AGENDA ITEM

REPORT TO HEALTH AND WELLBEING PARTNERSHIP AND BOARD

25th SEPTEMBER 2013

REPORT OF DIRECTOR OF PUBLIC HEALTH

ALLOCATION OF NON-RECURRENT PUBLIC HEALTH GRANT FUNDS

SUMMARY

The purpose of this report is to provide members with a summary of non-recurrent funds available within the Public Health Grant and to seek views on allocation of available funds. Award of funds will preferably be via a grant process.

RECOMMENDATIONS

1. That members agree one or two priority areas on which spend should be focussed based on health and deprivation data.

DETAIL

From 1 April 2013 Local Authorities became responsible for the provision of some public health activities. This responsibility came with a ring-fenced Public Health Grant, the detail of which members have had sight of previously. The Public Health Grant has been managed cautiously due to the transition of contracts and the unpredictability of some levels of contract activity. In addition, reserves were held to address any unforeseen circumstances arising from the transition.

This has resulted in a non-recurrent amount of £500,000 being available within this financial year for the consideration of the Health & Well Being Partnership and Board to utilise in targeting areas of identified need.

The Joint Health & Wellbeing Strategy provides an overarching framework which maintains an oversight of the six Marmot principles[1]:

1) Give every child the best start in life
2) Enable all children, young people and adults to maximise their capabilities and have control over their lives
3) Create fair employment and good work for all
4) Ensure a health standard of living for all
5) Create and develop health and sustainable places and communities
6) Strengthen the role and impact of ill-health prevention

In recognition of consultation feedback to inform the Strategy and the need to focus on shared priorities around the areas of greatest need it was agreed that emphasis would be placed on:

- Give every child the best start in life
- Addressing ill health prevention, and
- Getting the infrastructure right

Therefore, it is suggested that spend should be targeted at giving every child the best start in life and/or addressing ill health prevention within the context of health inequalities linked to deprivation.

INFORMATION TO INFORM DISCUSSION

Giving every child the best start in life

The Child Health Profile for Stockton (2013)[2] (Appendix 1) highlights that children in Stockton-on-Tees have significantly poorer outcomes than the England average for several indicators, including the % (16-18yrs) not in education, employment or training; the rate of under-18 conceptions (15-17yr olds); the rate of hospital admissions due to substance misuse (15-24yr olds); and rates of breastfeeding initiation and maintenance at 6-8 weeks post-birth.

As highlighted by the Marmot Review of health inequalities (2010)[1], these poor outcomes are founded on inequalities in society and have their roots in early life. The Review outlined the impact of key factors in early life, particularly poor cognitive development and low birth weight on a child's mental and physical health outcomes throughout the life course; and on future life chances. Educational attainment (dependent on cognitive development and speech and language development; and closely associated with deprivation) is a particularly good indicator or this (Appendices 2 and 3). Low birth weight and low breastfeeding rates are also closely associated with deprivation and these are risk factors for obesity in childhood and later life. Obesity is also associated with deprivation (Appendix 4).

The impact of these disadvantages in early life is summarised in the 'Marmot indicators' for Stockton Borough (Table 1):

Table 1: Marmot Indicators for Stockton Borough (London Health Observatory 2012)

Indicator	Stockton	England Average	England best
Male life expectancy at birth (years)	77.6	78.96	85.1
Inequality in male life expectancy at birth (years)	15.3	8.9	3.1
Inequality in disability-free male life expectancy at birth (years)	16.6	10.9	1.8
Female life expectancy at birth (years)	81.8	82.6	89.8
Inequality in female life expectancy at birth (years)	11.3	5.9	1.2
Inequality in disability-free female life expectancy at birth (years)	13.1	9.2	1.3
Children achieving a good level of development at age 5 (%)	60.1	58.8	71.4
Young people not in education, employment or training (%)	10.6	6.7	2.6
People in households in receipt of means-tested benefits (%)	16.3	14.6	4.7
Inequality in percentage receiving means-tested benefits (% points)	43.6	29.0	4.6

Stockton Borough Council data show significant differences between wards in the numbers of children looked after and children with a child protection plan – numbers are greatest in the wards with the greatest levels of deprivation (highlighted - Table 2).

Table 2: Active Children Social Care Cases at 21/08/13

Ward	% of active cases by Ward	Active cases as a % of total Borough Cases	% of CiN cases by Ward	% of Child Protection cases by Ward	% of Children in Care (CiC) cases by Ward
Billingham Central	5.12%	4.63%	4.01%	0.79%	0.32%
Billingham East	6.76%	6.87%	4.51%	1.27%	0.99%
Billingham North	1.63%	1.62%	1.39%	0.05%	0.19%
Billingham South	4.80%	4.20%	3.05%	0.65%	1.09%
Billingham West	1.00%	0.43%	0.89%	0.11%	0.00%
Bishopsgarth and Elm Tree	2.70%	1.72%	1.88%	0.53%	0.30%
Eaglescliffe	1.77%	2.05%	1.60%	0.04%	0.12%
Fairfield	2.46%	1.34%	0.97%	1.06%	0.44%
Grangefield	2.16%	1.67%	1.85%	0.18%	0.12%
Hardwick	7.82%	7.44%	4.86%	1.65%	1.30%
Hartburn	1.23%	0.76%	1.15%	0.00%	0.08%
Ingleby Barwick East	1.75%	2.43%	1.68%	0.00%	0.07%
Ingleby Barwick West	1.15%	2.00%	0.95%	0.16%	0.03%
Mandale and Victoria	6.35%	9.39%	4.09%	1.51%	0.74%
Newtown	8.59%	9.59%	4.96%	1.97%	1.75%
Northern Parishes	1.09%	0.43%	0.72%	0.00%	0.36%
Norton North	6.13%	4.77%	4.66%	0.67%	0.80%
Norton South	3.24%	2.58%	2.64%	0.18%	0.42%
Norton West	1.53%	0.86%	1.36%	0.09%	0.09%
Parkfield and Oxbridge	8.18%	7.77%	5.97%	0.85%	1.36%
Roseworth	6.16%	6.06%	3.98%	1.60%	0.58%
Stainsby Hill	6.46%	5.01%	5.04%	0.43%	0.98%
Stockton Town Centre	13.67%	11.02%	7.28%	3.02%	3.61%
Village	5.02%	3.72%	3.35%	0.58%	1.09%
Western Parishes	1.76%	0.62%	1.49%	0.27%	0.00%
Yarm	1.15%	1.05%	1.10%	0.00%	0.05%
Borough Total	**4.41%**	**100.00%**	**3.03%**	**0.73%**	**0.67%**

Addressing ill health prevention

The 2012 Health Summary for Stockton on Tees ranks Stockton borough's health and mortality against the rest of England in 32 indicators. Of those 32 indicators the five indicators that are the furthest away from the England average, ie, much worse than the rest of England, are:

	Stockton	England Average	England best
Breast Feeding Initiation	58.4%	74.5%	94.7%
Health Eating in Adults	21.9%	28.7%	47.8%
Hospital Stays for Self Harm	369.4	212.0	49.6*
Hospital Stays for Alcohol Related Harm	2523	1895	910*
Early deaths from cancer	131.6	110.1	77.9[a]

*Age/sex standardised rate per 100,000 population
[a]Age/sex standardised rate per 100,000 population aged under 75 years

A summary of premature deaths, ie, avoidable deaths under the age of 75, between 2009-2011 was recently produced by the Tees Valley Public Health Shared Service. *Longer Lives* highlighted Stockton data as follows:

	Per 100,000 Pop. Rate	LA Rank out of 150	Common Causes of Disease
For all premature deaths	301	102	poverty, smoking, alcohol, poor diet and activity and high blood pressure.
All Cancers	125	127	Smoking/alcohol/poor Diet
Heart Disease & Stroke	69	89	Smoking/high blood Pressure/poor nutrition, Obesity & physical Activity
Lung Disease	27	95	Smoking/occupation/air Pollution
Liver Disease	16	83	Alcohol/Obesity/ Hepatitis

DEPRIVATION

Deprivation maps – see Appendices and Attachment 'Stockton Wards Health Data.'

CONSIDERATION OF PRIORITY AREAS

Adults

The data regarding the prevention of ill health, common causes of disease and deprivation relating to adults would indicate that targeting activity linked to smoking cessation in the most deprived wards would have the most beneficial effect. This is where the risks to health are greatest and where disproportionately greater resources would need to be invested to reduce inequalities in health within Stockton. Targeting smoking cessation in deprived wards would reduce premature deaths, cancer, heart disease and lung disease and improve the quality of life for those living in households where smoking occurs.

Children and Young People

The data, supported by the evidence outlined in the Marmot Review (2010) and other reports (e.g. the Allen Review, 2011[3]), would suggest that intervening in the early years (0-3yrs) with a particular focus on cognitive development, speech and language and nutrition among children in the most deprived wards, would have a significant positive impact on a child's health and wellbeing outcomes in the short-term and throughout the life course. Key outcomes measures would be educational attainment, childhood obesity rates and health outcomes in adulthood e.g. obesity rates, prevalence of diabetes. These factors would be expected to contribute to reducing the number of children in the social care system; to improving life expectancy in the most vulnerable groups, particularly those affected most by poverty; and to reducing inequality in life expectancy and healthy life expectancy in the longer-term.

PROCESS FOR ALLOCATION OF FUNDS

It is proposed that, following recommendations made by Partnership members and the final decision made by Board members on fund allocation, the activity to support the allocation and management of the funding process will be taken forward by the Children and Young People's Health and Wellbeing Commissioning Group and/or the Adult Health and Wellbeing Commissioning Group (dependent upon where the funds will be targeted). Whether a grant process can be followed will be agreed with the Local Authority's procurement team once the allocations have been decided.

Example of Fund Allocation Management

Give every child the best start in life	£250,000	Management via C&YP Commissioning Group
Preventing ill health	£250,000	Management via Adult Commissioning Group

FINANCIAL IMPLICATIONS

There are no financial risks associated with this plan. A grant process will be followed for allocation of funds which will clearly identify the non-recurrent nature of the funding and will request specific detail on exit planning.

It should be noted that financial amounts managed via the Drug and Alcohol Commissioning Group are excluded from this process.

LEGAL IMPLICATIONS

The legal implications associated with this paper are linked to grant allocation and management. Close liaise with the Local Authority's procurement and legal team will take place via lead Officers on the Commissioning Groups.

RISK ASSESSMENT

There are no risks relating to this discussion document.

SUSTAINABLE COMMUNITY STRATEGY IMPLICATIONS

It is considered that public health activities will have a positive impact on all the Sustainable Community Strategy themes.

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References

1. The Marmot Review (2011) Fair Society, Healthy Lives. Available from: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
2. Child and Maternal Health Observatory (2013) Child health Profile – Stockton-on-Tees. Available from: http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES_STATIC_RES&SEARCH=S*
3. Allen, G. (2011) Early intervention: The Next Steps. Available from: http://www.dwp.gov.uk/docs/early-intervention-next-steps.pdf

Appendices

Appendix 1: Child Health Profile 2013[2]

Summary of child health and well-being in Stockton-on-Tees

The chart below shows how children's health and well-being in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Not significantly different
- Significantly better than England average
- Regional average

England average — 25th percentile — 75th percentile

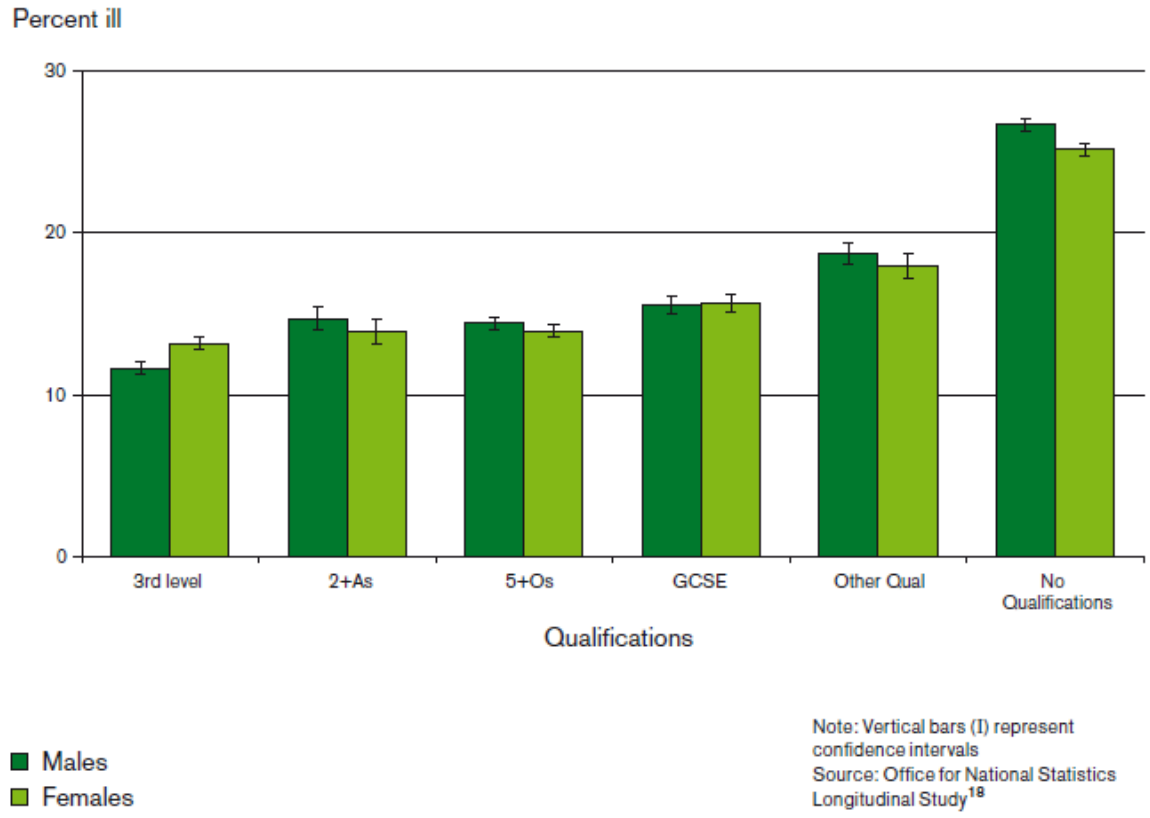
range of values that differ significantly from the average

	Indicator	Local no. per year	Local value	Eng. ave.	Eng. worst	Eng. best
Preventable mortality	1 Infant mortality rate	9	3.8	4.4	8.0	2.2
	2 Child mortality rate (age 1-17 years)	5	13.8	13.7	23.7	7.5
Health protection	3 MMR immunisation (by age 2 years)	2,230	90.8	91.2	78.7	97.2
	4 Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	2,384	97.1	96.1	85.7	98.8
	5 Children in care immunisations	185	92.5	83.1	0.0	100.0
	6 Acute sexually transmitted infections (including Chlamydia)	782	30.7	35.6	75.2	19.9
Wider determinants of ill health	7 Children achieving a good level of development at age 5	1,471	61.9	63.5	51.5	76.5
	8 GCSE achieved (5A*-C inc. Eng and maths)	1,213	54.3	59.4	40.9	79.6
	9 GCSE achieved (5A*-C inc. Eng and maths) for children in care	-	-	14.6	0.0	40.0
	10 Not in education, employment or training (age 16-18 years)	750	10.3	6.1	11.8	1.6
	11 First time entrants to the Youth Justice System	249	1,279.1	876.4	2,436.3	342.9
	12 Children living in poverty (aged under 16 years)	8,270	22.8	21.1	45.9	7.4
	13 Family homelessness	58	0.7	1.7	7.4	0.1
	14 Children in care	335	80.0	59.0	150.0	19.0
	15 Children killed or seriously injured in road traffic accidents	11	28.7	22.1	47.9	4.4
Health improvement	16 Low birthweight	180	7.4	7.4	11.0	5.0
	17 Obese children (age 4-5 years)	252	10.9	9.5	14.5	5.8
	18 Obese children (age 10-11 years)	421	22.1	19.2	27.8	12.3
	19 Participation in at least 3 hours of sport/PE	13,242	55.3	55.1	40.9	79.5
	20 Children's tooth decay (at age 12)	-	0.9	0.7	1.5	0.2
	21 Teenage conception rate (age under 18 years)	145	39.1	35.4	64.7	6.2
	22 Teenage mothers (age under 18 years)	53	2.2	1.3	2.8	0.3
	23 Hospital admissions due to alcohol specific conditions	26	60.4	55.8	138.3	16.9
	24 Hospital admissions due to substance misuse (age 15-24 years)	35	136.8	69.4	186.3	25.7
Prevention of ill health	25 Smoking in pregnancy	426	17.7	13.2	29.7	2.9
	26 Breastfeeding initiation	1,368	56.9	74.0	41.8	94.3
	27 Breastfeeding at 6-8 weeks	669	27.8	47.2	19.7	82.8
	28 A&E attendances (age 0-4 years)	6,719	552.1	483.9	1,187.4	136.3
	29 Hospital admissions due to injury (age under 18 years)	630	149.0	122.6	211.1	72.4
	30 Hospital admissions for asthma (age under 19 years)	65	144.6	193.9	484.4	73.4
	31 Hospital admissions for mental health conditions	30	71.0	91.3	479.7	22.6
	32 Hospital admissions as a result of self-harm	82	194.0	115.5	311.9	26.0

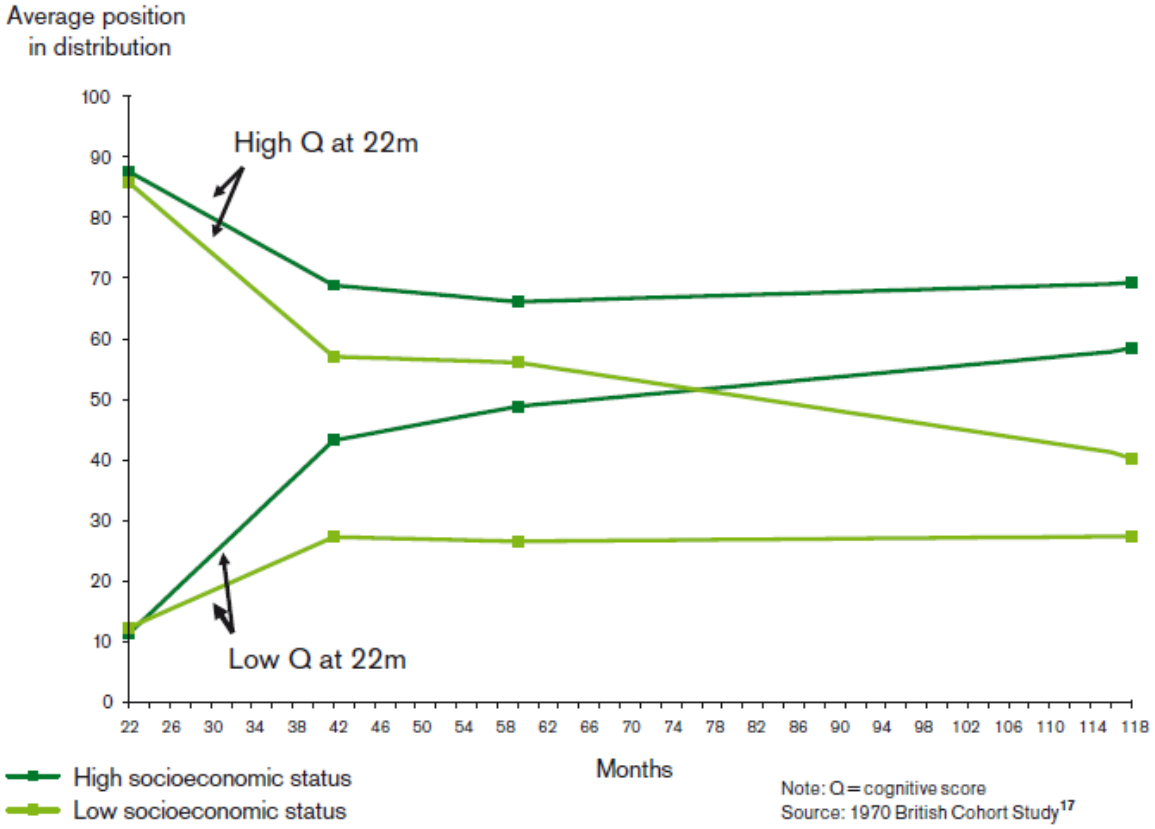
Notes and definitions - Where data are not available or have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2009-2011
2 Directly standardised rate per 100,000 children age 1-17 years, 2009-2011
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2011/12
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2011/12
5 % children in care with up-to-date immunisations, 2012
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2011
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2011/12
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2011/12 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local Connexions services, 2011
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2010/11
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2010
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2011/12
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2012
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2009-2011
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2011
17 % school children in Reception year classified as obese, 2011/12
18 % school children in Year 6 classified as obese, 2011/12
19 % children participating in at least 3 hours per week of high quality PE and sport at school age (5-18 years), 2009/10
20 Weighted mean number of decayed, missing or filled teeth in 12 year olds, 2008/09
21 Under 18 conception rate per 1,000 females age 15-17 years, 2010
22 % of delivery episodes where the mother is aged less than 18 years, 2011/12
23 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2008-11
24 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2009-12
25 % of mothers smoking at time of delivery, 2011/12
26 % of mothers initiating breastfeeding, 2011/12
27 % of mothers breastfeeding at 6-8 weeks, 2011/12
28 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2010/11
29 Crude rate per 10,000 (age 0-17 years) for emergency hospital admissions following injury, 2011/12
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2011/12
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2011/12
32 Crude rate per 100,000 (age 0-17 years) for hospital admissions for self-harm, 2011/12

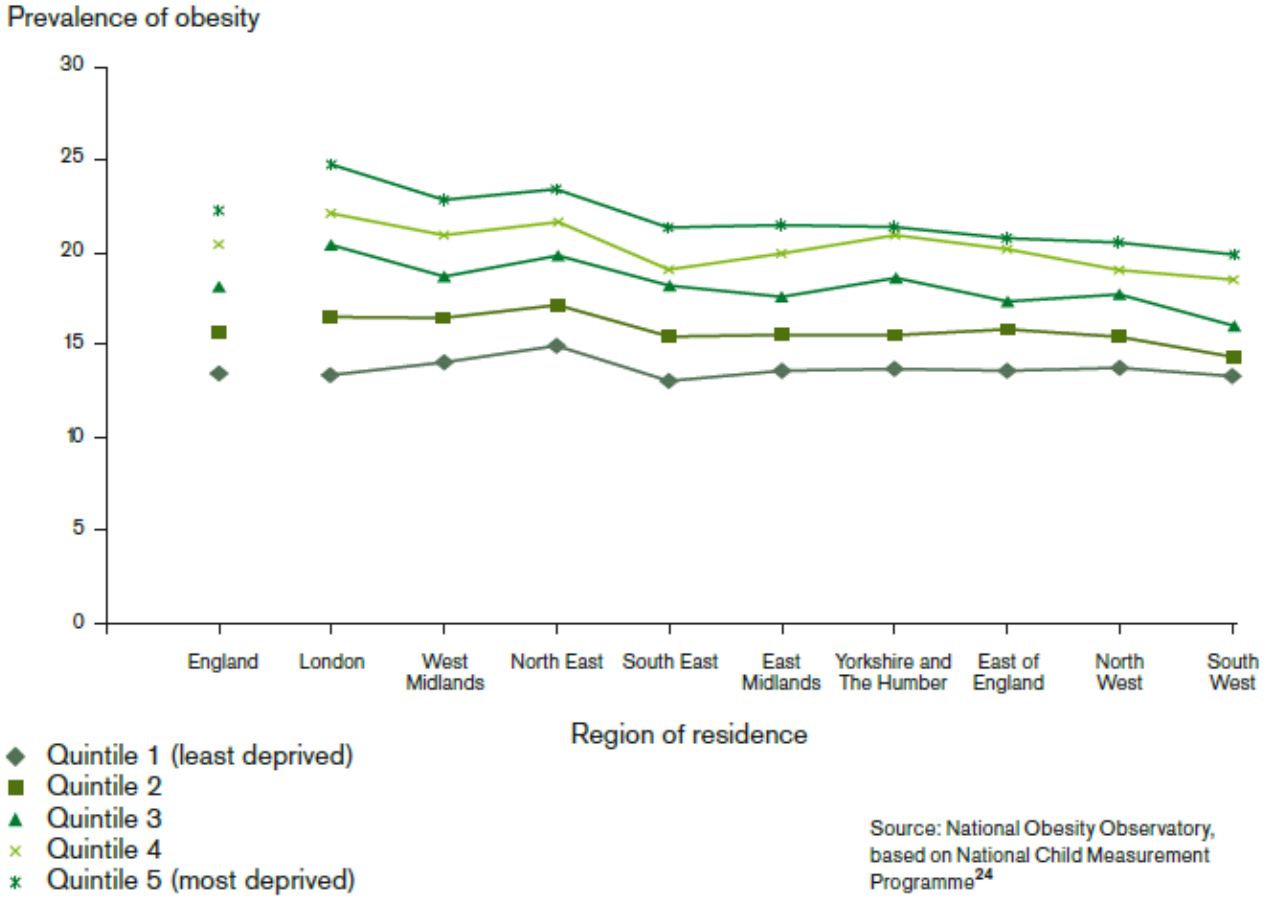
Appendix 2: Standardised limiting illness rates in 2001 at ages 16-74, by education level recorded in 2001(Marmot Review 2010)[1]



Appendix 3: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years (Marmot Review 2010)[1]



Appendix 4: Prevalence of obesity (>95 centile), by region and deprivation quintile, children aged 10-11 years, 2007/08 (Marmot Review 2010)[1]



Source: National Obesity Observatory, based on National Child Measurement Programme[24]

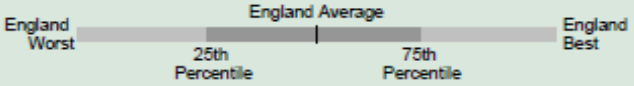
Appendix 5

Health summary for Stockton-on-Tees

E06000004

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	51565	27.3	19.8	83.0		0.0
	2	Proportion of children in poverty ‡	8415	23.3	21.9	50.9		6.4
	3	Statutory homelessness ‡	66	0.8	2.0	10.4		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1297	57.3	58.4	40.1		79.9
	5	Violent crime	2050	10.7	14.8	35.1		4.5
	6	Long term unemployment	1057	8.4	5.7	18.8		0.9
Children's and young people's health	7	Smoking in pregnancy ‡	430	18.4	13.7	32.7		3.1
	8	Breast feeding initiation ‡	1351	58.4	74.5	39.0		94.7
	9	Obese Children (Year 6) ‡	405	20.7	19.0	26.5		9.8
	10	Alcohol-specific hospital stays (under 18)	32	74.3	61.8	154.9		12.5
	11	Teenage pregnancy (under 18) ‡	173	45.1	38.1	64.9		11.1
Adults' health and lifestyle	12	Adults smoking ‡	n/a	19.6	20.7	33.5		8.9
	13	Increasing and higher risk drinking	n/a	22.6	22.3	25.1		15.7
	14	Healthy eating adults	n/a	21.9	28.7	19.3		47.8
	15	Physically active adults ‡	n/a	12.3	11.2	5.7		18.2
	16	Obese adults ‡	n/a	27.7	24.2	30.7		13.9
Disease and poor health	17	Incidence of malignant melanoma	24	12.5	13.6	26.8		2.7
	18	Hospital stays for self-harm ‡	682	369.4	212.0	509.8		49.6
	19	Hospital stays for alcohol related harm ‡	5571	2523	1895	3276		910
	20	Drug misuse	1847	14.5	8.9	30.2		1.3
	21	People diagnosed with diabetes ‡	7958	5.2	5.5	8.1		3.3
	22	New cases of tuberculosis	9	4.7	15.3	124.4		0.0
	23	Acute sexually transmitted infections	1067	555	775	2276		152
	24	Hip fracture in 65s and over ‡	170	440	452	655		324
Life expectancy and causes of death	25	Excess winter deaths ‡	76	14.3	18.7	35.0		4.4
	26	Life expectancy – male	n/a	77.6	78.6	73.6		85.1
	27	Life expectancy – female	n/a	81.8	82.6	79.1		89.8
	28	Infant deaths ‡	10	4.1	4.6	9.3		1.2
	29	Smoking related deaths	339	252	211	372		125
	30	Early deaths: heart disease and stroke ‡	151	71.8	67.3	123.2		35.5
	31	Early deaths: cancer ‡	275	131.6	110.1	159.1		77.9
	32	Road injuries and deaths ‡	64	33.3	44.3	128.8		14.1

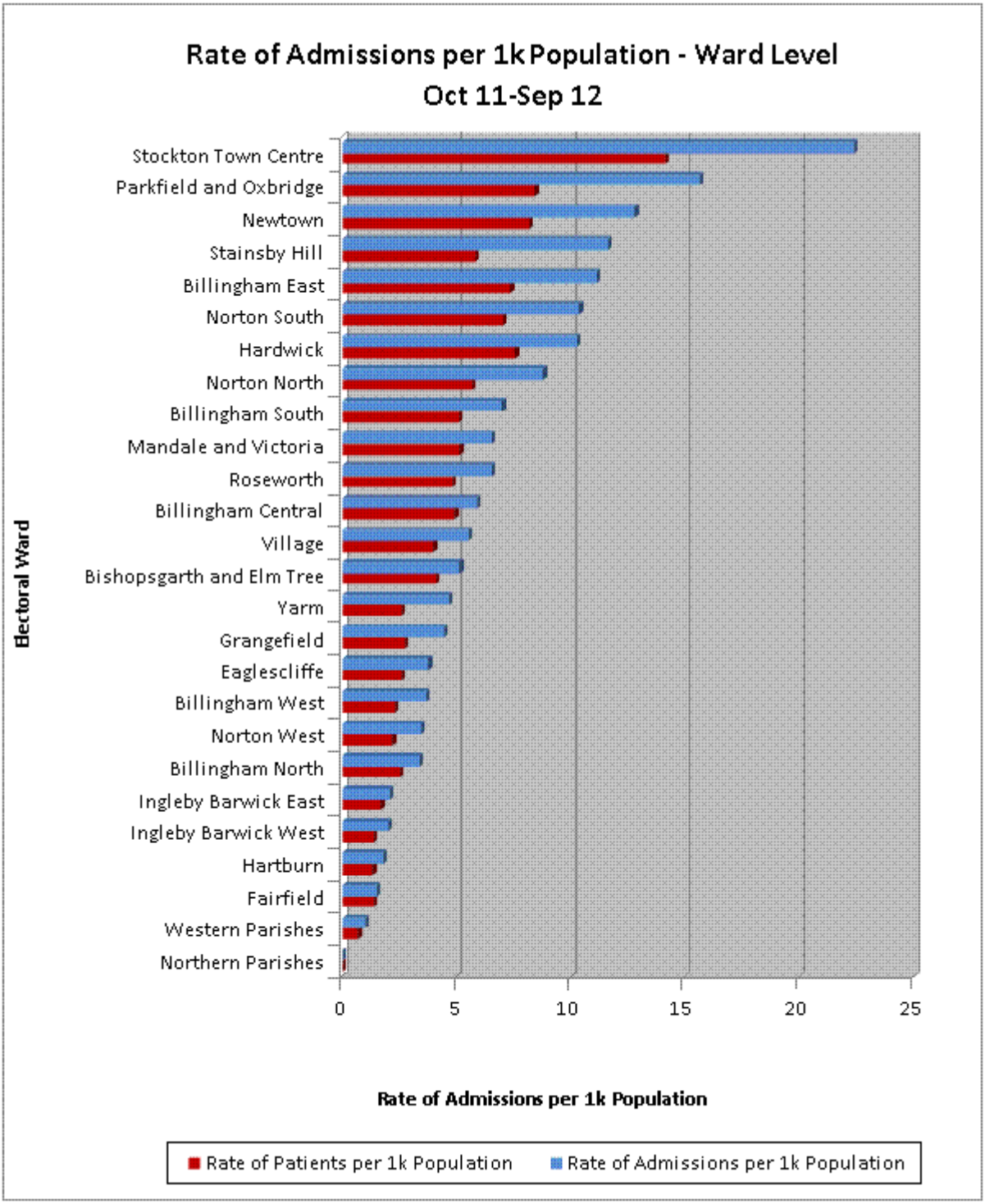
‡ Substantially similar to indicator proposed in the Public Health Outcomes Framework published January 2012

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2009 3 Crude rate per 1,000 households, 2010/11 4 % at Key Stage 4, 2010/11 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2010/11 6 Crude rate per 1,000 population aged16-64, 2011 7 % mothers smoking in pregnancy where status is known, 2010/11 8 % mothers initiating breast feeding where status is known, 2010/11 9 % school children in Year 6 (age 10-11), 2010/11 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2008-2010 12 % adults aged 18 and over, 2010/11 13 % aged 16+ in the resident population, 2008/2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % aged 16 and over, Oct 2009-Oct 2011 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2006-2008 18 Directly age sex standardised rate per 100,000 population, 2010/11 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2009/10 21 % people on GP registers with a recorded diagnosis of diabetes 2010/11 22 Crude rate per 100,000 population, 2008-2010 23 Crude rate per 100,000 population, 2010 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2010/11 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.07-31.07.10 26 At birth, 2008-2010 27 At birth, 2008-2010 28 Rate per 1,000 live births, 2008-2010 29 Directly age standardised rate per 100,000 population aged 35 and over, 2008-2010 30 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 31 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 32 Rate per 100,000 population, 2008-2010

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@sepho.nhs.uk

Appendix 6 – Wholly alcohol related hospital admissions



Map 1: Ward-level deprivation in Stockton (Source: Tees Valley Unlimited)