trends where an ambivalent attitude towards obesity brings a psychological conflict between what people want to eat (high calorie high sugar high fat foods) and their desire to be healthy and/or slim combined with mixed feelings about broader lifestyles choices complicates individual choices. Many people do not perceive obesity as an issue that affects them personally and consequently public demand for action on obesity is relatively weak.[120]

Obesity takes time to develop and the risks of obesity start at an early stage with growth patterns in the first few weeks and months of life can affect the risk of obesity and chronic disease later in life.[117] [121] Obesity in a parent increases the risk of childhood obesity by 10%.[122] Although this is the result of many biological, social and environmental factors, it is important to break this reinforcing pattern.[123] However most children are not obese and currently most cases of obesity become apparent in adulthood.

4.3 National Picture of Overweight and Obesity

4.3.1 Adults

Data from the 2014 Health Survey for England reveals that obesity prevalence has increased from 15% in 1993 to 26% in 2014 (Figure 12). The rate of increase has slowed down since 2001, although the trend is still upwards. Morbid obesity (BMI >40) has more than tripled since 1993 2% men and 4% women. The prevalence of overweight has remained broadly stable during this period at 36-39%. The rapid increase in the prevalence of overweight and obesity has meant that the proportion of adults in England with a healthy BMI (18.5 - 24.9) decreased between 1993 and 2014 from 41.0% to 32.7% among men, and 49.5% to 40.4% among women.

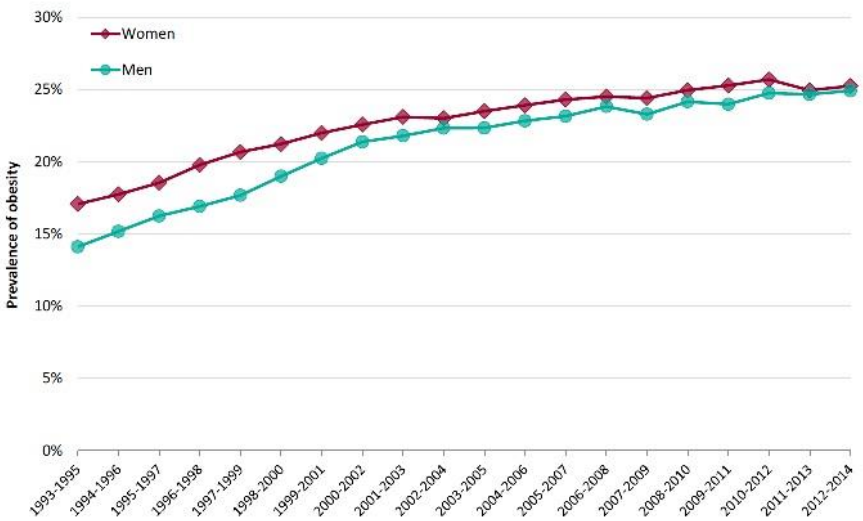


Figure 12 Prevalence of obesity among adults aged 16+ years 3-year average (Health Survey for England 1993-2014)

4.3.2 Prevalence by Gender

Overall rates of overweight and obesity are 58% in women and 65% in men. A similar proportion of men and women are obese (24% of men and 27% of women) but men more are likely than women to be overweight (41% men and 31% women). The mean BMI for both sexes is 27.2 kg/m^2 which sees the average BMI in the UK is now in the overweight range.

The prevalence of obesity increases with age in both groups peaking in the 55-64 year old age group in men and the 64-75 age group in women with over three quarters of women over 45 being overweight or obese. The prevalence then decreases in the oldest age groups for both genders. More women than men have higher waist circumference (66% of women and 54% of men) however this is more marked in very high waist circumference (45% of women and 32% of men).

By 2050 obesity is predicted to affect 60% of adult men and 50% of adult women.[110]

4.3.3 Children

Data from the most recent National Child Measurement Programme[124] for England has shown that the prevalence of obesity and overweight in Reception children is gradually falling from the 2006/07 data. However in Year 6 children the prevalence is increasing in both overweight and obese categories (obese 19.1% from 17.5% and either overweight or obese 33.2% from 31.6%). When comparing Reception with Year 6 measurements, the percentage of obese children in Year 6 (19.1%) was over double that of reception year children (9.1%).

The prevalence of obesity has increased since 1995 but remains similar between boys and girls, when 11% of boys and 12% of girls aged 2-15 were obese and in the following 10 years prevalence is at 19% of boys and 16% of girls. By 2050 obesity in children is predicted to affect 25% of children.[125]

4.4 Obesity and Health

The effects of obesity on the body include both obvious physical changes, due to the increased mass of fatty tissue, and changes at the cellular and metabolic level due to increased production of various products by enlarged fat cells.

The physical changes caused by increased fat are behind the musculoskeletal problems suffered by overweight and obese people (increased wear and tear on joints), sleep apnoea (partly due to fatty deposits around the airway) and the psychological and social difficulties caused by altered body image and stigma.

Most other effects of overweight and obesity are due to 'invisible' changes such as an increase of fat in blood and an altered response to insulin. There are also indirect effects through lifestyle factors associated with obesity, such as poor diet and sedentary lifestyle, which have an independent impact on health.

There is now a considerable body of evidence linking obesity with a wide range of health issues as described below:

Circulatory System

- Raised BMI increases the risk of hypertension (high blood pressure), which is itself a risk factor for coronary heart disease and stroke and can contribute to other conditions such as kidney failure.
- The risk of coronary heart disease (including heart attacks and heart failure) and stroke are both substantially increased.

Musculoskeletal System

- Raised body weight puts strain on the body's joints, especially the knees, increasing the risk of osteoarthritis (degeneration of cartilage and underlying bone within a joint).
- There is also an increased risk of low back pain.

Metabolic and endocrine system

- The risk of Type 2 diabetes is substantially raised.
- There is a greater risk of dyslipidemia (for example, high total cholesterol or high levels of triglycerides), which also contributes to the risk of circulatory disease by speeding up atherosclerosis (fatty changes to the linings of the arteries).
- Metabolic syndrome is a combination of disorders including high blood glucose, high blood pressure and high cholesterol and triglyceride levels. It is more common in obese individuals and is associated with significant risks of coronary heart disease and Type 2 diabetes.

Cancers

- The risk of several cancers is higher in obese people, including endometrial, breast and colon cancers.

Reproductive system

- Obese women are at greater risk of menstrual abnormalities, polycystic ovarian syndrome and infertility.
- Obese men are at higher risk of erectile dysfunction.
- Maternal obesity is associated with health risks for both the mother and the child during and after pregnancy

Respiratory System

- Overweight and obese people are at increased risk of sleep apnoea (interruptions to breathing while asleep) and other respiratory problems such as asthma.

Non-alcoholic fatty liver disease

- The term 'non-alcoholic fatty liver disease' (NAFLD) refers to a range of conditions resulting from the accumulation of fat in cells inside the liver. It is one of the commonest forms of liver disease in the UK. If left untreated, it may progress to severe forms such as non-alcoholic steatohepatitis (NASH), fibrosis and cirrhosis. It has also been linked to liver cancer.
- Obesity is an important risk factor for the condition: over 66% of overweight people and over 90% of obese individuals are at risk of NAFLD. As levels of obesity have risen, so has the prevalence of NAFLD.[126]

Healthy Lives, Healthy People: A call to action on obesity in England[125] reported that the health risks for adults with obesity are stark. For example, compared with a non-obese man, an obese man is:

- five times more likely to develop type 2 diabetes
- three times more likely to develop cancer of the colon
- more than two and a half times more likely to develop high blood pressure – a major risk factor for stroke and heart disease.

An obese woman, compared with a non-obese woman, is:

- almost thirteen times more likely to develop type 2 diabetes
- more than four times more likely to develop high blood pressure
- more than three times more likely to have a heart attack.

Risks of other diseases, including angina, gall bladder disease, liver disease, ovarian cancer, osteoarthritis and stroke, are also increased (Figure 13).

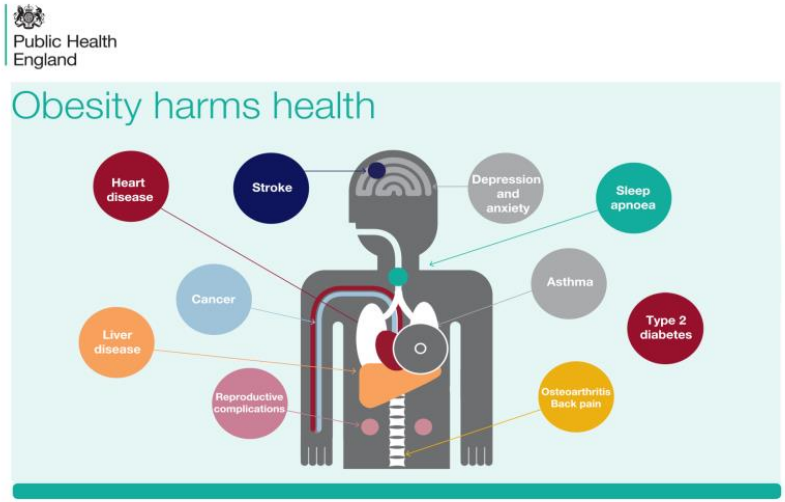


Figure 13 How obesity harms health (Public Health England, 2015)

4.4.1 Hypertension

Recent data has shown that obese adults have about twice the prevalence of hypertension when compared with adults who were normal weight (42% of obese men and 37% obese women compared to 22% men and 18% women of normal weight).[127]

4.4.2 Diabetes

Obesity is described by Public Health England as the main modifiable risk factor for type 2 diabetes in a new report which explores the links between the two.[128] Obese adults are five times more likely to be diagnosed with diabetes than those of a healthy weight, and 90% of those with type 2 diabetes are overweight or obese. Type 2 diabetes is anything up to five times more common than average in some BME groups, and strikes at a younger age. For people of black, Asian and other minority ethnic heritage, being overweight (as measured by their body mass index, or BMI) carries an even higher risk of type 2 diabetes than it does for white Europeans. After applying alternative BMI thresholds for BME groups the differential risk of diabetes in these groups show Asian men and women are at greater risk of diabetes despite Asian men having the lowest mean BMI (77% of Asian men compared to 68% of all men and 98% Asian women compared to 59% of all women).[128]

4.4.3 Potential health risks of obesity in children and young people

Recent research is showing some potentially frightening statistics in terms of the potential health risks posed to obese children and young people. Type 2 diabetes usually appears in adults, but recently more children in the UK are being diagnosed with the condition, some as young as seven.[129] A surveillance programme of children under 17 in the UK found that 95% of those diagnosed with type 2 diabetes were overweight and 83% obese. Type 2 diabetes was found to be increasing with children from minority ethnic groups at higher risk than white children.[130] Recent analysis of the National Longitudinal Study of Adolescent Health found that diabetes risk was particularly high in adults who were obese as adolescents compared to those with adult-onset obesity[131] making early intervention crucial in averting a potential health time bomb.

Overweight and obese children are at a 40-50% increased risk of asthma compared to normal weight children.[132] It is also suggested that a higher BMI contributes to asthma development and may also lead to more severe asthma[133] with the possibility of a causal link between obesity and asthma in children, with rapid growth in BMI during the first 2 years of life increasing the risk of asthma up to age 6 years.[134] A recent review on childhood obesity and obstructive sleep apnoea reported that prevalence of among obese children and adolescents could be as high as 60%.[135]

US studies have shown that obese children are at increased risk of cardiovascular disease with one study showing 70% of obese 5-17 year olds were found to have at least one risk factor for cardiovascular disease for example high cholesterol levels, high blood pressure and abnormal glucose tolerance[136] and further study also found that childhood obesity is associated with a quadrupled risk of adult hypertension (26% of obese children had hypertension as adults compared to 6% of normal weight children).[137]

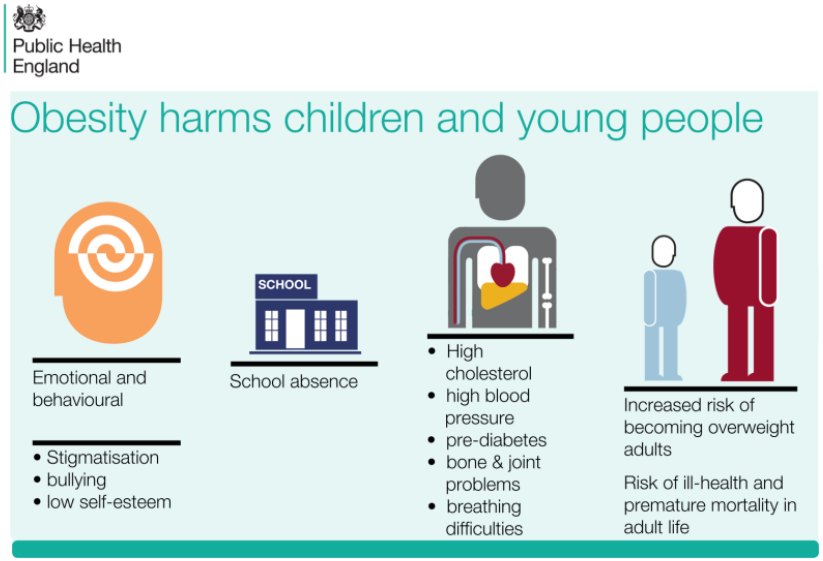


Figure 14 How obesity harms children and young people (Public Health England, 2015)

4.4.4 Underweight & Health

The prevalence of adults underweight has remained stable over the last few years at around 2% of the population[138] which is approximately the same prevalence as the rate of morbidly obese adults in the UK. According to NCMP data, the prevalence of underweight children in Reception is currently 1% and Year 6 at 1.4% however underweight prevalence was significantly higher than the national average in both years in the 'Asian or Asian British' group (3.6% in both years). Recent PHOF indicators have shown that 2.9% of all babies born in the UK are a low birth weight.[139] Babies of South Asian heritage are 2.5 times more likely to be of low birth weight[140] and there is a large body of evidence to suggest that low birth weight and chronic disease are closely linked and therefore there may be a suggestion that addressing low birth weight will help to reduce chronic disease in later life however when looking more closely at the biological make up of Pakistani-origin born infants it can be seen that they are relatively more adipose than white British infants[141] with BME babies being markedly lighter but have similar skinfold thickness and greater total fat mass than White British infants. Efforts to reduce ethnic inequalities in birth weight need to consider that increasing birth weight will also increase fat mass and may inadvertently worsen health outcomes in the long term.

Whilst there is an issue with the prevalence of underweight people in the UK and that being underweight carries its own risks the prevalence of overweight and obesity is far greater and carries a greater public health concern which requires addressing through policy change and the delivery of population approach initiatives.

4.5 Cost of Obesity

The impact of overweight and obesity on individuals and families in terms of ill-health places a significant burden on NHS resources. The direct cost to the NHS in 2006/07 of people being overweight and obese was £5.1 billion, and is expected to reach £9.7 billion by 2050.[111] The impact on wider society and the economy is also a concern. Obesity impacts on employment opportunities and life chances in general but employers bear the major cost. There are an estimated 16 million days of certified incapacity per annum

directly related to obesity. Alongside the growing burden on the public sector there is an impact on Local Authorities including the cost to social services for caring for housebound people suffering from illness as a consequence of obesity. The estimated annual social care costs to local authorities are an estimated £352 million. In relation to the wider economy the indirect costs could be as much as £27 billion (Figure 15).[111]

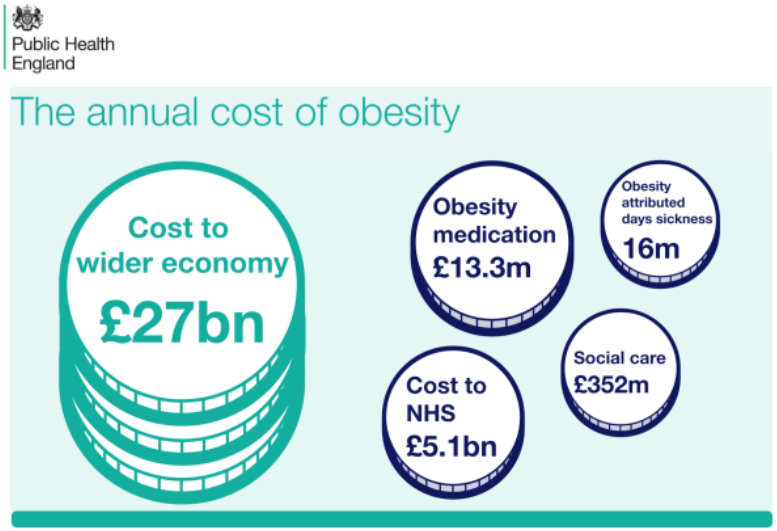


Figure 15 Adult Obesity: applying All Our Health (Public Health England, 2015)

4.6 Maternal Healthy Weight

Maternal obesity increases health risks for both the mother and child during and after pregnancy. Statistics on the prevalence of maternal obesity are not collected routinely in the UK, but trend data from the Health Survey for England show that the prevalence of obesity among women of childbearing age increased during the period 1997-2010. Women who are obese are significantly more likely to be older in pregnancy, to have a higher number of pregnancies, and live in areas of high deprivation, compared with women who are not obese.

The Centre for Maternal and Child Enquiries (CMACE), conducted a national audit of obesity during pregnancy between 1 March and 30 April 2009, of all maternity units in the UK, Channel Islands and Isle of Man. The results showed that out of a total of 128,290 women reported to have given birth (≥24 weeks' gestation), 6413 were identified as having a BMI ≥35 at any time during pregnancy. The UK prevalence rate was 4.99%.[142] It is important to emphasise that the BMI threshold of ≥35 is higher than the standard threshold for obesity which is ≥30kg/m2 due to the physiological changes experienced during pregnancy. The median maximum reported pregnancy BMI for women within the cohort was 39.1.

Obesity increases the health risks to the mother during the antenatal, intrapartum, and postnatal periods. The CEMACH report (2003-2005) summarises the risks related to obesity during pregnancy for the mother as:[143]

- maternal death or severe morbidity
- cardiac disease
- spontaneous first trimester and recurrent miscarriage
- pre-eclampsia
- gestational diabetes

- thromboembolism
- post-caesarean wound infection
- infection from other causes
- postpartum hemorrhage
- low breastfeeding rates

Maternal obesity can lead to the need for additional healthcare due to complications associated with the pregnancy with increased numbers of caesarean sections, increased length of hospital stay and increased admissions for complications during pregnancy:[144] [145]

The CEMACH report for the period 2003-2005 identifies the risks of maternal obesity to the child as:

- stillbirth
- neonatal death
- congenital anomalies
- prematurity

In 2005, 22.9% of mothers who had late fetal loss were obese, as were 30.4% of the women who experienced stillbirths, and 30.6% of those who experienced neonatal deaths. [146]

It is well recognised that children who are obese are likely to have obese parents.[147] [148] Life course research suggests that adult health and inequalities can be influenced whilst in the womb.[149] There is a significant relationship between maternal obesity, babies of heavier weight, and the subsequent development of childhood and adult obesity in their offspring.[150] [151] [152] [153] [154]A systematic review of the childhood predictors of adult obesity showed that maternal obesity and weight gain during pregnancy are related to higher BMI in childhood and subsequent obesity in adulthood.[147]

It is clear that there is a lot of work already being done by many individuals and organisations to tackle the issue. However to impact on the population's current and future health we need to act at a greater scale, using evidence based and properly targeted interventions. A multi-agency approach will be necessary to ensure that the delivery of local strategies through their plans and actions to contribute to improving the health and wellbeing, and add value to those identified actions.

4.7 Healthy Weight and Inequalities

4.7.1 Adults

Obesity prevalence in England is known to be associated with many indicators of socioeconomic status, with higher levels of obesity found among more deprived groups. Socio-economic indicators are a greater factor for women with increased obesity seen in the most deprived areas at 33% compared to 22% in the least deprived areas which is a trend that is not seen in men.[155]

Amongst men white groups had the highest average BMI at 27.4 and Asian groups the lowest at 26. Similarly Asian women have the lowest average BMI (26.2). As discussed previously BMI does not account for differences in ethnicity [156] and much discussion continues around the accuracy of the use of

BMI in the South Asian population when linking it to obesity related conditions.

4.7.2 Children

Obesity prevalence in children is also strongly correlated with deprivation and is highest in the most deprived areas. There is a steady rise in obesity prevalence with increasing deprivation for both Reception and Year 6 children. Whilst there is some emerging evidence that national child obesity levels have plateaued, rates in the more deprived areas continue to rise. The obesity prevalence among Reception year children living in the most deprived areas was 12.0% compared with 5.7% among those living in the least deprived areas. Similarly, obesity prevalence among Year 6 children living in the most deprived areas was 25% compared with 11.5% among those living in the least deprived areas. [124]

Obesity prevalence was significantly higher than the national average for children in both school years in the Asian and Asian British and 'mixed' ethnic groups. There are known associations between ethnicity and area deprivation. Deprived urban areas in England tend to also have a higher proportion of individuals from non-White ethnic groups, so it is likely that there are confounding factors which affect obesity prevalence by ethnic group.

4.8 Physical Activity & Obesity

The Health Survey for England 2008-9 report[81] had a special focus on physical activity and it revealed that both men and women who were overweight or obese were less likely to meet the recommendations compared with men and women who were not. 46% of men who were not overweight or obese met the recommendations, compared with 41% of overweight men and 32% of obese men. A similar pattern emerged for women, with 36% of women who were not overweight or obese meeting recommendations, compared with 31% of overweight and 19% of obese women. Given these findings, it is not surprising that obese men and women had the highest rates of low activity (36% and 46% respectively).

When considering time spent being sedentary (measured by an accelerometer) by BMI category, those who were not overweight or obese spent fewer minutes on average in sedentary time (591 minutes for men, 577 minutes for women) than those who were obese (612 minutes for men, 585 minutes for women).

New research is beginning to show that there is a new risk group for overweight development. [157] This group is young adult female 'computer gamers'. In the prospective study, leisure time computer gaming was a prospective risk factor for overweight in women even after adjusting for demographic and lifestyle factors, but not in men. Working to reduce gaming time and screen time in general will be a key factor in reducing obesity levels in children and young adults.

4.9 Obesity and the Environment

It is now widely recognised that the built environment is one of the many complex factors that influence whether or not people are obese or overweight and the choices we make on a day to day basis that are influenced by the environment, the behaviour of those around us and the current culture relating to food and physical activity which favours over consumption and inactivity make it increasingly difficult to be a healthy weight.

These factors can be exacerbated in deprived areas. Children living in the most deprived areas are twice as likely to be obese as children living in the least deprived areas.[158] People who live in deprived areas are more likely to live near fast food outlets [159] and ten times less likely to live in the greenest areas.[160] So, place is important and the connection between people living in a deprived area with little access to green spaces and poor health and wellbeing is evident and it is crucial that public health and planning work together to ensure good quality housing with access to lots of green space and tighter controls over the number and location of fast food outlets.

With a whole systems approach to tackling obesity, joining up policy actions for tackling obesity from the health and planning perspectives is a priority in tackling obesity. Local strategies should include specific priorities to guide planners about how to achieve healthy weight environments when reviewing plans to maximise opportunities to be physically active. It is recommended that councils should encourage their public health and planning team to agree a process that supports public health teams to comment on relevant planning applications at a useful point in the development management process.

Public Health England and the Town and Country Planning Association's planning healthy weight environments [161] identified six elements to achieve healthy weight environments through the planning process. These elements provide a useful framework to consider the impact of new developments with a local planning and health checklist could be created as part of guidance given to developers

- Movement and access – walking & cycling environment, local transport services
- Open spaces, recreation and play – open spaces, natural environment, leisure and recreational spaces, play spaces
- Food environment – food retail, food growing, access to
- Neighbourhood spaces – community and social infrastructure, public spaces
- Building design – homes, other buildings
- Local economy – town centres and high streets, job opportunities and access

It is envisaged that with the recognition of the impact of the environment on obesity, the development of local strategies and close working between

public health and planning can make a real difference to the health and wellbeing of the population.

The UK has become a nation where being overweight has become usual, rather than unusual. The rate of increase in overweight and obesity in both children and adults is striking. Obesity threatens the health and wellbeing of individuals and will place an intolerable burden on the economy as a whole. Once a person has gained weight, it is hard to lose it therefore we must start early to help people avoid becoming overweight and obese in the first place, as well as providing support to enable and empower people to help themselves.

Whilst it is recognised that all our behaviours are interconnected and overweight and obesity are the outcomes of our food intake and activity levels the environment we live in along with our social-economic status and ethnicity plays a major role in our likelihood of becoming overweight or obese. The development of this strategy should consider both a population based approach with special consideration for those most at risk.

4.10 Key Documents

Building the Foundations: Tackling obesity through planning and development

CG43 Obesity Prevention

NG13 Workplace Health

NG7 Maintaining a Healthy Weight and preventing excess weight gain amongst adults and children

PH42 Obesity Working with local communities

PH47 Weight Management: Lifestyles services for overweight and obese children and young people

PH11 Maternal and child nutrition

PH27 Weight management before during and after pregnancy

PH53 Type 2 Diabetes Prevention: population and community level interventions

PH25 CVD Prevention

PH46 BMI: preventing ill health and premature deaths in black Asian and other minority ethnic groups

PH49 Behaviour Change; Individual approaches Public Health England; Obesity and the environment briefing; regulating the growth of fast food outlets

TCPA Planning healthy weight environments

What is the local picture in Blackburn with Darwen?

5.1 Population

Data from the 2016 summary review of Blackburn with Darwen's Integrated Strategic Needs Assessment [162]tells us that the population estimate is around 147,000 with a much younger age profile than average with 28.7% of its population aged under 20, which is the fifth highest proportion in England. The North (32.8%) and East localities (33.4%) have a higher than the borough average of children and young people. There is a projected slow, steady rise in population driven by the growth of the over 65 age group. The Darwen and Rural locality currently has the highest proportion of over 65's (15.4%).

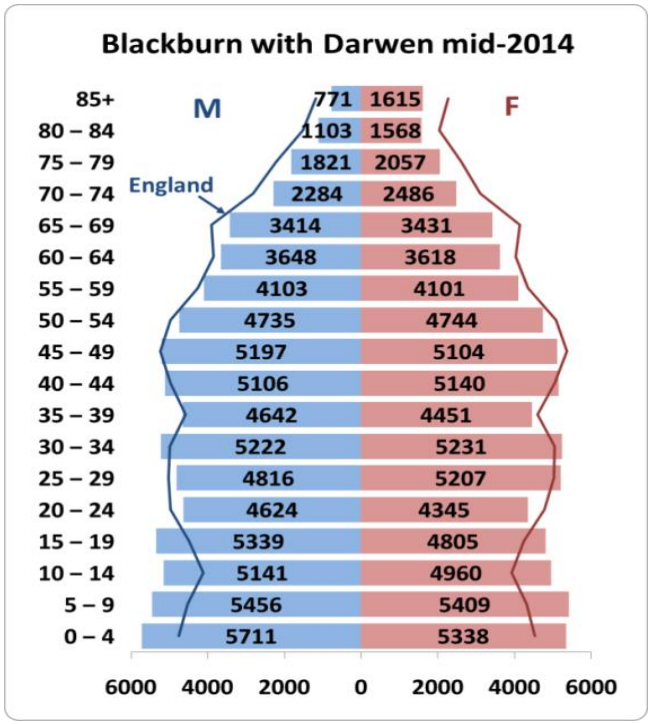


Figure 17 ONS mid-2014 population estimate for Blackburn with Darwen (with England profile for comparison)

5.2 Ethnicity

Blackburn with Darwen's black and ethnic minority community make up just over 30% of the population and the main ethnic groups have markedly different age profiles from each other as can be seen in Figure 17. The proportion of residents who are Indian or Pakistani are the 11th highest and the 6th highest respectively of any local authority in England. There is a stark difference in ethnicity between localities with more than two out of three residents (67%) in the North locality have South Asian ethnicity whereas 95.5% of residents in Darwen and Rural locality are white British.

The most recent Child Health Profile for Blackburn with Darwen reveals that 52% of school children are from a minority ethnic group which compares to a national average of 28.9%.[163]

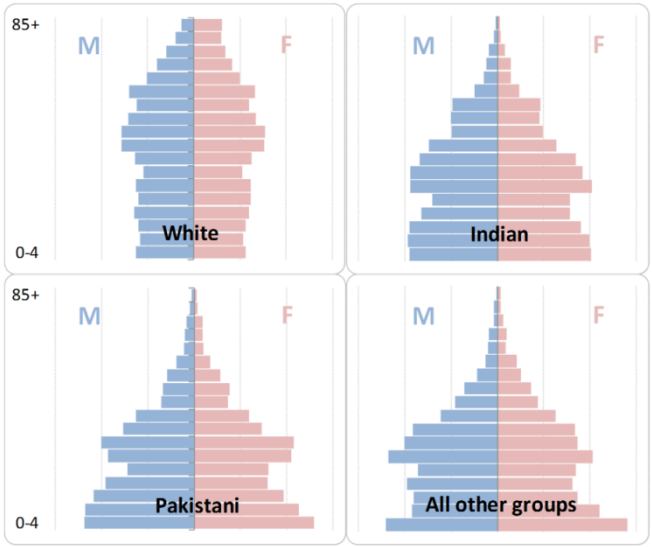


Figure 16 Ethnicity Blackburn w Darwen vs North West & England 2011

5.3 Deprivation

Blackburn with Darwen is the 15th most deprived borough in England. Nearly half (45 out of 91, or 49%) of the Borough's Lower Super Output Areas (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. On the local Children in Low Income Families Local Measure, 9105 children in Blackburn with Darwen, or 22.5% of the total, were 'in poverty' in 2013. In some areas this figure is higher – 40% of children in parts of Sudell and a third of children in parts of Shadsworth and Highercroft are 'in poverty'.

5.4 Life Expectancy

Life expectancy in Blackburn with Darwen has risen over the years, but the England average has risen faster. There is also striking inequality in life expectancy *within* Blackburn with Darwen. In 2012-14, the difference in male life expectancy between the most and least deprived deciles was 13.5 years and in women it was 8.8 years and this gap appears to be growing.

The public health system is concerned not just with extending life, but with improving health and wellbeing across the life course. Healthy Life Expectancy in Blackburn with Darwen is 58.0 years for males and 60.3 years for females, both of which are significantly lower than the England average (63.4 and 64.0 respectively).

5.5 Obesity

In 2012-14, an estimated 75,000 (66.5%) adults in Blackburn with Darwen adults were overweight or obese. [164] This is not significantly different from the England average of 64.6%, but that itself is of course far from ideal. Within Blackburn with Darwen obesity levels are highest in the East and Darwen and Rural localities but are still not significantly higher than the national average.

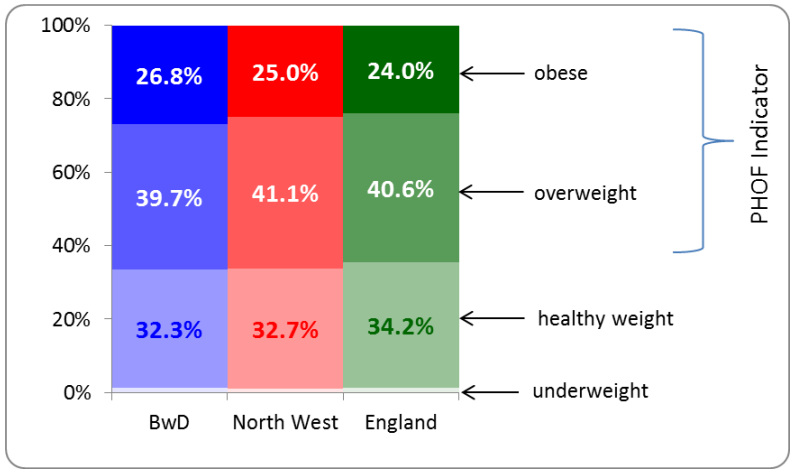


Figure 18 Adult excess weight 2012-14 (Blackburn with Darwen, NW and England)

The most recent NCMP data (2015-16) has shown that, as with adults, children in Blackburn with Darwen have average obesity levels. 9.4% of children aged 4-5 and 22.1% of children aged 10-11 are classified as obese. Levels of obesity and overweight have remained static over the past years in 10-11 year olds however there appears to have been an overall reduction in

the 4-5 year olds in the past 5 years. When broken down further into locality areas obesity rates in reception age children in the East locality are higher than the borough average. Obesity levels reach 15% in Highercroft, Earcroft and Ewood wards. The North locality has higher rates of obesity by year 6 which is a picture replicated in Darwen and Rural locality with obesity prevalence reaching 25% in parts of Sudell.

The 2014-15 NCMP data revealed that the proportion of children who are underweight in Blackburn with Darwen, though small, is significantly higher than average. The Reception rate of 1.8% is the 15th highest out of all upper-tier local authorities in England, and the Year 6 rate of 2.9% is the third highest.

Local Public Health Outcome Framework data shows that Blackburn with Darwen has a low birth rate of 4.3% of all babies born which is significantly higher than the national average (2.9%).[164]

5.6 Health Picture in Blackburn with Darwen

5.6.2 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 27.2% of all deaths in England & Wales in 2014[165] and 28.6% in Blackburn with Darwen. In 2012-14, the Borough had the second highest all-age mortality rate for CVD out of 152 upper-tier authorities in England.[166]

Attention tends to focus on the portion of CVD mortality which is considered 'premature' – i.e. below age 75. Blackburn with Darwen's rate in this age-group is consistently higher than average (Figure 19), and was the 6th highest out of 152 upper-tier authorities in 2012-14.

Blackburn with Darwen has the 7th highest premature death rate from 'preventable' types of CVD, and the 5th highest from CHD in particular. The borough also has the ninth highest premature death rate from Stroke, which is not so readily preventable in this age group.

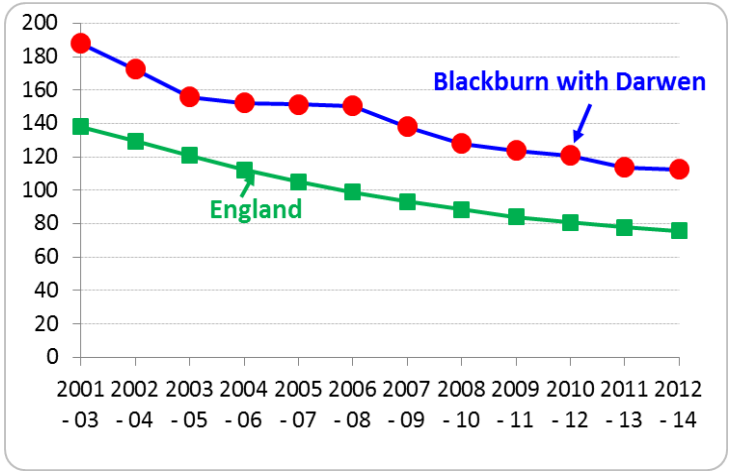


Figure 19 - CVD mortality under age 75 (directly standardised rate per 100,000 persons)

5.6.3 Diabetes

In the case of type 2 diabetes, prevalence varies greatly with age (Figure 20), and is much higher in Blackburn with Darwen (hatched+solid) than in England generally (hatched portion only).

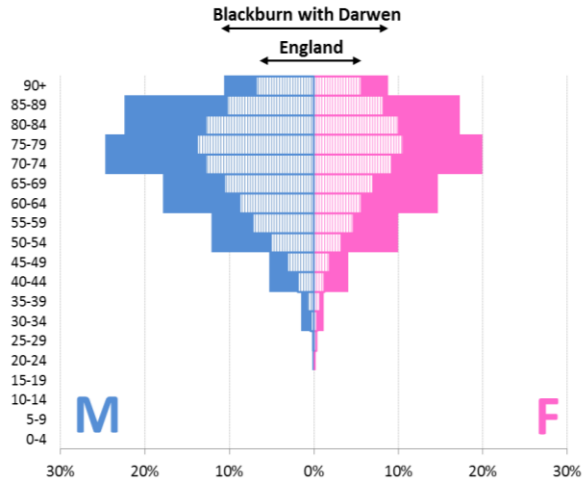


Figure 20 - Prevalence of type 2 diabetes by 5-year age-group (England) / 10-year age-group BwD

5.6.4 Hypertension

The recent hypertension profile suggests that Blackburn with Darwen is 220 out of 326 authorities for hypertension lifestyle risk factors - physical inactivity, obesity and excess alcohol drinking.[167] The total spend on prescriptions for hypertension in Blackburn with Darwen in 2104-15 was £472,000 and whilst some of this spend is for the treatment of heart failure and kidney failure a large percentage could be saved by increasing physical activity levels and reducing obesity levels in the borough.

5.6.5 Falls

The Public Health Outcomes Framework records the annual age-standardised rate of falls-related emergency hospital admissions among residents aged 65+. Blackburn with Darwen had 515 such admissions in 2014/15, and its rate is consistently higher than the national average.[139]

Almost half of falls-related emergency admissions in Blackburn with Darwen residents aged 50+ (46%) of the 3948 admissions during this five-year period were in the oldest (80+) age category).[168] As age increases, female patients account for an ever higher proportion of falls admissions. Hospital admission statistics only give a part of the whole picture as many more people will have been seen by their GP after a fall or had a fall that has gone unreported as they have not sought medical assistance.

5.6.6 Dementia

At the last count (August 2014), 813 patients with a Blackburn with Darwen GP had been diagnosed with dementia.[169] Recorded prevalence, however, only tells part of the story. A further unknown number are likely to be living with dementia without ever having received a diagnosis. According to the new estimates, Blackburn with Darwen probably had approximately 1420 residents with dementia in 2013 (either diagnosed or undiagnosed). If dementia prevalence rates remain unchanged for each age-group these numbers *might* rise to about 2440 residents by the year 2035.

5.6.7 Breastfeeding

Breastfeeding initiation rates in Blackburn with Darwen have risen steadily over the last few years from 72.8% in 2010-11 to 74.4% (most recent figures from East Lancashire Hospital 27th July 2016) in 2015-16 and current initiation rates are only slightly lower than the national average (74.3%). Similarly breastfeeding prevalence has increased over the years but still falls short of other nations.

5.6.8 Dental Health

Following a consultation exercise PHE has decided to change definition of the Public Health Outcomes Framework indicator[139] (PHOF 4.02) from "*tooth decay in children aged 5*" measured in terms of dmft (decayed, missing and filled teeth) to "*proportion of five year old children free from dental decay*", stating that the new prevalence measure is easier to interpret for non-dental experts. This may be true, but it requires us to get used to the idea that a higher proportion is desirable (previously the proportion was usually quoted the other way round).

Nationally, the results show a continued increase in the proportion of children with no obvious dental decay from 69.1% in 2008 and 72.1% in 2012 to 75.2% in 2015, equating to a change of six percentage points and an improvement of 8.8% since 2008. Unfortunately, Blackburn with Darwen has not experienced a similar trend but has in fact shown the opposite. The proportion of children with no obvious decay was 48.9% in 2008, and rose to 58.9% in 2012 but then dropped to 43.9% in 2015. Blackburn with Darwen was ranked the worst local authority with the lowest proportion of children aged 5 with no obvious dental decay in 2015.[170] The average child in the borough had 2.4 decayed, missing or filled teeth, which was the second highest in England

Public Health England's first ever dental survey of 3-year old children found that 20.6% in Blackburn with Darwen had decayed, missing or filled teeth, compared with an England average of 11.7%.[171] The average child in the borough had 0.79 decayed, missing or filled teeth (England average 0.36). On both measures, Blackburn with Darwen ranks 10th highest out of all upper-tier authorities.

9.1% of 3-year olds surveyed in the borough had 'Early Childhood Caries', an aggressive form of decay affecting the upper incisors, associated with the long-term use of bottles with sugar-sweetened drinks. This is the 12th highest rate, and compares with an England average of only 3.9%.

5.7 Local Food Facts

Data on fruit and vegetable consumption from 2014 shows the Blackburn with Darwen value of 47.1% to be significantly worse than the national average of 53.5% for reaching the target of '5 a day The mean number of pieces of fruit eaten daily in Blackburn with Darwen is 2.4 and the mean number of vegetables slightly lower at a value of 2.[172]

5.8 Physical Activity

Turning the Tide UK Active's 2014 report identifies Blackburn with Darwen as one of the most inactive local authorities in England (Figure 21) with 36.95% of adults classified as physically inactive. The report also estimates that this level of inactivity per 100,000 people costs the borough £24,225,029.

Most inactive 15 local authorities

Highest Levels of Inactivity	Percentage of Inactive Adults (%)
Stoke-on-Trent	35.07
Newham	35.11
Barking and Dagenham	35.14
Luton	35.88
Kingston upon Hull	36.07
Oldham	36.28
Coventry	36.81
Blackburn with Darwen	36.95
Sunderland	36.99
Slough	37.58
Dudley	37.67
Bradford	37.68
Salford	39.07
Sandwell	39.13
Manchester	40.24

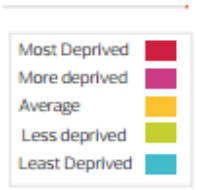


Figure 21 Most inactive 15 local authorities (UK Active, 2014)

When UK Active produced 'Steps to Solving Inactivity' later in 2014[173], Blackburn with Darwen had moved out of the top 15 of most inactive local authorities into 16th place with new inactivity levels of 35.73% showing a reduction in physical inactivity of just over 1%. That means that 52,500 people in Blackburn with Darwen are not doing enough physical activity to benefit their health.

More recent data from the Public Health Outcomes Framework [174] shows that the level of inactivity has remained relatively stable at 35.6%. The new dataset gives more detailed local information around physical activity habits as shown in Figure22. The table also shows the comparison at regional and national level.

Whilst most adults are around the national average for 30-149 minutes of physical activity per week there are a significantly higher than average number of inactive adults participating in less than 30 minutes of physical activity per week and significantly lower than average achieving the recommended minimum levels of physical activity. 15 year olds in Blackburn with Darwen are significantly less sedentary than the national average, however only 12.4% are active to the minimum recommended levels

Sport England's Local Sport Profile Tool shows participation in sport once a week.[175] In 2014-15 48,000 people in Blackburn with Darwen were participating once a week (32.7% locally, national participation 35.8%). Whilst there has been a steady increase in participation in sport and physical activity over the years it does not mean that we can be complacent as there is still a great deal of work to be done to encourage more people in the borough to become physically active at recommended levels. Whilst this is not significantly worse than the national average some work is required to embed physical activity as a routine and natural way of life moving into adulthood.

Compared with benchmark | Better | Similar | Worse | Lower | Similar | Higher

Indicator	Period	England	North West region	Blackburn with Darwen
Percentage of adults doing 150+ minutes physical activity per week	2015	57.0	53.7	48.7
Percentage of adults achieving less than 30 minutes of physical activity per week	2015	28.7	32.0	35.6
Percentage of adults doing 30-149 minutes physical activity per week	2015	14.3	14.2	15.7
Percentage of 15 year olds physically active for at least one hour per day seven days a week	2014/15	13.9	13.2	12.4
Percentage of 15 year olds with a mean daily sedentary time in the last week over 7 hours per day	2014/15	70.1	71.2	63.2
Percentage of adults who do any walking, at least five times per week	2014/15	50.6	48.5	45.3
Percentage of adults who do any walking, at least once per week	2014/15	80.6	78.4	77.3
Percentage of adults who do any cycling, at least three times per week.	2014/15	4.4	3.4	1.1
Percentage of adults who do any cycling, at least once per month	2014/15	14.7	12.7	6.5
Utilisation of outdoor space for exercise/health reasons	Mar 2014 Feb 2015	17.9	15.8	15.3

Figure 22 BwD Physical activity dataset compared to North West & England Public Health Outcomes Framework (2016)

When looking at the new active travel indicators only 45.3% of adults do any walking 5 times a week and almost a quarter of adults do not walk at all. Cycling figures for the borough are very poor with only 1.1% cycling 3 times a week and 6.5% cycling at least once a month versus 4.4% and 14.7% nationally.

The cost of physical inactivity to the local economy amounts to £3,206,550 or £2,071,723 per 100,000 population (£1,817,285 nationally).[176] This expenditure is clearly unsustainable and the development of this strategy is essential in reducing the cost to the individuals, communities and the public purse.

6. Assets, Challenges & Insights

As already highlighted earlier, Blackburn with Darwen faces a number of challenges when addressing the health of the population and in changing behaviour of individuals and communities however the borough has a wide variety of assets of which it can be proud and all of which can assist in the delivery of this strategy.

6.1 Assets

6.1.1 Physical and Geographical

Blackburn with Darwen has a variety of parks and open spaces within its borders including 14 formal parks and gardens the largest park of which being Witton Country Park. Blackburn with Darwen is also well situated geographically in Lancashire to access many other parks and open spaces outside the borough for recreational purposes. The recent Pennine Reach project with improved transport links and the reopening of the Todmorden Curve has extended the transport links to open up more possibilities across Lancashire and into Yorkshire and covers both green and blue spaces including the coast along with urban and rural open spaces.

Witton Country Park encompasses a variety of opportunities for physical activity including Witton Park Arena, Cycle Hub, grass and all weather pitches, play areas, woodland and farmland. There are designated, well signposted routes for walking and cycling in the 480 acre site. However there are many other Green Flag parks and many other high quality parks and open spaces across the borough including the River Darwen Parkway, allotments and a number of formal and informal play areas for children and young people.

Witton Country Park has been identified as the natural starting point of the Weavers Wheel[177] which is a 26km circular route with a further 66km of route will be signed to create several 'spokes' and 'spurs' to connect the Wheel into Blackburn Town Centre as well as various neighbouring towns and employment sites. It is intended that the Weavers Wheel will be the start of a strategic cycle network for Blackburn with Darwen and East Lancashire and encourage more active travel along with recreational cycling.

6.1.2 Community & Volunteers

Both mottos of Blackburn – 'Arte Et Labore' - and Darwen – 'Absque Labore Nihil' - are indicative of the resilience and attitude of the people of Blackburn with Darwen in that by hard work, perseverance and skill great things can be achieved. Communities in both towns are built on these mottos and strong networks of community groups and volunteers exist that empower those around them to contribute positively and live a fulfilled life.

Locality teams are at the heart of the people and are able to pass on messages to their communities in a non-threatening, non-judgemental way. There is a strong network of third sector organisations which work with residents across the life course and well established access points for information – Your Support Your Choice[178] and the Wellbeing service[179]. Blackburn with Darwen Council supports the Your Call campaign to enable residents to make a difference in their community from a call to shop locally to taking action on road safety and by taking pride in the borough and working together to make it a safer, healthier and happier place to live, work and play.

There is an extensive network of volunteers who support a variety of activities including Couch 2 5ks, Park Run, Young Weavers, the re:fresh programme of activities, Age UK, local sports clubs and many more. This network of volunteers is becoming more and more important in the sustainability of population level physical activity and will be reflected and recognised within the borough's new Volunteer Strategy.

6.1.3 Sport & Leisure Sector

Blackburn is a proud footballing town with Blackburn Rovers having a long history being a founder member of the Football League. Blackburn Rovers fan base extends beyond the boundaries of Blackburn with Darwen and attracts fans and visitors form far and wide. The power of the football club brand can transcend the game and be used to engage a large number of people in the borough and beyond to improve their health. Other sporting brands with large fan bases include Blackburn Hawks Ice Hockey and Blackburn Harriers Athletics Club both of which have the ability to influence residents in the benefits of a healthy lifestyle.

Blackburn and Darwen have a number of sporting heroes, both current and past, for children and young people to aspire to. Engaging with these sporting heroes to endorse the strategy has the potential to encourage more residents to become more active and to eat well.

The local community sports forum is a well-established group who are working towards being constituted to enable them to attract funding to develop the volunteer network and support and develop the children, young people and adults who attend the clubs.

Blackburn with Darwen has an extensive network of cycling enthusiasts who develop cycling opportunities for local residents through Ride Social and Breeze Rides which is in partnership with British Cycling. These networks work to further encourage and assist Groups to grow organically including: Friendly cyclists, Bus Stop Bikers and the Young Weavers.

Blackburn with Darwen has a variety of leisure facilities including Blackburn Sports and Leisure Centre, Darwen Leisure Centre, Witton Park Arena – including athletics track, Shadsworth Leisure Centre, Audley Sports Centre, Daisyfield Swimming Pool, Blackburn Rovers Indoor Centre – with plans for expansion in the near future, secondary schools sports hall and gym facilities and multi-use games areas amongst many other facilities.

The re:fresh scheme was introduced in 2008 to tackle Blackburn with Darwen's poor health statistics and low levels of physical activity. The Council and the Care Trust Plus entered into a unique partnership to deliver a programme of free physical activity to people who lived, went to school, registered with a GP or worked in Blackburn with Darwen. The re:fresh scheme has contributed greatly to the increase in physical activity levels over the last eight years and even though a small fee has been introduced for some activities the scheme remains one of the most heavily subsidised leisure scheme in the area and has been able to encourage participation from all age and socioeconomic groups.

6.1.4 Healthy Settings – Homes, Education, Workplaces and Health & Social Care Settings

There is a large network of educational establishments at the heart of communities in the borough including 13 Children's Centres, 63 primary schools, 17 secondary schools, Blackburn College and University Centre and a number of other Higher Education centres all of which can play a role in the community to encourage intergenerational activity, to empower families and communities to make behaviour changes and to become a trusted hub of information and activity.

Social Housing providers Twin Valley Homes and Great Places manage around 9,000 homes in Blackburn with Darwen and have access to some of the most deprived and vulnerable residents. Working with key contacts within these organisations may enable those most at risk of poor health to receive information and support at a time when they are ready to make changes to their lifestyles. The workforce within these organisations is important in passing on simple messages about physical activity and access to good food as appropriate.

Blackburn with Darwen has a large programme of regeneration attracting new business and supporting existing businesses. The Hive, Blackburn with Darwen's Business Leader Network alongside the BwD WorkWell programme can reach a large number of employees to reinforce healthy lifestyle messages and provide support and signposting to activities within the borough.

Care settings – including the Royal Blackburn Hospital, Health centres, GP surgeries, care homes and domiciliary care providers, presents lots of opportunities for passing on healthy lifestyles messages and encouraging behaviour change. This social movement can affect both the large workforce and the people who visit and receive care in these settings with the potential for change on a wide scale.

6.1.5 Health & Social Care Opportunities

The Healthier Lancashire programme brings opportunities across the Pennine Lancashire footprint and beyond in recognising the importance of prevention and early intervention as opposed to a treatment based health and social care system. As already described in great detail good nutrition and physical activity are the cornerstones of living a healthy life along with the wider determinants of health and should be a priority in the new health and social care system.

Health care professionals play an important role in promoting behaviour change and are in a powerful influencing position as reflected in the recent public consultation. The recognition of this influence and the development of the competences in behaviour change amongst the workforce through Making Every Contact Count[180] programme have the potential to empower 'patients' and their families. Blackburn with Darwen has a very dedicated

and passionate healthcare workforce delivering high quality programmes of support and care and this is a network that can really make a difference across the population.

6.2 Challenges

6.2.2 Demographics

Blackburn with Darwen is a deprived borough with significant pockets of deprivation and high levels of child poverty. In these areas behaviour change can be a real challenge. An ageing population and a large under 20 population will present public health challenges in future years and this compounded with low levels of physical activity will place further pressure on the health and economic systems in the borough.

6.2.1 Health Statistics

Overweight and obesity rates across the population are high and of most concern as the doubling of obesity from reception to Year 6 age pupils and dental health rates are amongst the worst in the country. There is also a cohort of underweight young people who are also at risk of health problems. CVD rates across the borough and hip fracture rates in over 80's are higher than the national average and healthy life expectancy is particularly poor in men in the borough.

6.2.3 Geography

The topography in Blackburn with Darwen could be a barrier for many people looking to start walking and cycling with many areas of the borough having challenging inclines to tackle and may be an explanation as to the very poor cycling participation rates in the borough. The weather in the area is also inconsistent and again can be cited as a barrier for being more physically active.

6.2.4 Budgets

Blackburn with Darwen has been through a difficult time and it will continue to be difficult. Spending cuts mean that Council services have changed forever and level of service provided will no longer be at previous levels though needs are still there. Public Health grants from the Department of Health continue to be cut year on year which affects commissioning of health improvement programmes and challenges the public health team to find innovative ways to partnership work and enable low cost or no cost initiatives.

Whilst there are excellent examples of service provision across the borough there are still gaps some areas affecting consistency of access to services for parts of the borough. More could be done to ensure more effective communication and cross organisation working to increase awareness of services and avoid duplication. It is envisaged that this strategy will enable better communication, improved partnership working and avoid the duplication of services in times of budget pressures.

Budget reductions across the council have led to the introduction of a nominal fee for the re:fresh programme along with the potential introduction of car park fees at Witton Country Park. There are also a number of other

proposals for service reduction all of which may affect the implementation of parts of the proposed action plan.

6.3 Consultation and Insight

6.3.1 National Insight

The Eat Well Move More Shape Up strategy aims to support the national Sustain strategy (2015-2020)[32]. The aims and objectives of the local strategy echo those of the national strategy with practical guidance available in the '*Sustain Guide to Good Food'*[181] document which details ideas to reduce waste, ways to promote locally produced, seasonal and environmentally friendly produce, encourage the use of Fairtrade products, developing skills to 'grow your own' and ways to ensure we choose fish from sustainable sources.

There have been a number of nationally produced pieces of insight focussing on underrepresented groups which has been used to inform this strategy.

Sport England's '*This Girl Can'* campaign was developed from the insight provided by the '*Go Where Women Are'*[182] and provides detailed insight into barriers and motivators and how better to engage with women and girls.

Recent publications by Women in Sport[183] into keeping women motivated over the autumn and winter, which is traditional 'drop off' point also provides some valuable insight to support that of Sport England.

'*Changing the Game For Girls: In Action'*[184] and Women's Sport and Fitness Foundation '*Changing the game for girls'*[185] are specific insight reports for girls in addressing the low levels of physical activity in girls generally but also in addressing the traditional drop off points in the transition from primary to secondary school and low participation throughout secondary school. By providing education for staff around the issues of participation, helping schools maximise the student voice, drawing on the power of peer support and ensuring the right opportunities are available for the least active it may be possible to increase participation in sport and physical activity. Both the Sport England '*Go Where Women Are'* report and these two reports for girls provide valuable information as to how to motivate women and girls to be more active and this insight will be reflected in the action plan.

The 2012 '*Move It'* report[186] into young people's participation in sport paved the way for the changes in the way Sport England direct their resources. 'Towards and Active Nation will focus on getting those who are inactive to become physically active and encourage new and innovative partnerships to deliver programmes across the life course and recognises that increased participation is not driven by elite sport but by increasing participation in lifestyle activity.

Sport England's 2014 Youth Insight[187] details the need for a more diverse provision of sport to meet the needs of teenagers who do not wish to engage in competitive sport. There is a shift towards recreational and lifestyles participation and young people seek a meaningful experience from activity which allows them to engage with peers in a social environment. New or

unusual sports can break the norms of sport participation and can level the playing field for participation.

Early exposure to outdoor activities such as walking, rambling, cycling, orienteering, running, water sports etc. can make a lasting impression. More who are introduced to outdoor activities as children and adolescents grow up to choose and active outdoors lifestyles. Evidence suggests that participants in health referral exercise programmes based in outdoor green environments are more likely to continue with their programme than if it is based within a gym or leisure centre therefore this should be considered as a development for the Healthwise programme moving forward to support improved adherence and outcomes. However there are many perceived barriers to participation in outdoor activity including cost, time, confidence, distance to activities and lack of opportunities and for older people there was a concern over mobility levels, safety and inclement weather.[188] The characteristics of those who are most likely to be active outdoors live in more affluent areas, are employed, male and white British.[189] Breaking down some of the perceptions around accessibility of outdoor activities for the less represented groups may help to increase participation. Bringing cycling taster activities closer to the more deprived neighbourhoods may encourage people to become involved in outdoor activity. Better engagement with local clubs that offer outdoor activities may provide more opportunities and widen the demographics of participation and allow people to engage longer term.

18.4 million people in the UK have a long standing disability or illness and the North West region has the second highest proportion of people living with a disability in the UK. Four out of five disabled people are currently not active but research suggests that 70% want to increase the level of activity they currently take part in.[190] The English Federation of Disability Sport and Sport England completed insight work with disabled people and their families and carers into effective engagement and communication.[191] [192]Key findings from this work will be used to inform the action plan in more effective communication with disabled people and in ensuring the provision of activity opportunities is fit for purpose. An important aim will be to engage more disabled people in being a physical activity champion and inspiring others to become more active and to provide the support for more disabled people to become activity leaders. Further work into better inclusion of disabled people into existing provision rather than creating new, specific sessions which may be seen to be divisive rather than inclusive is needed to offer different options for people. Further local insight work with disabled people, their families and local organisations will be required to map out current provision and to develop activity opportunities as identified during the consultation work.

Promoting effective partnerships will be the key to increasing activity levels in Blackburn with Darwen. As public funding cuts force services to be trimmed back and in some cases stopped completely it is even more crucial that organisations do not work in silo or duplicate programmes of activity. UK Active's recent report on engaging with the health sector around physical

activity[193] provides some insightful case studies for best practice which can be woven into the action plan. UK Active's '*Blueprint for an Active Britain*'[194]provides a detailed plan for policy development to address physical inactivity across the life course. The action plan which accompanies Blackburn with Darwen's Eat Well Move More Shape Up strategy includes many of the recommendations within the '*blueprint*' to support an increase in participation in physical activity and will draw upon community and workforce development and mobilising the many previously discussed assets to get the residents of the Borough moving more often.

The national play strategy[195] which was released in 2008 had a long term vision for 2020 to provide more places to play, playing safely and embedding play in local priorities and whilst this is now an old document the insight work done with children and young people can be very informative for the Eat Well Move More Shape Up action plan in terms of barriers and enablers for safe outdoor play.

During the consultation the main barrier to outdoor play was a lack of places to go and things to do followed by concern for their own safety, the cost of play activities and a preference to stay at home. Other reasons included bad weather, their parents' and carers' reluctance to allow them out to play, difficulties in travelling to play areas and a lack of people to go with. The greatest barrier identified by 8–13 year olds was a lack of safe and clean play areas near to their homes. They wanted to have more interesting things to do such as better play equipment and activities, places to meet friends and school grounds to use outside school hours. Designating specific areas in which children can play in was considered to be the best way to prevent them being stopped from playing for no reason. Safety was a key factor affecting children's enjoyment of their playtime, with most wanting safer play areas and roads.

As traditional play areas are under review due to budget cuts, a more innovative approach to safe places to play will be required. Use of non-traditional spaces such as car parks, requesting schools consider the use of their spaces out of school hours where appropriate, particularly for supervised activities and encourage and support local residents and community groups to apply for funding which may become available to maintain play areas. Options for safe street play will also be explored through temporary street closure orders in consultation with residents in the area and the local children and families. A pilot street play programme of activities could be offered and evaluated before deciding on wider roll out across the Borough.

The recently released '*Childhood Obesity: A Plan for Action*' [196] is a 14 point plan designed to reduce levels of obesity in children. Of those within the scope of this strategy's action plan are

- Supporting early years settings with food and physical activity provision

- Supporting primary schools in ensuring the coordination and delivery of quality sport and physical activity
- Encouraging primary schools to develop a framework to achieve optional 'healthy' rating in the changes to the Ofsted report
- Making school food healthier

The plan also calls for the public sector to ensure healthy options are available in their buildings including hospitals, leisure centres etc. Intervention in vending and food procurement will be included in the Local Authority Declaration on Healthy Weight which is large part of the Shape Up action plan.

6.3.2 Local Insight and Consultation

Extensive consultation has taken place over the last 18 months with the initial phase of consultation forming the strategic aims and objectives of the strategy and the second phase of consultation developing the action plan with input from the public, stakeholders including the health sector and executive members.

Blackburn with Darwen's Public Health Department recognised that there was very limited insight and information about the people of the borough accessing food banks and the circumstances in which they did this. A plethora of anecdotal evidence was available but a lack of evidence based information to support this restricted the true picture of food insecurity within the Borough. In late 2014, the local authority's Culture, leisure, Sport and Young People's Department were commissioned to co-ordinate and oversee the Dragon's Apprentice, the full recommendations of which are detailed in appendix ii. In summary there appears to be a need for education around food poverty amongst communities and healthcare professionals to ensure equity of access to all and to help to reduce the stigma associated with seeking assistance with access to food. The formation of a strategic food poverty network will assist in mapping all existing provision which supports the food poverty agenda and inform future work to tackle food poverty in the Borough.

Consultation has taken place with primary school catering managers and there was a genuine concern about the amount of sugar children were having in their diets and the apparent lack of education of both children and parents. The multicultural nature of schools in the borough and the varying diets experienced at home bring some challenges with the some managers giving examples of children who come from a variety of backgrounds who will not eat the school meals as they did not recognise the foods. Further examples around food used as rewards and the lack of packed lunch guidance highlight the requirement of school food policies. Changes have already begun to happen in some schools as a result of the session with some schools already having 'pudding free' days and 'no added sugar' days. There was a genuine commitment to try to influence schools food plan wherever possible with the support of the schools catering manager with the support of public health.

Online public consultation highlighted the appetite for a variety of family activities in parks and open spaces and more opportunity to be active in a social group. There was good support for community food growing, couch to 5ks and the mile a day initiative in schools. There was a very strong feeling in both the public consultation and the health professionals consultation that sugar is a cause for concern in terms of obesity and dental health and should be a focus within the action plan.

Two ladies only groups were consulted at Bangor Street Community Centre and Audley and Queens Park Neighbourhood Learning Centre (Women 4 Women group – Inter Madrassah Organisation) and a number of suggestions around communicating messages and encouraging increased physical activity were made some of which are discussed below.

Both groups of ladies cited fun and social activities as something that would motivate them along with game based family activities. The ladies also enjoy being active in parks and open spaces but found that safety was an issue for them and would prefer to access them during the day. The ladies feel that opening school facilities for family use may encourage more families to be active as those schools are within easy reach of their homes and community 'pester power' works very well in their community. They also felt that schools could play a role in educating the parents as well as the children and could host family learning sessions where they felt many parents would attend. The suggestion of better use of the Asian television and radio channels as a good way to communicate health messages will be explored through the action plan. With a large percentage of the community watching the Ummah channel or listening to local radio networks this may be an effective way to pass on healthy lifestyle messages.

A recent consultation with young people in Blackburn with Darwen conducted on behalf of Healthwatch provides a snapshot of their perception of health services in the borough. [197] Almost a third recognised food and a healthy diet as an important factor in having good health and almost 15% recognised physical activity, including both sport and exercise, as being important. The young people consulted also recognised that community leisure facilities, parks and open spaces and sports and physical activity were the places or things that made it easiest for them to look after themselves and feel good. A quarter of those young people identified takeaways and fast food as being the things that make it most difficult to be healthy citing them as too tempting and too easily available.

70% of young people who took part in the insight stated that if they needed help they felt that they could get it from home, school, friends and family. Effective communication with young people varies widely between social media, video media such as You Tube, face to face and visual media. Only a small percentage cited print media such as leaflets as being the format they

preferred communication to be delivered but social media is still the most popular method of communicating messages.

A large number of older adults were consulted via the Older Person's Forum and Age UK and there was an overwhelming number that cited that transport was an issue in accessing services particularly with reducing bus services. More locality based sessions were seen to be important but also being able to access parks and open spaces for activities was thought to be important. Older people enjoy activities such as dancing and tai chi and would like to see more of these available in the community. Making activities fun and social with appropriate music will motivate people to attend and to keep coming back in the long term. There was a suggestion that a handbook which contains all the activities available for older people in the Borough would be very useful and would encourage more people to try new activities. The main theme running through discussions around food and nutrition were the issues of cooking for one and the loss of motivation for cooking and eating well, particularly after illness. Identifying those people within the community who love to cook and may be able to make an extra meal and support and encourage others those who have lost their interest in food to find their enjoyment in cooking again, helping to address social isolation. Training and support for domiciliary care workers was thought to be a way to support people to eat more healthily and be having nutritious meals.

Full details of all the consultations carried out can be found in appendix ii and all information gleaned from these will be woven into the action plan.

7. Action Plan

8. Appendix

Eat Well Move More Shape Up Strategy Steering Group Membership

Blackburn with Darwen Borough Council

- Public Health (Chair and minutes)
- Commissioning & Procurement Services
- Communications – Corporate Services
- Culture, Leisure Sport & Young People
- Early Years
- Environment
- Localities & Prevention
- Planning & Prosperity
- Public Protection
- Services to Schools
- Transport Team

Blackburn with Darwen Clinical Commissioning Group

Lancashire Care Foundation Trust

- Healthy Child Programme – Health Visitors & School Nurses

East Lancashire Hospitals Trust

- Nutrition Department
- Physiotherapy Department
- Specialist Infant Feeding Team

Voluntary, Community and Faith Sector

- Age UK Blackburn with Darwen
- Blackburn Rovers Community Football Trust
- Blackburn with Darwen School Games Organiser
- Blackburn Youth Zone
- Canal & River Trust
- Families Health & Wellbeing Consortium
- Inter Madrassah Organisation
- Lancashire Mind
- Lancashire Sport
- Newground
- Together Lancashire

Strategy Consultation

9. References

[1] World Health Organisation(2015). Using pricing policies to promote healthier diets. Accessed online 2nd May 2016.

[2] McGill et al. (2015). Are interventions to promote healthy eating equally effective for all? Systematic review of socioeconomic inequalities in impact. *BMC Public Health* 15, 457.

[3] Newton et al. (2015). Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* 386: 2257–74.

[4] Bates et al. (2014). National Diet and Nutrition Survey: Headline results from Years 1 to 4 (combined) of the rolling programme from 2008 and 2009 to 2011 and 2012. Accessed online 2nd May 2016 Online.

[5] NHS Digital (2013). Health Survey for England 2013. Health, social care and lifestyles. Summary of key findings. Accessed online 2nd May 2016.

[6] The Scientific Advisory Committee on Nutrition. (2015) Carbohydrates and Health. Online. Accessed online 2nd May 2016.

[7] Butland et al. (2007). Tackling obesities: future choices – project report (2nd Ed). London: Foresight Programme of the Government Office for Science. Accessed online 2nd May 2016.

[8] Department of Health. (1989) Dietary Sugars and Human Disease. Report on the panel on dietary sugars, 37. London: HMSO.

[9] NHS Digital. (2013) National Child Measurement Programme data source. 2012/13. Online. Available from: http://content.digital.nhs.uk/searchcatalogue?productid=13778&q=national+child+measurement+programme+2012&sort=Relevance&size=10&page=1#top

[10] Public Health England. (2012) National Dental Epidemiology Programme for England: oral health survey of five year old children 2012. A report in the prevalence and severity of dental decay. Accessed online 2nd May 2016

[11] Victora et al. (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *The Lancet Series*: Breastfeeding 1. Volume 387, No. 10017, p475–490, 30 January.

[12] Public Health England (2016). Public Health Outcomes Framework. Accessed online 27th October 2016. http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000042/pat/6/par/E12000002/ati/102/are/E06000008

[13] Unicef UK (2012). The evidence and rationale for the UNICEF UK Baby Friendly Initiative standards. Accessed online 27th October 2016.

[14] Acta Paediatrica (2015) Special Issue: Impact of Breastfeeding on Maternal and Child Health, December, 104, Issue Supplement S467, Pages 1–134.

[15] All Parliamentary Party Group (APPG) (2014) The 1001 Critical Days – Breastfeeding Supplement: The Importance of the Conception to Age Two Period. Available online from: http://www.infantmentalhealthweek.com/sites/default/files/The%201001%20Critical%20Days%20Breastfeeding%20supplement%20%20.pdf%20Wednesday%2025th%20February%202015.pdf

[16] Brown et al. (2016). Understanding the relationship between breastfeeding and postnatal depression: the role of pain and physical difficulties. *Journal of Advanced Nursing*, 72,2,273-282 DOI: 10.1111/jan.12832

[17] Food and Agriculture Organisation (2012). Sustainable diets and Biodiversity. Directions and solutions for policy, research and action. FAO. Rome.

[18] Sustain Website (http://www.sustainweb.org/sustainablefood/what_is_sustainable_food/ Accessed: August 2015

[19] United Nations (2008). An overview of urbanization, internal migration, population distribution and development in the world. Population Division. New York

[20] Vermeulen et al. (2012). Climate Change and Food Systems. *Annual Review of Environment and Resources*, 37, 195-222.

[21] DEFRA (2013). Food Statistics Pocketbook 2013. *Governmental Department for Environment, Food and Rural Affairs.*

[22] Taylor-Robinson et al. (2013). The rise of food poverty in the UK *BMJ,* 347:f7157.

[23] Downing and Kennedy (2014), *Food Banks and Food Poverty,* London: *House of Commons Library*

[24] Department of Health (2005). Choosing a better diet: a food and health action plan. London: *Department of Health*

[25] Perry et al. (2014). Emergency Use Only. Understanding and reducing the use of food banks in the UK. Oxfam.

[26] Feeding Britain (2014). A strategy for zero hunger in England, Wales, Scotland and Northern Ireland. The report of the All-Party Parliamentary Inquiry into Hunger in the United Kingdom. *The Children's Society.*

[27] Wales et al. (2014). Economic review. London: *Office for National Statistics*.

[28] Press. V. (2004). Nutrition and Food Poverty. A toolkit for those involved in developing or implementing a local nutrition and food poverty strategy. London. *The National Heart Forum.*

[29] Burns et al. (2010). Community level interventions to improve food security in developed countries. DOI: 10.1002/14651858.CD008913. *Cochrane Library*.

[30] Mwatsama et al. (2005) Food Poverty and Health. Briefing statement. *Faculty of Public Health.*

[31] Bonfield, P. (2014). A Plan for Public Procurement Enabling a healthy future for our people, farmers and food producers. *DEFRA*.
[32] Sustain (2015). Better food. Better farming. Better lives. Sustain Strategy 2015-2020. London. *Sustain*.
[33] Bull et al. (2004) Chapter 10 Physical inactivity. In: Ezzati M, Lopez, AD, Rodgers A, Murray CJL, editors. Comparative quantification of health risks: Global and regional burden of disease attributable to selected major risk factors. *Volume 1*. Switzerland: *WHO Press*; *p. 729-881*
[34] WHO (2010). Global recommendations on physical activity for health. *Geneva, Switzerland*: WHO Press.
[35] WHO (2002). The World Health Report 2002 – Reducing Risks, Promoting Healthy Life. *Geneva, Switzerland*: WHO Press
[36] Elwood et al. (2013*).* Healthy Lifestyles Reduce the Incidence of Chronic Diseases and Dementia: Evidence from the Caerphilly Cohort Study. *PLoS ONE.* 8: 12 e81877.
[37] Norton et al. (2014). Potential for primary prevention of Alzheimer's disease: an analysis of population-based data. *The Lancet Neurology.* 13: 8, 788–794.
[38]Maude P (2010). Physical literacy and the young child. In: Whitehead M, editor. Physical literacy throughout the lifecourse. p. 100-16. Oxon: *Routledge.*
[39] Ginsburg KR. (2007). The importance of play in promoting healthy child development and maintaining strong parent-child bonds. *Pediatrics* 119:182-91.
[40] Hillman et al. (2014), Effects of the FITKids Randomized Controlled Trial on Executive Control and Brain Function. *Pediatrics*. 134(4): e1063-71.
[41] Laureus Sport for Good Foundation (2011) Teenage Kicks: the value of sport in youth crime. *Laureus Sport for Good Foundation*. London.
[42] Marmot, M. (2005). Social determinants of health inequalities. *The Lancet*. 365:1099-1104.
[43] Morris JN. (1994). Exercise in the prevention of coronary heart disease: Today's best buy in public health. *Medicine & Science in Sports & Exercise*. 26(7):807-14.
[44] GBD 2015 Risk Factor Collaborators.(2016).Global, regional, and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. *Lancet*. 388:1659-1724.
[45] Public Health England (2016). Physical inactivity: economic costs to NHS clinical commissioning. *Public Health England.* London.
[46] Black C. (2008). Working for a healthier tomorrow - Dame Carol Black's review of the health of Britain's working age population. *Crown.* London, England.
[47] Department of Health (2010). 2009 Annual Report of the Chief Medical Officer. *Department of Health.* London.
[48] Jarrett et al (2012). Effect of increasing active travel in urban England and Wales on costs to the National Health Service. *The Lancet*. 379:9382.
[49] Townsend et al. (2015). British Heart Foundation Physical Activity Statistics. *British Heart Foundation*. London.
[50] Ng SW, Popkin B (2012). Time Use and Physical Activity: a shift away from movement across the globe. *Obesity Review*. 13:8:659-80.
[51] Fischbacher et al. (2004). How physically active are South Asians in the United Kingdom? A literature review. *Journal of Public Health*. 26:3:250–8.
[52] Williams et al. (2011). Assessment of physical activity levels in South Asians in the UK: findings from the Health Survey for England. *Journal of Epidemiology & Community Health.* 65:6, 517-521.
[53] Hayes et al. (2002). Patterns of physical activity and relationship with risk markers for cardiovascular disease and diabetes in Indian, Pakistani, Bangladeshi and European adults in a UK population. *Journal of Public Health Medicine.* 24:3,170–178.
[54] Townsend et al. (2012) Coronary Heart Disease Statistics 2012 edition. *British Heart Foundation*. London.
[55] Tremblay, M. (2012). Sedentary Behaviour Research Network. Standardized use of the terms "sedentary" and "sedentary behaviours". *Applied Physiology Nutrition and Metabolism*. 37:540–542.
[56] Tremblay et al. (2010). Physiological and health implications of a sedentary lifestyle. *Applied Physiology Nutrition and Metabolism*. 12:35,725-40.
[57] Proper et al. (2011). Sedentary behaviours and health outcomes among adults: a systematic review of prospective studies. *American Journal of Preventative Medicine.* 40:2:174-82.
[58] Grontved A, Hu FB. (2011). Television Viewing and Risk of Type 2 Diabetes, Cardiovascular Disease, and All-Cause Mortality: A Meta-analysis. *JAMA*. 15:305:23, 2448-2455.
[59] Chinapaw et al. (2011). Relationship between young peoples' sedentary behaviour and biomedical health indicators: a systematic review of prospective studies. *Obesity Review*. 12:7, e621-32.
[60] Thorp et al. (2011). Sedentary behaviours and subsequent health outcomes in adults a systematic review of longitudinal studies, 1996-2011. *American Journal of Preventative Medicine*. 41:2, 207-215.
[61] Boyle et al. (2011) Longterm sedentary work and the risk of subsite-specific colorectal cancer. American Journal of Epidemiology. 15:173,1183-1191.
[62] Marshall et al. (2004). Relationships between media use, body fatness and physical activity in children and youth: a meta-analysis. *International Journal of Obesity Related Metabolic Disorders*. 28:10,1238-1246.

[63] Pearson N, Biddle SJH. (2011). Sedentary behaviour and dietary intake in children, adolescents, and adults. A systematic review. *American Journal of Preventative Medicine.* 41:2, 178-188.
[64] Tremblay et al. (2011). Systematic review of sedentary behaviour and health indicators in school aged children and youth. *International Journal of Behavioural Nutrition and Physical Activity.* 8:98.
[65] Department of Health, Physical Activity, Health Improvement and Protection (2011). Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers. *Department of Health*. London.
[66] British Heart Foundation National Centre for Physical Activity and Health (2014). Current Levels of sedentary behaviour. Available online: http://www.bhfactive.org.uk/research-and-evaluation-resources-and-publications-item/335/index.html
[67] Matthews et al. (2008). Amount of Time Spent in Sedentary Behaviours in the United States, 2003-2004. *American Journal of Epidemiology.* 167:7,875-881.
[68] Heffernan et al. (2010) Self-Reported Sitting Time Is Associated With Higher Pressure From Wave Reflections Independent of Physical Activity Levels in Healthy Young Adults. *Journal of Applied Physiology.* 109:484-490.
[69] Wareham et al. (2005). Physical activity and obesity prevention: a review of the current evidence. *Proceedings of the Nutrition Society*. 64, 229-247.
[70] Mekary et al. (2009). Physical activity patterns and prevention of weight gain in premenopausal women. *International Journal of Obesity (London)*. 33,1039-47.
[71] Seo DC, Li K. (2010). Leisure-time physical activity dose-response effects on obesity among US adults: results from the 1999-2006 National Health and Nutrition Examination Survey. *Journal of Epidemiology and Community Health.* 64,426-31.
[72] Lewis et al. (1997). Seven-year trends in body weight and associations with lifestyle and behavioral characteristics in black and white young adults: the CARDIA study. *American Journal of Public Health*. 87,635-42.
[73] Hu FB. (2008). Physical Activity, Sedentary Behaviors, and Obesity. In: Hu FB, ed. Obesity Epidemiology. *New York: Oxford University Press*; 301-19.
[74] Carek et al. (2011). Exercise for the treatment of depression and anxiety. *International Journal of Psychiatry Medicine*. 41:1,15-28.
[75] U.S. Dept. of Health and Human Services. (2008) Physical Activity Guidelines for Americans. Available online https://health.gov/PAGUIDELINES/pdf/paguide.pdf
[76] Lusk et al. (2010). Bicycle riding, walking, and weight gain in premenopausal women. *Archives of Internal Medicine*. 170, 1050-1056.
[77] Slentz et al. (2005). Inactivity, exercise, and visceral fat. STRRIDE: a randomized, controlled study of exercise intensity and amount. *Journal of Applied Physiology.* 99,1613-8.
[78] Institute of European Food Studies (1999). A Pan EU Survey on consumer attitudes to physical activity, body weight and health. *European Commission*. Luxembourg.
[79] Cavill, N and Rutter, H. (2013). Healthy People Healthy Places Briefing: Obesity and the environment: increasing physical activity and active travel. *Public Health England*. London.
[80] Sport England (2015). Active Design Planning for health and wellbeing through sport and physical activity. *Sport England*. London
[81] The NHS Information Centre for health and social care. (2008) Health Survey for England Physical Activity and Fitness. *The NHS Information Centre for health and social care.* London
[82] Benedicte et al. (2006). Attitude toward physical activity in normal-weight, overweight and obese adolescents. *Journal of Adolescent Health.* 38: 5, 560–568.
[83] Bouchard and Shephard (1994). Physical activity, fitness, and health: The model and key concepts. In: Bouchard C, Shephard RJ, Stephens T, editors. Physical activity, fitness and health: International proceedings and consensus statement. Champaign, Ill: *Human Kinetics*;77-88
[84] Appleyard B (2011). Street Conflict, Power and Promise: *Liveable Streets*: Humanising the Auto-Mobility Paradigm. Hart and Parkhurst (2011) Impacts of Motor Vehicles on the Quality of Life of Residents of Three Streets in Bristol UK. *World Transport Policy and Practice*. 17 available online: http://www.eco-logica.co.uk/pdf/wtpp17.2.pdf
[85] Faculty of Public Health (undated) Transport and Health. Briefing Statement accessed 10th June 2016 from http://www.fph.org.uk/uploads/briefing%20statement%20transport%20V2.pdf
[86] Sustainable Development Commission (2011). Fairness in a car-dependent society London: SDC.
[87] Department for Transport (2015). Reported Road Casualties in Great Britain: Main Results 2014. *Department for Transport.* London.
[88] Grayling, T. (2002). Streets ahead: safe and liveable streets for children. *Institute for Public Policy Research.*
[89] Public Health England (2014) Everybody Active Every Day. What works – the evidence. *PHE.* London
[90] Play England website accessed 10th June 2016: http://www.playengland.net/what-we-do/street-play/

[91] Public Health England & Royal Society for the Prevention of Accidents (2016). Road injury prevention – resources to support schools to promote safe active travel. *PHE.* London

[92] Cairns et al. (2014). Go Slow: an umbrella review of the effects of 20mph zones and limits on health and health inequalities. *Journal of Public Health.* 37:3, 515-520.

[93] Department of Transport British Social Attitudes Survey various years.

[94] Tapp and Nancarrow (2013) 20mph: A survey of GB attitudes and behaviours. *University of the West of England.*

[95] 20splenty website Accessed 10th June 2016: http://www.20splenty.org/20mph_places

[96] Stewart et al. (2015). Quantifying the contribution of utility cycling to population levels of physical activity: an analysis of the Active People survey. *Journal of Public Health* p1-9 doi:10.1093/pubmed/fdv182

[97] Bassett et al. (2008). Walking, cycling and obesity rates in Europe, North America and Australia. *Journal of Physical Activity and Health* pp1-9 doi:10.1093/pubmed/fdv182

[98] European Environmental Agency (2014). Health and environmental costs. Copenhagen. EEA.

[99] Cabinet Office (2009). The wider costs of transport in English urban areas in 2009. Accessed online 1st November 2016 http://webarchive.nationalarchives.gov.uk/+/http:/www.cabinetoffice.gov.uk/media/307739/wider-costs-transport.pdf

[100] Davis A. (2014). Claiming the Health Dividend: A summary and discussion of value for money estimates from studies of investment in walking and cycling. *Department for Transport.* London

[101] Rosso et al. (2011). The Urban Built Environment and Mobility in Older Adults: A comprehensive review. *Journal of Aging Research*, Article ID 816106.

[102] Cairncross L. (2016). Active ageing and the built environment. *Housing Learning and Improvement Network*. London

[103] World Health Organisation (2014). Dementia and age-friendly environments in Europe (AFEE). *WHO*: Copenhagen.

[104] Institute of Health Equity/Public Health England (2014) Improving Access to Green Spaces – Health Equity Briefing 8. *Institute of Health Equity.* London.

[105] Natural England (2009). Technical Information Note TIN055: An estimate of the economic and health value and cost effectiveness of the expanded WHI scheme 2009. *Natural England.*

[106] Coombes et al. (2010). The relationship of physical activity and overweight to objectively measure green space accessibility and use. *Social Science & Medicine*, 70(6) 816-822.

[107] Gong et al. (2014). Neighbourhood green space, physical function and participation in physical activities among elderly men: the Caerphilly Prospective study. *International Journal of Behavioural Nutrition and Physical Activity*, 11:40 doi:1186/1479-5868-11-40.

[108] Sport England (2016). Sport England: Towards an Active Nation Strategy 2016-2021. *Sport England*. London.

[109] HM Government (2015). Sporting Future: A New Strategy for an Active Nation. *Cabinet Office*. London.

[110] McPherson et al. (2007). *Modelling Future Trends in Obesity and the Impact on Health*. Foresight Tackling Obesities: Future Choices (http://www.foresight.gov.uk).

[111] Morgan E. and Dent M. (2010). The economic burden of obesity. *National Obesity Observatory*. Oxford.

[112] Farooqi et al. (2007). *Genetic Factors in Human Obesity*. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):37–40.

[113] Trayhurn, P. (2007). *Adipocyte Biology*. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):41–44.

[114] Speakman et al. (2007). *Animal Models of Obesity*. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):55–61.

[115] Bloom, S. (2007). *Hormonal Regulation of Appetite*. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):63–65.

[116] Rolls, E.T. (2007). *Understanding the Mechanisms of Food Intake and Obesity*. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):67–72.

[117] Barker, D.J.P. (2007). *Obesity and Early Life*. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):45–49.

[118] Jebb et al. (2007). *Executive Summary Foresight Tackling Obesities: Future Choices Project.* Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):vi–ix.

[119] Gallagher et al. (1996). How useful is body mass index for comparison of body fatness across age, sex, and ethnic groups? *American Journal of Epidemiology, 143*(3), 228-239.

[120] Maio et al. (2007) . *Social Psychological Factors in Tackling Obesity*. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):123–125.

[121] Singhal et al. (2007). *Breast-Feeding, Early Growth and Later Obesity*. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):51–54.
[122] Reilly et al. (1999). Prevalence of Overweight and Obesity in British Children: Cohort Study. *British Medical Journal*, 319(7216):1039.
[123] Canoy et al. (2007). *Challenges in Obesity Epidemiology*. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews*, 8(s1):1–11.
[124] Lifestyles Statistics Team National (2015). Child Measurement Programme: England, 2013/15 school year. *Health and Social Care Information Centre*.
[125] Department of Health (2011). Healthy Lives, Healthy People: A call to action on obesity in England. *DOH*. London.
[126] Argo et al. (2009). Epidemiology and natural history of non-alcoholic steatohepatitis. Clinics in Liver Disease. 9; 13: 511-531.
[127] Scantlebury et al. (2014). Adult obesity and overweight. HSE. Vol 1 Chapter 9. *Health and Social Care Information Centre*. London.
[128] Public Health England (2014). Adult obesity and Type 2 Diabetes. *PHE.* London.
[129] Diabetes UK. (2012). Diabetes in the UK 2012. Key statistics on diabetes. *Diabetes UK.*
[130] Haines et al. (2007). Rising incidence of type 2 diabetes in children in the U.K. *Diabetes Care*. 30,5,1097-101.
[131] The et al. (2013). Timing and duration of obesity in relation to diabetes: findings from an ethnically diverse, nationally representative sample. *Diabetes Care*. 36,4,865-72.
[132] Egan et al. (2013). Childhood body mass index and subsequent physician-diagnosed asthma: a systematic review and meta-analysis of prospective cohort studies. *BMC Pediatrics* 3;13(1):121.
[133] Black et al. (2013). Increased Asthma Risk and Asthma-Related Health Care Complications Associated with Childhood Obesity. *American Journal of Epidemiology* 6, 6.
[134] Rzehak et al. (2013). Body mass index trajectory classes and incident asthma in childhood: results from 8 European Birth Cohorts--a Global Allergy and Asthma European Network initiative. *Journal of Allergy and Clinical Immunology*. 131,6,1528-36
[135] Narang et al. (2012). Childhood Obesity and Obstructive Sleep Apnea. *Journal of Nutrition and Metabolism* 2012:8.
[136] Freedman et al. (2007). Cardiovascular risk factors and excess adiposity among overweight children and adolescents: the Bogalusa Heart Study. *Journal of Pediatrics*. 150,1,12-17.e2.
[137] Watson et al. (2013). Adult Hypertension Risk is More than Quadrupled in Obese Children. High Blood Pressure Research 2013 Scientific Sessions: *American Heart Association*. Dallas
[138] Health Survey for England (2011). National Obesity Observatory data briefing Adult Weight. *NOO*.
[139] Public Health England (2014). Public Health Outcomes Framework. Accessed 1st November 2016 http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015
[140] Kelly et al. (2009). Why does birthweight vary among ethnic groups in the UK? Findings from the Millennium Cohort Study. *Journal of Public Health.* 31, 1, 131-137.
[141]West et al. (2013). UK-born Pakistani-origin infants are relatively more adipose than White British infants: findings from 8704 mother-offspring pairs in the Born-in-Bradford prospective birth cohort. *Journal of epidemiology and community health*. 67,7.
[142] Centre for Maternal and Child Enquiries (2010). Maternal obesity in the UK: Findings from a national project. London: *CMACE*.
[143] Lewis, G. (2007). Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2003-2005. The seventh report on confidential enquiries into maternal deaths in the United Kingdom. London: *Confidential Enquiry into Maternal and Child Health*.
[144] Heslehurst, N. et al. (2007). Obesity in pregnancy: a study of the impact of maternal obesity on NHS maternity services. *International Journal of Obstetrics & Gynaecology*. 114, 334-342.
[145] Heslehurst, N. et al. (2008). The impact of maternal BMI status on pregnancy outcomes with immediate short-term obstetric resource implications: a meta-analysis. *Obesity Reviews*. 9, 6, 635-683.
[146] Winkvist et al. (2015). Maternal Prepregnant Body Mass Index and Gestational Weight Gain Are Associated with Initiation and Duration of Breastfeeding among Norwegian Mothers. *Journal of Nutrition*. 145, 6, 1263-70.
[147] Parsons, T.J. et al. (1999). Childhood predictors of adult obesity: a systematic review. *International Journal of Obesity.* 23, 12, S1-S107.
[148] Patrick et al. (2005). A review of family and social determinants of children's eating patterns and diet quality. *Journal of the American College of Nutrition.* 24, 2,.83-92.
[149] Barker, D.J. (1998). Mothers, babies and health in later life. Edinburgh: *Churchill Livingstone.*
[150] Curhan et al. (1996). Birth weight and adult hypertension, diabetes mellitus, and obesity in U.S. men. *Circulation*. 94, 3246-3250.

[151] Curhan, et al. (1996). Birth weight and adult hypertension and obesity in women. *Circulation*. 94, 1310-1315.
[152] Larsen et al. (1990). Influence of maternal overweight among a low income-population. *American Journal Obstetrics Gynecology.* 162, 2, 490-494.
[153] Whitaker et al. (1998) Early adiposity rebound and the risk of adult obesity. *Pediatrics*. 101, 3, E5.
[154] Power et al. (2003). Combination of low birth weight and high adult body mass index: at what age is it established and what are its determinants? *Journal of Epidemiology & Community Health*. 57, 12, 969.
[155] National Obesity Observatory. (2010). NOO data briefing Adult obesity and socioeconomic status. *NOO.*
[156] Deurenberg, et al. (1998). Body mass index and percent body fat: a meta-analysis among different ethnic groups. *International Journal of Obesity, 22*, 1164-1171.
[157] Thomée ret al. (2015). Leisure time computer use and overweight development in young adults – a prospective study. *BMC Public Health.* 15, 839.
[158] Public Health England (2014). From evidence into action: opportunities to protect and improve the nation's health. *PHE*. London.
[159] Glasgow Centre for Population Health (2013).The built environment and health: an evidence review. *Glasgow Centre for Population Health.* Glasgow.
[160] Allen et al. (2014). Natural solutions for tackling health inequalities. *UCL Institute of Health Equity*. Accessed on 31st May 2016 from https://www.instituteofhealthequity.org/projects/natural-solutions-to-tackling-health-inequalities
[161] Ross and Chang. (2014). Planning healthy weight environments – a TCPA reuniting health with planning project. London. *TCPA.*
[162] Blackburn with Darwen Specialist Public Health Directorate (2016). Integrated Strategic Needs Assessment. Summary Review 2016. Available from http://bwdhub.org.uk/wp-content/uploads/Summary-Review-2016.pdf
[163] Public Health England (2016). Child Health Profile Blackburn with Darwen March 2016. London. *PHE.* Available from http://www.chimat.org.uk/resource/view.aspx?RID=101746&REGION=101629
[164] Public Health England (2016). Public Health Outcomes Framework Blackburn with Darwen. PHE. Available from http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000049/pat/6/par/E12000002/ati/102/are/E06000008
[165] Office for National Statistics (2015). Mortality statistics: deaths registered in England and Wales (Series DR), 2014. Available from http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-378961
[166] Health and Social Care Information Centre (2016). *Indicator Portal*. Available from https://indicators.ic.nhs.uk/webview/
[167] PHE(2016). Hypertension profile Blackburn with Darwen. http://www.yhpho.org.uk/hypertensionla/pdfs/E06000008_hypertension.pdf
[168] Blackburn with Darwen Specialist Public Health Directorate (2015). Integrated Strategic Needs Assessment. Trips and Falls. Available from: https://www.blackburn.gov.uk/Lists/DownloadableDocuments/Falls-ISNA.pdf
[169] Health and Social Care Iinformation Centre (2014). *Quality Outcomes Framework (QOF), recorded dementia diagnoses, August 2014*. Available from http://www.hscic.gov.uk/catalogue/PUB14866
[170] Public Health England (2016). National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2015. Available from http://www.nwph.net/dentalhealth/14_15_5yearold/14_15_16/DPHEP%20for%20England%20OH%20Survey%205yr%202015%20Report%20FINAL%20Gateway%20approved.pdf
[171] Public Health England (2014). *Dental health – results of survey of 3-year old children, 2013*. Available from http://www.nwph.net/dentalhealth/survey-results%203(12_13).aspx
[172] Lifestyles Statistics Team (2015). Statistics on Obesity, Physical Activity and Diet. Health and Social Care Information Centre. London.
[173] ukactive (2014). Steps to solving inactivity #turnthetide. ukactive Research Institute.
[174] Public Health England (2016). Public Health Outcomes Framework. Physical Activity Tool. Available from: http://fingertips.phe.org.uk/profile/physical-activity/data#page/0/gid/1938132899/pat/6/par/E12000002/ati/102/are/E06000008
[175] Sport England (2015). Local Sport Profile Tool. Blackburn with Darwen Data 2014-15. Available from (accessed 14th November 2016): http://localsportprofile.sportengland.org/ProfileReport.aspx?g=00EX&t=D,H,P&s=D01,D02,D03,D04,D06,D07,D08,D09,D09A,D10,D10A,D11,D12,D13,H01,H02,H03,H04,H05,H06,H07,H08,H09,H10,P01,P02,P03,P04,P05,P06,P07,P19,P20,P28,P21,P22,P23,P24,P25,P27
[176] Lancashire County Council (2016). Physical activity report and resources. Available from (accessed 14th November 2016): http://www.lancashire.gov.uk/media/898073/physical-activity-report-and-resources-2016.pdf
[177] http://www.bwdconnect.org.uk/travel-choices/cycling/weavers-wheel/
[178] http://www.yoursupportyourchoice.org.uk/

[179] http://www.refreshbwd.com/change/
[180] http://www.makingeverycontactcount.co.uk/
[181] Sustain: The alliance for better food and farming (2013). The Sustain Guide to Good Food. What you can do – and ask others to do – to help make our food and farming system fit for the future. ISBN: 978-1-903060-58-2
[182] Sport England (undated post 2014). Go where women are. Insight on engaging women and girls in sport and exercise. Available from (accessed 14th November 2016): https://www.sportengland.org/media/10083/insight_go-where-women-are.pdf
[183] Women in Sport (2016). Keeping women warm to sport in winter. Available from: https://www.womeninsport.org/resources/wintersport/
[184] Women in Sport (2016). Changing the game for girls: In action. Available from: https://www.womeninsport.org/resources/changing-the-game-for-girls-in-action/
[185] Women's Sport and Fitness Foundation (undated). Changing the game for girls. Available from: http://www.bhfactive.org.uk/userfiles/Documents/ChangingTheGameForGirlsl.pdf
[186] Kahn and Norman (2012). Move It. Increasing young people's participation in sport. Young Foundation. London.
[187] Sport England (2014). The challenge of growing youth participation in sport. Youth insights pack. Sport England. Available from: https://www.sportengland.org/media/10113/youth-insight-pack.pdf
[188] Colley et al. (2016). Access to outdoor recreation by older people. Social, Economic and Geographical Sciences Group. Aberdeen.
[189] Sport England (2015). Getting Active Outdoors: A study of Demography, Motivation, Participation and Provision in Outdoor Sport and Recreation in England. Sport England. London.
[190] Sport England (2016). Mapping Disability: the facts. A statistical review of disabled people in England. London.
[191] Sport England and English Federation of Disability Sport (2016). Mapping disability. Engaging disabled people: the guide. A practical guide for organisers of grassroots community sport. Sport England. London.
[192] Slater, C. (2013). Engaging disabled people in sport and physical activity. A guide for County Sports Partnerships to support their engagement with disabled people. English Federation of Disability Sport and County Sports Partnership Network.
[193] Sport & Recreation Alliance and ukactive (2016). Physical Activity and Health. Working together to get the nation moving. Sport & Recreation Alliance and ukactive. London.
[194] ukactive (2016) ukactive's Blueprint for an Active Britain. More people more active more often. ukactive. London.
[195] HM Government (2008). The Play Strategy. Department for Children, Families and Schools and Department for Culture, Media and Sport. London. Available from: http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/The_Play_Strategy.pdf
[196] HM Government (2016). Childhood Obesity: a plan for action. Department for Health. London.
[197] Healthwatch Blackburn with Darwen (2016). Amplify Community Researchers Project 2015/16: A snapshot of Young People's perceptions of Health Services in Blackburn with Darwen. Healthwatch BwD. Blackburn. Available from: http://www.healthwatchblackburnwithdarwen.co.uk/sites/default/files/amplify_report_-_youth_experience_of_health_and_social_care_services_0.pdf

For more information please contact:

Beth Wolfenden
Public Health Development Manager
Blackburn with Darwen Borough Council
Specialist Public Health Directorate
10 Duke Street, Floor 6
Blackburn
BB2 1DH

Tel 01254 666960
Email beth.wolfenden@blackburn.gov.uk
www.blackburn.gov.uk

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Sayyed Osman (Director Adults & Prevention (DASS))
DATE:	08/11/2019

SUBJECT: Vulnerable People Strategy

1. PURPOSE

To present the Vulnerable People Strategy to the Board for approval.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Health and Wellbeing Board are asked to approve the strategy and seek co-operation from agencies of the Board to assist with the implementation of the strategy.

3. BACKGROUND

The Local Safeguarding Adult Board (LSAB) commissioned a Vulnerable People Review in 2018 to contribute to the understanding of the relationship between demand and agency responses to the needs of vulnerable adults.

The Office for National Statistics show that forty-two registered homeless people have died in Blackburn with Darwen since 2013. In 2018, eight homeless adults died from accidents, overdoses and diseases – the second highest in the country per head of population.

The Vulnerable People Review outlined the recommendations for the Vulnerable People Strategy.

4. RATIONALE

The Vulnerable People Strategy sets out the developments, processes and tools for a better integrated system that will build on existing infrastructure, to support the most vulnerable adults with complex needs in Blackburn with Darwen.

5. KEY ISSUES

The document will be key to promoting local accountability for the most vulnerable adults. For individual partners, their commitment and involvement in meeting the recommendations within the strategy will be a key area of judgement in their partnership work.

6. POLICY IMPLICATIONS

All partner agencies of the Health and Wellbeing Board will be required to have regard to the priority areas set out in the strategy.

7. FINANCIAL IMPLICATIONS

Using existing service provision is at the centre of the strategy, but how this is commissioned and monitored, in the future, will need to be reviewed and changed.

8. LEGAL IMPLICATIONS

Implementing the Vulnerable People Strategy will assist Blackburn with Darwen Borough Council in seeking to fulfil its target Care Act duties to promote the well-being of individuals in this borough, prevent or delay needs for care and support arising, and promote integration of care and support with health-related provision (via the MDT approach noted in the strategy).

9. RESOURCE IMPLICATIONS

Whilst existing provision is to be utilised there may be the requirement to consider new resources and revised commissioning arrangements to ensure the implementation of the strategy.

10. EQUALITY AND HEALTH IMPLICATIONS

Checklist completed only had 1 factor (commissioning) suggesting that a full EIA may be required. However, the strategy builds on existing infrastructures and plans for commissioning to be redesigned rather than new commissions being made. The strategy will not disproportionally affect anyone as its implementation is for all adults equally, so a full EIA was not required, and has not been undertaken, at this time.

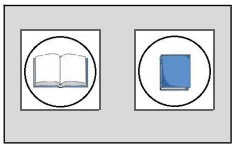
11. CONSULTATIONS

All partners of the LSAB, including the voluntary sector and service users have been consulted throughout the process of producing the document**.**

VERSION:	**1**

CONTACT OFFICER:	Dawn Walmsley
DATE:	08/11/2019

BACKGROUND PAPER:	Vulnerable People Strategy.docx Vulnerable People Review 2019, Dr Teresa Young LSAB Homelessness and Complexity Audit



VULNERABLE PEOPLE STRATEGY

2020-2023

Abstract

A collaborative, coordinated and flexible support system in Blackburn with darwen that works for people whatever you're going through, whoever you are and however you present

Contents Page

Vulnerable People Strategy Overview

Challenges	Objectives	Outcomes
Forms part of a whole system designed for 'single issue' users Significant number of stakeholders makes for a complex delivery infrastructure. Has to be delivered within existing resources and be sustainable.	***Accountability and Oversight*** • Agree within existing systems and structures of accountability and oversight where this agenda will sit • Agree the appropriate reporting and strategic leadership that will drive it forward • A coordinated integrated commissioning approach • Develop outcome measures that align with KPI frameworks and consideration of a save/cost benefit model as part of evaluation process	Whole System Approach agreed Good Governance with wide and consistent engagement of partners Improved offer from within existing resources – using what we have differently
Delivery landscape needs simplifying for service users Needs of service users are bespoke requiring flexible response. Referral to support by professionals lacks consistency	***Coordination and Integration*** • Develop processes for a multi-agency complex case conference for those with the most complex issues • Integration and coordination of all services to deliver the best, most sustainable outcomes for services users • Improved pathways for accessing, sharing and updating records to discuss support and agreement of risk domains	Engagement with services to develop individual plans &reduce revolving door presentations Improved pathways to support those most at risk Consistent offer for all persons requiring support.
Services are geographically diverse making access harder Support requires multiple appointments and lacks Commitment from service users to change	***Spaces*** • Explore the potential for more formal and extensive work through Enhances Service Hubs • Recognition of the complexities of service users and the need for more than one service • Work with those with lived experience to develop support and training packages	Advances in integration and collaboration around needs. Fewer appointments with better engagement Making the most of first contact
No one lead agency or department Service users difficult to engage and maintain engagement Skill set of partners and volunteers for this client group	***Partnership Engagement*** • Working together to develop an integrated offer for vulnerable people • Implement a person centre Trauma Informed Approach across the integrated offer • Work collaboratively with those with live experience to inform and shape service development	Practitioner and volunteers better supported Consistent approach to assessment service users Develop person centred solutions with service user and not for

1. Introduction

There is growing concern nationally for the number of adults who are escalating into crisis for multifarious reasons, and an acknowledgement of the lack of coordinated responses to their needs across the public, private and voluntary sectors exacerbated by challenges posed by austerity and government policy.

This Vulnerable People Strategy will set out a new approach built on the already positive work being undertaken across Blackburn with Darwen, redesigning our services and access points to achieve better outcomes for those who need it most.

Work undertaken by professionals from key stakeholders with service users led by the Making Every Adult Matter (MEAM) initiative and a Vulnerable People Review commissioned by the Local Safeguarding Adults Board (LSAB) will shape the relationship between demands and agency responses to need.

Blackburn with Darwen's Vulnerable People Vision:

'We will have a collaborative, co-ordinated and flexible support system in Blackburn with Darwen that works for people whatever you're going through, whoever you are and however you present'

We are committed to ensuring that;

- Our accommodation and housing options are safe, supportive and there is choice for people that meets their individual needs
- Our services are person centred and trauma informed across Blackburn with darwen
- People will feel empowered, motivated, and have a sense of purpose. Everyone should have opportunities to develop their strengths, interests and feel connected.
- People's voices and experiences are heard, listened to and acted upon, influencing policy at both local and national level
- Our commissioning focuses on building a joined up support system that works for people who are falling through the gaps or trapped in 'revolving doors'

Definition of a Vulnerable Person

There is no agreed national definition of vulnerability but for the purposes of this strategy, a vulnerable person is defined as a resident who finds themselves in extremely difficult circumstances that requires additional help and support to enable them to deal with their situation and live independently without the need for statutory services. Also due to their complexity of need it currently makes it difficult for any 'one' service with a particular specialism to support the person to make significant and lasting change. This will encompass mainly (but is not limited to):

- Those who are homeless or at risk of homelessness;
- People affected by broader issues relating to social exclusion and homelessness;
- Those who have mental health and substance misuse issues in addition to the above;
- Those at risk of anti-social behaviour as a result of their vulnerability; and,
- Those who have risk factors (such as those identified above) and live in poverty, or are unable to find/keep employment, have debt or financial management difficulties or are socially and digitally isolated.

Aim

Blackburn with Darwen Borough Council aims to have the right services, in the right place, at the right time so that those who need it can feel safe, be part of, and positively contribute to the community. They will have access to services and support that they need to have and, agencies who can meet those needs, will be identified to provide that support.

2. Vulnerable People Statistics and Overview

One of the challenges of planning services to meet the needs of this group is that it is difficult to get a clear picture of demand within a fragmented service landscape. In other words, the nature of services in Blackburn with Darwen means that individuals are required to access multiple services, have multiple assessments and this leads to the risk of double counting.

Indicative assessment suggests approximately 750 individuals within Central Blackburn have high levels of complexity with 67% identified with a number of health and social issues that place them at risk of developing complex needs, 27% are already considered to have complex needs and the remaining 7% are highly complex having many additional needs[1].

Many of those who have complex needs are not considered/assessed to have 'care and support needs' as outlined in the Care Act 2014, they do not meet safeguarding criteria and rarely will be assessed as lacking capacity. That said their needs can be and often are significant therefore we need to respond to them more effectively.

Both the Vulnerable People Review and LSAB Homelessness and Complexity Audit identified that service users with complex needs present across the spectrum of mental health issues, from anxiety and depression that may be the result of their current situation, or an effect of complex trauma, to personality disorder and more challenging conditions, both diagnosed and undiagnosed. This is challenging for both specialist mental health staff and non-specialist services.

One of the key challenges facing those at most risk is the co-presentation of mental health and substance misuse alongside homelessness and this has been seen as a barrier to them being able to access services effectively or for professionals to unpick whether they are in a state of crisis or chaos. Even where service users do manage to access services it is reported they will engage well for a period then miss appointments and in order to be able to continue treatment require re-referrals (and assessments). This leads to self-medication via licit or illicit substances over using their money to pay for housing.

Many people with complexities do access primary care services such as GPs, treatment centres and pharmacies but there remains a challenge for secondary health services as individuals present with a combination of physical ill health, substance misuse, mental ill health including self-harm and overdose and become intensive users of the hospital's Emergency Department.

The difficulties resulting from welfare reform and changes to the benefit system have exacerbated vulnerability. The Universal Credit (UC) system is only available online and is a multi-layered process, which is far from straightforward. This means many vulnerable people can fall through (fail to access benefits or complete their claim), have delayed benefits or due to the 'loan' system end up in debt.

[1] Vulnerable People Review 2019, Dr Teresa Young

Blackburn with Darwen has one of the highest rates of death amongst the homeless amongst English authorities and whilst there are short term housing solutions for the homeless with complex needs there are few long-term solutions. In Blackburn with Darwen many homeless individuals who are single and claiming benefits simply cannot afford social housing plus there are few one bedroom apartments that they can afford within the private rented sector and many are being described as 'substandard terraced housing'. This has led to an increase in the availability of bedsits with Blackburn having a high proportion of private Homes of Multiple Occupation (HMOs). There are currently regulatory powers in respect of the physical conditions of property but no regulatory powers to enable public authorities to address the actual welfare and health and wellbeing of individuals in HMOs.

Vulnerable people have been found to be reported as both involved with and the subject of criminal activity. However, the largest number of adult reports from the police are for those whereby there has been particular concern for the individual's welfare and those living in HMOs were the highest number reported.

Service User and Stakeholder View

- *'No person should be waking up each morning and looking to anaesthetising themselves from society'*
- *'How can I get an appointment when I don't have an address or credit for my phone?'*
- *'They're not very good at organising themselves or responding to official organisation. People have fallen off ESA and onto Universal Credit and then they struggle to make a claim. They also don't ask (for help) so end up with nothing and then they go into crisis'*
- *'Universal Credit is so bloody complicated'*
- *'It's easy to misjudge people who decline all the help they are offered…the fact is the support or help offered may not be right support or at the wrong time. We have to get it right first time to help them move on'*
- *'There's no point giving me food that I have to cook as I don't have anything to cook it on'*

3. System and Change Processes

The strategy will deliver on its vision and commitment by using mainly existing service provision where possible. This will be undertaken using information from the Vulnerable People Review and the agreed actions necessary as reported by MEAM. It is planned that these will be undertaken between 2020 and 2023.

Future development will:

- Build on an asset based community development approach where those in receipt of services or who have lived experiences of services are fully involved in the development process
- Be underpinned by clear organisational commitment partnership arrangements and strategic scrutiny.

To support this, the remainder of this document will focus to support the development of how the strategy will be implemented. This is a commitment to a system that will be co-produced by a partnership of commissioners, agencies and those with lived experience. These partners will take forward the thematic recommendations that emerged from both the Vulnerable People Review and MEAM workshops and will do so via Person Centred Trauma Informed Approaches.

Developing Trauma Informed Approaches to service development and delivery is a key recommendation of this strategy and it should run through all decision making and whilst Blackburn with Darwen has strong foundations through ACE (Adverse Childhood Experiences), Embrace, MEAM and the Complex Case Hub, to mainstream this will need further commitment and championing.

For a Trauma Informed Approach to be integrated across provision; commissioners, managers and practitioners need to think about how service development will impact on the most vulnerable or complex, taking something akin to a Vulnerable People Impact Assessment approach. Those with lived experience will be ideally placed to inform the development of that assessment.

A Development Group to take this forward is proposed and this should include those in a position to enable change at strategic level as well as practitioners and those with lived experience who can inform what that change should look like. Developments in this area should also be cognisant of and co-ordinate with Pan-Lancashire developments within Lancashire Constabulary and the Public Service Board etc.

4. A New Vulnerable People Compact – Overview

The Compact was the name given in the Vulnerable People Review. Whilst the core element of this work will depend on partnership working, the aim was not to suggest another formal partnership with a hierarchy of members, but a broader approach which can be flexible and responsive and that will at times overlap and draw on and support existing developments and processes. This isn't about developing something 'new' but about how what is already in place can be flexed to meet the more complex needs of vulnerable groups locally.

Developments, processes and tools will build on the existing infrastructure as we develop a more integrated system. This is based on the belief that a move toward greater integration could ensure the most appropriate response at the right time and can be sustained beyond crisis presentation.

Building on existing infrastructure would also allow for a phased implementation of ideas proposed, accounting for varying amounts of work needed to agree and implement new practices and amend existing commissioning arrangements over time.

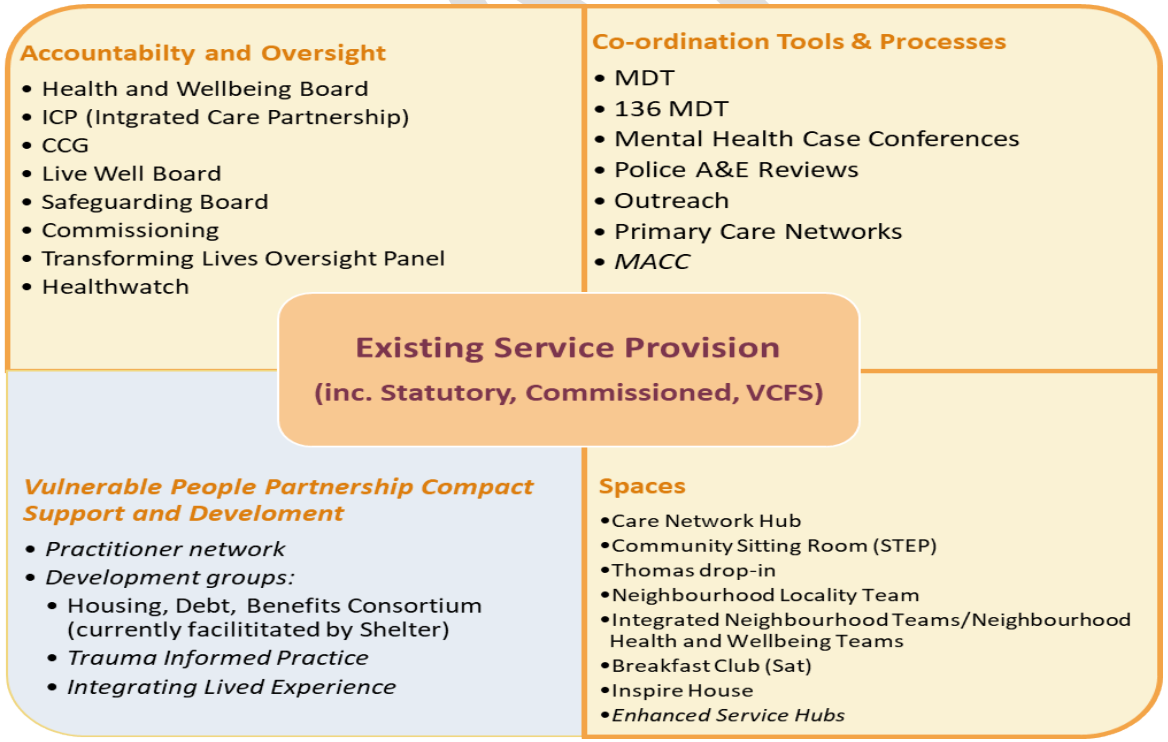
The areas proposed within the compact are:

1. Accountability and Oversight
2. Coordination and Integration
3. Spaces (including Enhanced Service Hubs)
4. Partnership Compact Support and Development

In the following diagram: The central orange and three yellow shaded segments show existing provision and approaches: **only the elements *italicised* are new**.

The grey/blue segment contains the new elements of the compact (again *italicised*) and the existing Housing, Debt, Benefits Consortium, currently facilitated by Shelter, is also brought under this heading.

Existing service provision is at the centre of this model reflecting the belief that there are a lot of services out there and they need to work together better. It's not simply about what you have or do, but how you do it. That said, how this is commissioned and monitored may change or be focused to more directly or explicitly address the needs of complex/vulnerable individuals. Commissions and services should be able to address the needs of the complex and vulnerable not just the straightforward. Similarly, they should be organised and delivered in a way that does not by 'default' exclude the vulnerable.



Accountability and Oversight

Systems of accountability for this agenda already exist however, to take integration forward effectively accountability will need to sit across all elements of the system. It will need to be built into each step and extend beyond KPI frameworks to carry the vision and keep pushing forward to achieve better outcomes. Accountability needs to be built into an integrated system at all levels as does leadership.

Co-ordination and Integration

The ultimate aim would be to engage individuals with services and to develop, with them, a plan that would then be taken forward through a Multi-Disciplinary Team (MDT). This approach is already used widely across services as noted above. If such a process is already in place, e.g. through specialist mental health provision, this would not be duplicated although consideration may be given as to whether the scope should widen to co-ordinate interventions more effectively, and how step down might happen when specialist interventions stops.

Again the aim is not to duplicate or replace any of these processes but to ensure that they are integrated and co-ordinated to deliver the best, most sustainable outcomes for the clients involved to reduce the revolving door of re-presentation

Spaces (including Enhanced Service Hubs)

This is not exhaustive but can include some of the existing spaces in the community which vulnerable individuals do, or can access, where 'community' type collective activity or groups can be, or are held. However, the one additional element that does not already exist is the Enhanced Service Hubs, a response to the fragmented nature of service delivery and a core element of building multi-disciplinary support around individuals.

Partnership Compact Support and Development

This is the partnership approach to integrated service development and delivery recommendations. It should reflect a shared commitment to:

- Working together to develop an integrated offer for vulnerable people;
- Working differently, implementing a person centred Trauma Informed approach across that integrated offer; and
- Working collaboratively with those with lived experience to inform and shape service development.

Appendix A; Recommendations

The below presents the thematic recommendations as advised by Dr Young in the Vulnerable People Review.

Individual actions, delivery mechanism/lead, focus of oversight or timeframe has not been pre-determined at this stage but should be completed once initial partnership arrangements are agreed. Actions generated by partners maybe delegated to other groups or partnership arrangements which have overarching responsibility for delivery against wider objectives. Where this is the case, a reporting and oversight process should be agreed.

Recommendation 1: Mental Health (p.17)

- Examine potential for developing programme for Vulnerable Adults aimed at preventing escalation, supporting individuals to manage their emotions, anxiety and stress and recognise triggers and develop greater treatment readiness. Involvement of those with lived experience should also be considered during the programme development phase and, if available, as peer mentors for those participating.

Recommendation 2: Health (p.19)

- Support CCG and other health providers (A&E, mental health, pharmacies) in their discussions as to how to join up the health offer to better address the needs of vulnerable adults within the wider community offer, via Primary Care Networks etc.

Recommendation 3: Financial exploitation (p.27)

- Work with those with lived experience, DWP (including fraud officers) and Police and Local Authority to examine potential responses and scope to act regarding financial exploitation and fraudulent activity. Such scope should be systemic rather than simply moving vulnerable adults out of 'harm's way', (although capacity for this may also be required) and not increase the vulnerability of informants. Work with these organisations to lever in support from their national leads with responsibility in this area to inform local responses and action.

Recommendation 4: Intermediate Labour Markets (p.29)

- Work with the DWP to explore the scope for the development of intermediate labour markets. Considerration of preventive work in Higher Education as well as inclusive of training for future employment

Recommendation 5: Volunteering (p.29)

- Work with the DWP to formalise recognition of volunteering by those with lived experience and/or in recovery as an appropriate part of the Claimant Commitment.

Recommendation 6: **Housing** p.36

- Explore potential mechanisms for reducing supply of hostels e.g. Blackpool

Recommendation 7: Housing p.36

- Work with other housing agencies operating locally, e.g. Shelter and Housing Link to lobby for change to the regulatory regime for hostels and for greater powers and safeguards to protect vulnerable adults in HMOs, including as a result of the implementation of Universal Credit.

Recommendation 8: Housing p.36

- Consider potential for working with innovative housing providers to explore options and develop from their expertise.

Recommendation 9: Housing p.36

- Explore possibilities through the Community Housing Fund and Housing Infrastructure Fund to improve access to appropriate housing for this Vulnerable People. This could be as a small element of a wider more ambitious bid.

Recommendation 10: Housing p.38

- The outcomes from Housing First models should be examined to identify learning to inform local implementation.

Recommendation 11: Housing p.38

- Further development of a Housing First model or approach may be strengthened by the involvement of rehab organisations and support from service staff and volunteers/peer mentors themselves with lived experience.

Recommendation 12: Voluntary Food Provision p.39

- Consider how to work with voluntary food provision to maximise contact with individuals and pathways to service

Recommendation 13: Foodbank for the homeless p.39

- Foodbank for Homeless option – work with those with lived experience re: best way of filling this gap.

Recommendation 14: Neighbourhood Provision p.40

- Consider how the Neighbourhood Offer could contribute to meeting the needs of Vulnerable Adults through supported activity and whether existing offer is accessible.

Recommendation 15: Commissioning p.56

- The development of a Vulnerable People Strategy should consider how partner commissioning processes can be mobilised to support integration.

Recommendation 16: Governance p. 57

- Review Governance and Information Sharing arrangements to ensure thy are adequate for and changes in working practices.

Recommendation 17: Monitoring Transitions p.71

- Monitor the transition to the CAB contract for the impact on vulnerable adults of changing liaison and support arrangements with CAB.

Recommendation 18: Out of Hours Provision p.74

- Consider out of hours and community based support for vulnerable people, to maximise impact and reduce vulnerability.

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Shirley Goodhew
DATE:	4th December 2019

SUBJECT: Child Death Overview Panel (CDOP) Annual Report 2018-19

1. PURPOSE

To update the members of the Health & Wellbeing Board of the work undertaken by the pan-Lancashire Child Death Overview Panel (CDOP) during 2018/19, which includes key findings from child death data, progress made on last year's recommendations (2017/18), partnership achievements, and priorities and recommendations for 2019/20.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Local Safeguarding and Health and Wellbeing Board partners are asked to:

a. Note the content of this report, and in particular the priorities for 2019/20.

b. Ensure all professionals providing information to CDOP ensure that forms are returned within the statutory three week deadline and are completed as fully as possible before they are submitted; 20% of cases reviewed during 2018/19 did not have the child's ethnicity recorded.

c. Ensure that the Child Death Review (CDR) processes remain embedded in the new safeguarding arrangements until at least April 2020.

d. Transfer the responsibility for CDR/CDOP to Health and Wellbeing Boards at some point after April 2020.

e. Clarify what interagency initiatives are required to reduce the prevalence of modifiable factors identified in the under one population including:

- Safe sleeping
- Risk factors for reducing premature births including:
  - High Body Mass Index (BMI) (including healthy diet and physical activity)
- High blood pressure (linked to high BMI)
- Smoking
- Alcohol use
- Substance misuse
- Domestic violence
- Mental health
- Diabetes (often linked to BMI)
- Lack of physical activity

3. BACKGROUND

CDOP has an independent chair, who has a responsibility to review all child death cases within pan Lancashire, and provide oversight and assurance of the child death review processes, on

behalf of statutory partners. The Working Together to Safeguard Children (2018) guidance states local areas should have a clear child death review process in place, whereby a child is defined in the Act as a person under 18 years of age, regardless of the cause of death.

3.1 CDOP Membership
During 2018/19 the CDOP had representation from: Lancashire Constabulary, the Sudden Unexpected Death in Childhood (SUDC) Service, Children's Social Care, the three Lancashire Safeguarding Children's Boards (and new arrangements), Community Health Services, Midwifery, Paediatrics, Clinical Commissioning Groups, Public Health, and Education and Early Years representatives were provided by Lancashire County Council, Blackburn with Darwen (BwD) Borough Council, and Blackpool Council respectively.

All business, case discussion and neo-natal review meetings had excellent or good (80-100%) representation by agencies, and by geographical coverage; however the panel is still without an Education representative for Lancashire.

CDOP is supported by Children's Safeguarding Business Managers, the SUDC Prevention Group, the Child Death Investigation Group, and the SUDC Service, and all have significant roles in leading, supporting and informing the developmental and prevention work with partners across pan Lancashire.

3.2 Progress on 2018/19 priorities
CDOP successfully completed four out of the eight priorities for 2018/19:

- New improved database and quality assurance monitoring system aligned to national eCDOP system
- Smooth transition of new SUDC service and updated SUDC protocol
- Action plan developed to implement recommendations from thematic reviews on trauma and Infection
- Implemented the recommendations from the Adverse Childhood Experience (ACE) audit

Progress has been made on the remaining four priorities, but as this is on-going, these will carry over to 2019/20 Priorities (Section 5.11).

3.3 CDOP key achievements 2018/19
The following campaigns have been developed and successfully delivered across pan Lancashire to promote key messages based on learning gained from child death reviews:

- Safer sleep campaign
- Safer sleep for Grandparents campaign
- Positive recognition
- ICON – Babies Cry, You Can Cope!
- SUDC 10 Year Recognition event
- CDOP Development Day
- Adverse Childhood Experiences approach
- Pharmacy campaign
- Two thematic reviews (Infection and Trauma)

4. RATIONALE
The death of all children under the age of 18 must be reviewed by a Child Death Overview Panel (CDOP) on behalf of the relevant Local Safeguarding Children Board. The CDOP in this area covers Blackpool, Blackburn with Darwen and Lancashire and is known as, the Pan-Lancashire CDOP, which reports annually to the Health & Wellbeing Boards, and pan Lancashire Local Safeguarding Children's Board.

5. KEY ISSUES

5.1 Findings from data analysis 2018-19

Between April 2018 to March 2019, CDOP received 106 child death notifications (7 Blackpool, 15 BwD and 84 Lancashire residents) in line with the statutory guidance Working Together to Safeguard Children. There has been a slight downward trend in child notifications over the last 10 years, however BwD and Lancashire saw a slight increase, whilst Blackpool showed a decrease. The Panel completed 111 reviews during 2018-19 (18 BwD, 13 Blackpool, 80 Lancashire) of which 51% were expected deaths, 45% were unexpected deaths and 4% unexpected but meeting the exclusion criteria. Nine ongoing cases were subject to Serious Case Review.

5.2 Modifiable factors

It is recognised that a number of child deaths had modifiable factors that could have reduced the risk of death. A modifiable factor is defined as: 'one or more factors, in any domain, which may have contributed to the death of a child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths' (Working Together, 2018). Across pan-Lancashire modifiable factors relating to child deaths accounted for around half (51%) of all deaths during 2018/19, which is an increase compared with 2017/18, whereby only 33% of cases reviewed had modifiable factors.

The most common modifiable factors identified (including expected and unexpected deaths) across pan Lancashire were smoking by parents/carer in the household (36%), high or low Body Mass Index (BMI) in mother (23%), followed by unsafe sleeping arrangements (7%).

5.3 Age

Of the deaths reviewed, the highest number of deaths (53%) that occurred were under one year of age, with 20% aged 1-9 years, and 27% 10-17 year olds.

5.4 Ethnicity

The ethnicity of the majority (53%) of child deaths reviewed for Lancashire were White-British. However, 11% of child deaths were children of South Asian heritage, which is an over representation for this ethnic group based on the 2011 Lancashire population census data (5.7%). For BwD, 22% of child deaths were of Asian or British Asian Pakistani heritage and 54% White British children. When compared to 2017/18, the latest data shows a decrease in proportion of Asian or British Asian Pakistani heritage (43%). However, caution is advised due to small numbers and this may be due to annual fluctuations.

5.5 Category

The most common category of death across pan Lancashire for cases reviewed was Perinatal/ neonatal event (29%) with chromosomal, genetic and congenital anomalies accounting for the second most common category (24%). This is consistent with England and Wales data where perinatal and congenital causes are the most common, especially in neonates (less than 4 weeks old). However, deaths from perinatal/neonatal events in Lancashire show a downward trend over the last 10 years, since 2008.

5.6 Place

The majority of children die within a hospital setting (77%), with 12% of children and young people dying at home, which includes unexpected deaths and children on end of life care plans.

5.7 Unexpected with modifiable factors

Due to the most common cause of child death in pan Lancashire being in perinatal / neonates and the small number of cases where modifiable factors are identified by Local Authority areas, it was not possible to identify one modifiable factor category, ie. BwD had 0-2 cases across the ten modifiable categories. Therefore, the second most common category of child deaths with modifiable factors identified across pan Lancashire included 'suicide or deliberate self-inflected harm' (13%), followed by 'trauma and other external factors' (9%). As the numbers are so small

they should be treated with caution.

An unexpected death is defined by Working Together (2018) as 'the death of an infant or child which was not anticipated as a significant possibility 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'. Generally, the majority of deaths occurred within the first year of life which were expected attributed to complications relating to prematurity or chromosomal, genetic/congenital abnormalities. In older children deaths tended to be unexpected. In 2018-19, over half (51%) of all child deaths were expected compared with 45% that were unexpected. 4% were reviewed as unexpected but met exclusion criteria.

Sadly, there were six young people who died by suicide in 2018-19 across pan Lancashire, which is consistent with the last two years (6 in 2016-17 and 6 in 2017-18). The majority of these suicides were children known to services. Lancashire and South Cumbria Integrated Care System is leading a comprehensive logic model action plan to reduce the number of suicides, including support for those who self-harm, and to improve outcomes for those affected by suicide.

5.8 Themes

The themes identified from all 48 child deaths in 2018-19 included the following, largest to smallest:

- Complex medical needs (joint first)
- Co-sleeping/inappropriate sleeping arrangements (joint first)
- Road Traffic Collision / Drowning / Accidental (joint second)
- Suicides (joint second)
- Neonatal cases
- Unresponsive / unascertained
- Concealed and denied pregnancy

5.9 Complex social circumstances

Of the 48 deaths in 2018-19, 18 were known to Children's Social Care. Key themes identified at the time of death or following death, included: Domestic violence between parents/carers (7); parental mental health problems (7) and parental alcohol/ substance misuse (13). These cases highlight the complex social circumstances, chaotic family dynamics and environmental factors that these children were living in at the time of their deaths. CDOP continues to collect data on Adverse Childhood Experiences with a view to making recommendations to partners.

5.10 Blackburn with Darwen data summary

- 75% of deaths reviewed during 2018/19 were completed within 12 months
- 45% of deaths were expected
- Of the BwD deaths reviewed, 22% were of Asian or Asian British Pakistani heritage
- 33% of deaths were female
- 50% of deaths had modifiable factors identified
- The most common modifiable factor identified was smoking

5.11 CDOP Priorities for 2019/20

1. Deliver the SUDC Prevention group priorities including:
   a. maintaining a supply of materials to agencies across pan-Lancashire;
   b. promote the safer sleep campaign throughout pharmacies during October 2019;
   c. raising awareness around water safety including cold water shock;
   d. auditing the safer sleep materials and create a harder hitting campaign;
   e. strengthen the current safer sleep materials and safer sleep guidelines; and
   f. support the roll-out of phase 2 of the ICON campaign.

2. Manage a smooth transition of the Child Death Review process from Local Safeguarding Boards to new governance arrangements and ensure that the new guidance is implemented including:

a. ensuring all child death review meetings (e.g. perinatal mortality; hospital mortality; etc.) inform the CDOP process in a standardised and structured manner;
b. ensure all agencies understand the new guidance and relevant processes;
c. ensure there is adequate resource to fulfill the new responsibilities;
d. Ensure all agencies understand the new guidance and relevant processes; and
e. Develop and oversee an implementation plan measured against national standards

3. Consider further analysis of the observed disproportionate Blackburn with Darwen deaths in certain population groups, and feedback to the LSCB and other partners
a. Implement the recommendations from the reviews into trauma (category 3) and infection (category 9)
b. Continue to collect data for Adverse Childhood Experiences (ACEs), and analyse patterns in links between ACEs and child deaths
c. Ensure that any preventive strategies and initiatives link with any existing health and wellbeing/ clinical workstreams.

6. POLICY IMPLICATIONS

- Child Death Review Statutory and Operational Guidance (England), October 2018.
- Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children (July 2018).
- Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016).

7. FINANCIAL IMPLICATIONS

Child death review partners should agree locally how the child death review process will be funded in their area. The SUDC Prevention Group is co-ordinated by the pan Lancashire CDOP and is funded by the CDOP budget (£15,000) within the Safeguarding partnership.

8. LEGAL IMPLICATIONS

A child death review partner in relation to a local authority area in England is defined under the Children Act 2004 as (a) the local authority, and (b) any clinical commissioning group for an area any part of which falls within the local authority area. The two partners must make arrangements for the review of each death of a child normally resident in the area and may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. They must also make arrangements for the analysis of information about deaths. The purposes of a review or analysis are (a) to identify any matters relating to the death or deaths that are relevant to the welfare of children in the area or to public health and safety, and (b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

Extract from *Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children* (July 2018).

9. RESOURCE IMPLICATIONS

The child death review partners should consider the core representation of any panel or structure they set up to conduct reviews and this would ideally include: public health; the designated, doctor for child deaths for the local area; social services; police; the designated doctor or nurse for safeguarding; primary care (GP or health visitor); nursing and/or midwifery; lay representation; and other professionals that child death review partners consider should be involved. It is for child death review partners to determine what representation they have in any structure reviewing child deaths.

10. EQUALITY AND HEALTH IMPLICATIONS

The CDOP review process is compliant with the Equality Act 2010, outlined in Child Death Review Statutory and Operational Guidance (England), October 2018.

11. CONSULTATIONS

- CDOP Business Group
- Pan Lancashire Local Safeguarding Children Board
- Health & Wellbeing Boards (BwD, Blackpool and Lancashire)

VERSION:	**1.0**

CONTACT OFFICER:	Shirley Goodhew, Public Health
DATE:	13.11.19
BACKGROUND PAPER:	Pan-Lancashire Child Death Overview Panel Annual Report 2018-19 (Not for dissemination).