Better Health, Fairer Health

Consultation on a Strategy for 21st Century Health and Well-being in North East England

By the Regional Director of Public Health

Full Text of Responses to the Consultation

Questions 1 to 8

February 2008

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Q1	Should a regional health and well being strategy for the North East exist and how can it add value?
	[Janine A Ogilvie A07 - North East Community Forests] Absolutely, a regional strategy should exist. Added value is possible through local and regional knowledge informing the translation of national policy, providing a framework for regional work with local impact. Also a regional strategy could provide added value by working/consulting with non health partners regionally (private sector, public sector, third sector, communities), to make health everyone's business. **[Louise Wilson A08 - Individual]** Yes. **[Mike Lauerman A09 - CSIP - individual]** Yes, BUT this has to be on the basis of all relevant agencies signing up and clarifying their potential contribution **[Louise Wilson A10 - Northern CFS/ME Clinical Network]** Yes – experiences from working as a collaborative region-wide network have shown the benefits of working together, both strategically and operationally. For CFS/ME, there is a gap in service in one area and a region-wide view would be helpful to tackle that inequality. **[Jan Welbury A12 - consultant paediatrician - individual]** Yes, an excellent idea, but am very disappointed that there is so little reference to children and in particular to vulnerable children, who are in need of care and investment they have potentially preventable difficulties – failure to address them perpetuates the cycle of deprivation. At the present time – quality protects has become redundant and the issues have been forgotten. Look forward 20-30 years the health measures will be those of today's children – this group will produce a disproportionate volume of ill health. **[Brian Hedley A14 - Newcastle CC Strategic Housing Service]** Yes; the Strategy needs to have a very high profile to ensure that its objectives are reflected in all other relevant strategies which are intended to raise the quality of life in the North East. **[David Chappel A16 - NEPHO - individual]** Yes. It's been an obvious gap for years. For example it is difficult to assess health impact of other regional strategies without a benchmark of a regional health strategy. I believe that regional level activity is likely to increase rather than decrease in the future making this very important. **[Karen Horridge A17 - consultant paediatrician - individual]** Yes, an excellent idea, but am very disappointed that there is so little reference to children and in particular to disabled children, who are so often at the bottom of the pile in any strategic planning **[David Chappel A18 - NEPHO response]** Yes. We fully support the proposal to develop a regional health strategy and the approach being taken. Some general points relating to whole strategy to consider: • This is a broad strategy but still needs focus. • We wonder if the 25 year time period too long – perhaps 10 years might be better. • We think actions are generally more effective below regional level so need to be clear about what can be done at regional level to help front line be most effective. • We think this is a highly medical model – needs to be broader • It is also too long and needs to be in plain English It would be good to have greater clarity as to whether the proposals within the strategy were evidence-based and/or what the motivation for inclusion of each proposal is (perhaps with an appendix). **[Denise Orange A19 - Regional Health in the Workplace Group]** A regional health and well being strategy should exist, to provide focus and strategic direction. A statement of priorities for workplace health is being developed to provide a detailed action plan to sit under the overall strategy **[Bharat Sibal A20 - Public Health Trainees Group]** Yes. It is needed to provide a framework of reference and would add the political and moral dimension to the strategic direction of travel for various health related organisations in the North East. **[Vivien Hollyoak A21 - North Tyneside PCT]** The Strategy should exist to give justification and 'moral weight' to a common frame of reference for collective cross sectoral public health action across the region at local and regional levels. **[Brendan Hill A22 - VOLSAG, GVOC, MHNE]** It should, but it will only add value if it is targeted at, and signed up to, by key service commissioners and providers of health and social care, as well as being relevant to our

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	mainstream institutions and the general public. As well established Third sector coalitions and networks, VOLSAG, GVOC and MHNE would hope that the comments and suggested amendments detailed in Q19 will be considered for inclusion in the final document. **[David Lacey A24 - Community Energy Solutions (CIC) Ltd.]** It can perform the task of focusing the minds of many organisations with exceedingly disparate aims and objectives. **[John Woodhouse A25 - HPA]** Thank you very much for giving the HPA the opportunity to comment on this excellent strategy. The HPA very much welcomes the development of a health strategy for North East England. We are convinced that it will help focus attention on those areas where greatest progress may be made. The region should have a health and wellbeing strategy because it will add value in terms of helping more agencies and sectors focus on how the region's poor health can best be tackled. **[Rachel Turnbull A26 - Northumberland CAB]** Yes – but it cannot work in isolation. All parts of the jigsaw – that is national and local strategies must fit and complement each other. **[Gwen Ellison A27 - Health Trainers Coordination]** Yes it should exist as it offers added value from :- * its vision and challenges are specific to collectively working for better and fairer health, otherwise this will becoming second fiddle to other aspirations such as a more affluent north east. Regional leadership is important whilst allowing for more local creative solutions. * a strategy is needed to get systematic change and focus on what should be one of our most important aspirations and expectations in the north east *for health trainers the issue of excessively prioritising equality is important, positive action has achieved quick results for catch up around inequalities in the past. Relative worsening inequality is ethically unacceptable even if the case for significant absolute gain for all is more rewarding in terms of the population's health as a whole. The problem is not one of excessively prioritising equality but of ensuring equality is constantly on the agenda and gets serious attention. We need evidence for the extent to which equality has been prioritised and if so, have the actions been successful? **[Angela Ellins A28 - C&L GONE]** Need to ensure that current strategies & workforce (including field forces working from GO) are joined up and working on and across agenda's together Need to ensure that improving population health is everyone's business – so D&A workers need to address sexual health / sexual risk taking and vice versa **[Elaine Richardson A29 - Jobcentre Plus NE Region]** Yes, to reduce inequalities in health and to support improvement of the regional economy. The strategy also reinforces the governments welfare reform programmes, but makes it local to the North East **[Louise Wilson A30 - Sport England]** We are supportive of the principle of the development of a regional health and wellbeing strategy. It can only add value if it ties together other strategies and policies in the region related to health and as such needs to be owned and developed with the wide range of partners that can deliver improved health in the NE. Similarly any targets within the strategy should be targets that can be shared to help ensure a concerted joint effort. The NE will not become the healthiest region in England if we work individually to disparate measures. **[Peter Wright A32 - NE Chief EHOs Group]** There are tremendous possibilities for such a strategy to create radical improvements in health. **[Barbara Harrison A33 - National Offender Management Service]** NOMS NE welcomes the publication of the consultation document on 21st century Health and Well-Being in North East England. As the piece of work acknowledges, the burden of poor health and premature death suffered by people in this region is well known. One of the most interesting aspects of the document is the way in which it looks not merely at health-related issues, but also wider considerations around well-being. This links health outcomes directly to socio-economic, educational and environmental factors and implies that diverse agencies should work more closely together to achieve shared aims. The principle of joined-up, collaborative working underpins this document, adding value to a number of agendas. This is particularly important from the point of view of the National Offender Management Service, as offenders tend to suffer from a wide range of issues related to 'well-being', such as poor educational attainment, limited access to health / treatment services etc. One of the main aims of this organisation is to mainstream services

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	for offenders, in order that they have the same opportunities as everyone else. This is not acknowledged in the current draft of the document and we would welcome the recognition that the principles of better health, well-being and most importantly 'fairer health' also apply to offenders in custodial and community settings. **[Jennifer Taylor A34 - Tees Public Health Dept]** "Yes. If we are all working towards the same goals and giving the same messages then people will have more opportunities to hear the message. We will get economies of scale from campaigns across the region" "The North East has particular health problems and needs which this document has identified. However, to make any significant gains delivery of actions should be supported by necessary resources and if some targets have not been met, a supportive approach is needed to identify problems why and extra support brought in to aid" "I think that we need a strategy at both national and regional levels. The guidance nationally is not always 'sensitive' enough to accurately reflect regional or local issues. We must acknowledge that 'one size doesn't fit all', and special requirements in the North East can be addressed more effectively through a regional/local strategy" **[Kevin Rowan A35 - TUC]** It is clear that there are many strategies and public policy interventions organised and focussed at the regional level that have an impact on health and well-being, although there is often no explicit reference to health and well-being. The current Regional Economic Strategy begins to appreciate the value of health in economic terms, referencing the importance of occupational health in preventing people moving from work to incapacity, and that is an important lever. However, it could be argued that the RES is not constructed with a specific purpose of improving 'quality of life' for the region (some may argue that it should not be). Equally, finite public resources are allocated indiscriminately when it comes to health and well-being. This apparent lack of focus toward a sustainable, people-focussed outcome perhaps represents a gap in our public policy process. A regional health and well-being strategy may provide a vehicle which coheres and stimulates collaboration in varying regional strategies toward a greater public good than merely creating more jobs, increasing public transport use or improving the 'cultural offer' of the region. There is a more significant benefit from a regional health and well-being strategy, and that is to assess, inform and review the way in which health expenditure is prioritised and allocated. Is the split between primary health care and something more preventative apposite? A shift away from primary care to investing in health and well-being may deliver greater impact and prove to be a more cost-effective allocation of public expenditure. This should certainly be examined. **[Martin Shaw A36 - Natural England]** Yes. Opportunity to make connections between players / sectors, particularly helpful in engaging beyond the traditional 'health' sector. Opportunity to say more about sustainable development and use that as a vehicle for better 'joined up thinking' **[Leah Blacklock A37 - Community Action on Health]** CAOH feels that a regional health and well being strategy would be a useful and important addition to aid the North East's overall strategic direction. In terms of added value we believe the strategy will: - create a strong and prominent vision for the region around public health, clearly stating what people should expect over the next 25 years. - focus efforts on the key issues affecting the health of the North East, enabling people to take a step back from very local, smaller scale issues - enable joint-working across the region and with a range of partners including PCTs, local authorities and the voluntary and community sectors and from this will come the sharing of ideas and solutions, expertise and best practice - provide an infrastructure for the sharing of resources around public health - avoid duplication of effort **[Janice McColm A40 - Tees Valley Rural Community Council]** Yes there should be a regional health strategy. Each region in the country is different and has its own problems which cannot be addressed by one generic national strategy but each sub region should also be taken into account. Whilst both rural and urban

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	areas face similar health problems there are specific issues in rural areas such as social isolation and inadequate public transport that must be addressed. **[Peter Heywood A41 - Middlesbrough PCT - Individual]** Yes – • Should provide leadership and be clear about regional priorities • Should act as a catalyst or 'magnet' to draw locality work together • Should look to facilitate greater collaborative work across localities **[Ann-Marie Gibson A42 - National Energy Action]** NEA supports the development and implementation of a regional health and well being strategy. The North East has the highest incidence of fuel poverty in England and a regional health and well being strategy can synthesise policy areas generally considered to be outside the health agenda (housing, income maximisation, energy efficiency, educational attainment, etc.) and help focus attention on the potential health benefits to physical and psychological health resulting from a regional commitment to address fuel poverty. The strategy will also help those working to eradicate fuel poverty at a local level to engage with local health partners to highlight the significance of including fuel poverty commitments within a regional strategy and how the involvement of local health practitioners can contribute to the achievement of regional targets/commitments. **[Charlotte Clarke A44 - University of Northumbria]** Any developments, such as a regional document, with the intention of enhancing strategy and leadership for pubic health is to be welcomed. The inclusion of health and well-being in the title is also to be welcomed, although some regional definition might have been useful to enhance the contextual nature of the document and set clear contextual vision However, some coherence due to the absence of clear differentiation of what is local (i.e. PCO level) strategy and focus and what is at the regional level. This created some difficulty in commenting on the comprehensiveness or priorities identified in the document. Similarly, appreciating that health protection has a strategy of its own, the connections were not apparent. Some further clarity on what the added value of this additional strategy level and how the connections would be made would be welcomed. **[Tony Moore A45 Community Safety & Tees Valley]** NE currently the unhealthiest region in the country – measured by life expectancy and rates of major diseases. Life expectancy is not just something that needs to be measured by "boundary". The life expectancy of Gypsy's & Travellers is generally several years lower than gorgio's (house dwellers). There are clear links here to the quality of sites & pitches, the stresses with unauthorised encampments & the pressure to move on and the accessibility of services including hospitals. The strategy should support & inform other local & regional strategies as well as national policies to provide decent affordable accommodation provision for this group. Life expectancy of rough sleepers is significantly lower than the norm. This link should be highlighted & means to address supported – regardless of other PSA targets to reduce rough sleeping – it will never be totally eradicated, however access to & engagement with services should be proactively pursued by strategic authorities. Smoking, obesity, alcohol consumption and health inequalities are some of the biggest issues for the NE region Any strategic approach to address alcohol consumption will impact positively on homelessness, particularly rough sleeping. A focus on street drinking and addressing the definite need for "wet" houses in the region would be welcome. **[Chris Drinkwater A46 - West End Health Resource Centre]** Yes, but it needs to be a strategy for the North East and not for the NHS in the North East. The current draft is much more about what the NHS will do for you and not about what you can do for the NHS. There needs to be more about working in partnership to address the wider determinants of health such as employment, workplace health and sustainable development. There also needs to be more about the settings in which people live their lives such as family, schools and educational establishments, the workplace and communities. This would help to counterbalance the inevitable focus on individuals that results from a life-course approach. **[Heidi Jobling A47 - Newcastle Healthy City Project]** Yes. By providing joined up thinking, joined up funding. Clear and specific priorities for the region. A greater understanding of partners and their roles – and their responsibilities. **[Melanie Laws A48 - ANEC]** Firstly, you and your team are to be congratulated in putting together a Strategy which is very different in feel and content – readable, understandable and refreshing in approach. I think it fair

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	to say that the general approach taken to the draft Strategy has been welcomed– focusing not on repeating what is happening elsewhere but placing an emphasis on where doing something together might make a real difference. This has worked in areas such as smoking and we share your confidence that it can work in other areas too. The document articulates clearly and cogently a broad action plan for the activities of the regional department of public health, which I think is a welcome first, and we are looking forward to further discussion on the broad propositions in the Strategy as the journey moves forward – and how we might take forward other issues too, which are undoubtedly being raised by local authority colleagues, including food and fuel poverty, health at work etc. Indeed, the themes have great resonance with local government which has a key responsibility for the well being of citizens and communities. Health and health inequalities priorities and targets have featured strongly in all the region's community strategies to date and in the first wave of local area agreements. Now that many of the centrally driven constraints on LAAs are being lifted and the new Comprehensive Area Assessment framework is being developed, there is growing confidence in the sector for a step change in performance on health related targets in the new LAAs from 2008. Furthermore, in a local government context, the trend is towards moving away from a plethora of targets, focussing more on high level outcomes. One of the things we are looking at in this context is how we support focused and potentially shared support activity in areas that are common across all LAAs and as these emerge this would merit further discussion with you in the context of the health strategy. The general feeling is that the Regional Health Strategy should be ambitious and that delivering this ambition will require a firm commitment of all planning and delivery agencies. A further discussion around the specifics of key targets would also be useful. For example, every LAA in the North East has included reductions in smoking rates as a priority –some going much further than that proposed in the Strategy. Regional activity, therefore, might best be first based on supporting the delivery of the locally-based targets (which will have been agreed with PCTs and others) and then considering what collaborative activity can be stimulated regionally as a form of stretch target. The issue of buy in and ownership will be key to the success of the Strategy and to build a strong base of support from localities to a range of regional targets, this kind of approach might be adopted across a range of lifestyle and other factors contained in the draft Strategy. Delivery of the Strategy will, of course, also require the deployment of resource. It is not yet clear from where the resource will come and authorities have pointed out that from their perspective, assumptions cannot be made given the tight spending round. I am sure that this is not the intention, and a continued and iterative dialogue with local authorities will be important in taking this forward. **[Karen Evans A49 - Age Concern and Years Ahead]** Age Concerns in the North East and Years Ahead: the Regional Forum on Ageing agree that there should be a regional health and well being strategy for the Region. It gives a long term vision for everyone to commit and work towards. There will be added value by brining all the various strands, across all ages, together in one vision. We also agree with point 1.2.4 that Local Authorities and PCTs should act collectively and they may make bilateral and cooperative agreements, but it is useful to provide a forum in which the debate can take place. A regional strategy can be that forum. There are clear links between health and employment – As a region we have the worst health and the highest levels of people over 50 who are economically inactive in the country. If a regional health strategy and actions that follow on from it can improve this situation then value will be added to our economy. Age Concerns in the North East and 'Years Ahead' together with CSIP held a consultation event for older people and people who work with older people on the 6th December to discuss this strategy. Over 80 people attended the event. **See further comments from our consultation event at Appendix 1** **[Ceri Mather A50 - Health Improvement Solutions / TPHN]** YES! It should drive full integration of H&WB across the region and may stimulate more imaginative collaborations e.g. • All RDA incentives to bring employers into the region should REQUIRE good citizenship, health at work and health promoting green policies as part of contracts

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	• ALL GONE/LA and SHA decisions and directions should be Environmentally and Health Improvement Impact assessed • Currently the major emphasis is on the economy. More emphasis should be put on the long term costs of decisions such as promoting night time economy and the impact on teen pregnancies, liver damage, accidents and environmental impact • Coherent and integrated workforce planning across the public sector to ensure we have the right people in the right place with the right skills at the right time. We must do this collaboratively if we are to a) address the scenarios outlined by Leitch b) provide seamless services c) attract and retain good quality workforce d) ensure entire public sector workforce can encourage health improving behaviour through brief interventions and motivational interviewing whilst undertaking core tasks • Regional strategy should include commitment to ensure every village/locality has somewhere to buy an unwrinkled apple rather than tanning booths • Scotland has new Education/School Act Jan 08 which requires numeracy, literacy and health and wellbeing to be core to every other strand • Improve health through public policy Nancy Milio **[Richard Briggs A51 - Cruse Bereavement Care]** A regional health & well being strategy should exist to guide the PCTs and other health care organisations to ensure the best possible service to all members of the public at every level of need. Recognising and contracting more fully with the voluntary sector will widen services available to the public and help to reduce the demands on GPs and other NHS services giving value for money. **[Sue Gordon A53 - PH Consultant - Individual]** A regional strategy is useful in identifying key priorities for partnership working. The focus of the document should be on specifying the key problems and then highlighting the scope for a multi-sectoral approach to addressing them. The focus should be wider than the NHS and offer the scope for other public bodies to consider policy development in different areas with respect to health impact. **[Richard Pow A54 - Forestry Commission]** Yes. It can add value by: ▪ Identifying the long term direction of travel, in particular, the health priorities for the region that have been agreed by the region; ▪ Encouraging, valuing and co-ordinating the efforts of all stakeholders –not just the traditional "health sector" in tackling the issues to address these health priorities; ▪ Making health and well-being a higher priority (perhaps the highest priority) for the sustainable development of the region by influencing other regional plans and strategies. **[Andy Roberts A56 - Ncle CC Children's Services]** Yes, if it focuses on issues identified locally, is supported by stakeholders and links to local plans. **[Jan Bostock A57 - Northumberland Care Trust and NYW NHS Trust]** Very useful in validating local approaches and engaging partners **[William Norman A58 - Newcastle Learning Disabilities Partnership Board]** Emphasising and linking partnership working. **[Cynthia Games A59 - Living Streets]** Such a strategy would be welcome. Value could be added to the document by: • Integrating the strategy with all regional and national strategic documents • Allocation of resources to implementation at local level (e.g. in LAAs, MAAs etc) • Creation of a Social Strategy which does more than link health and wellbeing to economic regeneration

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	[Tricia Cresswell A61 - Durham & Darlington PCTs] Yes, it can provide a consistent approach to improve and reducing inequalities – but should still allow for local priorities and innovation. It can add value by providing a concerted, joined up approach at regional level **[Tim Blackman A62 - Wolfson Research Unit]** Yes, but there is a danger of regional strategies being developed in parallel to each other. A regional health strategy should be a full part of the Integrated Regional Strategy for the North East, ensuring that other dimensions such as economic development, housing and transport play their parts in improving health and narrowing health inequalities. This could be encouraged through ensuring that processes for health (inequalities) impact assessment are incorporated into strategic decision making across sectors. Otherwise there is a danger of strategies being developed in parallel. There also need to be clear links with national and local strategies (so that, as appropriate, the regional strategy is joined up with them) and clarity about leadership and resourcing. **[Madeleine Johnson A63 - PHNE - Individual]** It is essential to have a clear strategy for improving the health of people in the North East. **[VONNE A64]** Given, as outlined in the document, national policies, strategies, actions and targets are already influencing local policies, strategies and delivery it is questionable whether there is a real need for a regional strategy. However it is widely considered that a regional strategy could add value, and indeed should only exist if it can demonstrate that it is making a difference in addressing the health and social care issues of the region. To add value the strategy needs to be a framework which brings together statutory and third sector organisations recognising the role and value that both can, and do, play in tackling health inequalities within the region. It needs to identify synergies and gaps in current provision, making best use of resources to ensure equity of access to the best regional provision and services, thereby reducing, and hopefully ending, the postcode lottery effect. The strategy also needs to effectively influence other areas, and obtain recognition and commitments from other agencies and bodies that health and well-being isn't just a health issues and needs a holistic approach to make sustainable improvements. This is particularly pertinent to the fields of transport, housing and economic development. Most importantly the strategy should level the playing field to ensure that patients have access to the best services and support, whether these are provided by statutory organisations, or more specifically the VCS. To do this the strategy needs to be explicit in its reference to the value of VCS as a service provider, and ensure that the principles of full cost recovery are attached to a commitment to increase levels of funding support provided to the VCS. **[Caroline Wild A65 - Northgate Hospital Ctte Group]** Yes, if it helps everyone to be healthier **[Caroline Wild A66 - Learning Disability Directorate NTW NHS Trust]** The strategy was discussed at the Clinical Strategy Forum of the directorate, approximately 30 Clinicians and managers were present. The idea of a regional strategy was welcomed if it addresses and promotes the needs of people with a learning disability who are exceptionally affected by poor health and suffer disproportionately. They are also unlikely to be able to access current or proposed public health and choosing health programmes aimed at the general population. People with a learning disability risk being left behind even further if the strategy doesn't address their needs specifically. **[Dave Parkin A67 - Wallsend Town Hall]** Yes. It will provide a regional overview of the current practices and outstanding issues. It will provide the big picture for service providers **[Angus Anderson / Arthur Probert A68 - Attend Rights to Warmth]** Yes. It adds value by prioritising the most effective interventions to prevent as well as address health issues and to coordinate action within the region. **[Emma Gibson A69 - Gateshead Partnership Board]** Yes it should exist but the strategy needs to be signed up to by all sectors and by both commissioners and providers for Health and Social Care to make any really difference and value to the region. The strategy needs to build upon existing good work in some areas of the region to ensure both better and fairer health. The regional strategy should propose regional initiatives this would ensure use of the tool across public bodies and voluntary bodies in the North East.

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	[Stephen Blair A70 - North of Tyne PEC] The Strategy should exist to provide a framework to share best practice and performance across the Region. It can add value by supporting organisations across the North East to work together to address inequalities and to embed performance management systems into practice **[Craig Duerden A71 - Middlesbrough Community Network]** The Strategy could offer added value to ongoing public health activities, giving the region a focus and a voice when influencing the national agenda. Added funding may mean local issues will be tackled in a focussed way. The structure for governance will allow good practice to be shared and provide opportunities for information sharing. Value can be also added when giving recognition for existing services. The document itself examines and supports a long term approach to health improvement which professionals from a variety of sectors would encourage and also hope that his would be reflected in future funding streams in order to sustain the provision that exists and could potentially be developed as a result of the strategy. The long-term approach would hopefully be echoed throughout national policy and at local government level. The existence of a local public health strategy for Middlesbrough could even evolve to become a local delivery plan for the larger overarching regional strategy. **[Vera Bolter A72 - Elders Council of Newcastle]** A regional strategy can add value to local strategies if it relates to wider issues in public health, and influences other regional strategies, in particular the regional economic, transport, housing and spatial strategies. **[Joanne Lavender A74 - North East Chamber of Commerce]** A regional health and wellbeing strategy for the North East should exist. Improving the health and wellbeing of people in the North East is an important factor in the growth of the economy and the individuals' quality of life. The strategy should be based upon and benchmarked against an evidence base to demonstrate how improved health can contribute toward improvements in education, the economy and individuals' quality of life. **[Angela Dinsdale A76 - St Cuthberts Hospice]** It should exist only if it can indeed be a link piece as per figure 1 **[Martin White A77 - Institute of Health & Society]** Yes, we definitely need a regional health and well-being strategy The greatest value it can add will be if it provides an agreed programme of work to which all major stakeholders (including all branches of the NHS and relevant public, voluntary and private sector organisations) sign up, commit resources to over the next 25 years, and review regularly against agreed targets for achievement. There is some concern that this may appear as a centrally written, top down strategy, albeit with the very best of intentions. It is therefore critical that any such strategy has firm and wide ownership, to ensure that the words and aspirations turn into reality. It may be helpful to say that the health of the people living in the North East should be as good as the health of people living in other parts of the UK. Having an annual conference to keep everyone focussed, as suggested. **[Ruth Stevens A78 - NE Physical Activity Group]** Yes, but it needs to be a strategy for the North East and not for the NHS in the North East. The strategy can add value by tying together existing strategies and work in the region. It is important that this is a partnership document and not just an NHS plan. The current draft is much more about what the NHS will do for you and not about what you can do for the NHS. There needs to be more about working in partnership to address the wider determinants of health such as employment, workplace health and sustainable development. There also needs to be more about the settings in which people live their lives such as family, schools and educational establishments, the workplace and communities. This would help to counterbalance the inevitable focus on individuals that results from a life-course approach. **[J Chexal A81 - Soroptomist Society]** Yes, a regional strategy should exist to improve health and well-being and to improve the standard of living, quality of life and the economy. A regional strategy should complement and link local and national strategy and action for health improvement. Health is fundamental to a good quality of life. **[Gateshead Public Health Partnership A82]** We support the development of a regional health and wellbeing strategy. It can add value by coordinating work at regional level and showing leadership for work at community level.

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[Alma Laing A83 - Local Engagement Board Gateshead PCT] Yes the Local Engagement Board Members at the meeting to discuss this on the 17th December endorsed the idea of a regional health and wellbeing strategy and identified the following areas where a regional approach could add value. The strategy was introduced through a PowerPoint presentation but was not circulated in full, so not all questions have been addressed. The comments below were made by members of the public in facilitated groups.

	Research & Development	Social Marketing	Lobbying/ Legislation	Service Changes & Funding	Links with other strategies	Measurement & Standards	Governance
Smoking		Not discussed					
Diet & Obesity		Not discussed					
Physical Activity	✓	✓	✓	✓	✓	✓	✓
Alcohol	✓	✓			✓		
Mental Health		✓		✓	✓	✓	✓
Broader action	✓	✓	✓	✓	✓	✓	✓
Early help	✓	✓		✓	✓	✓	
A good death	✓			✓	✓	✓	✓

[Anne Simpson A84 - Redcar & Cleveland Partnership, H&WB LIT] as promised here are the comments from the Redcar and Cleveland Partnership, Health and Well Being Local Implementation Team meeting held on 18th December, 2007 in response to the Regional Consultation Document, Better Health Fairer Health. One Team Member who attended the event did confirm that a lot of the issues raised by the Group had been addressed in the Workshops. However the Group agreed the following response -

Generally, the document was considered to be very adult focussed. There is little or no mention of children and young people's health (and where it focuses on education, there are some issues with it!). Whilst an argument may be that the strategy is age neutral, as good health should be, there are specific issues that affect young people more - teenage pregnancy for example, where the north east has one of the highest rates in the country, highlighting the need for an emphasis on sexual health amongst young people. Also young people's substance misuse is addressed very differently to adult substance misuse, and this priority i.e. trying to prevent young people getting into drugs, or get them off them so that they don't take it into adulthood, as opposed to the sometimes more managing drug use in adult treatment, should be represented here. Young people's substance misuse is about prevention, which would then impact on longer term adult health.

Emotional health also gets little or no mention, and it's so important for children and young people in achieving their potential. Mental health is mentioned, but only in the context of age neutrality again, and the needs are different. Adults are generally more able to recognise when they have a problem and know

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	where to go for help (not always, granted), but children and young people often won't, and are hence more vulnerable. Many of the sources of poor emotional health - bullying, domestic violence, impact of family break up, they hide There is no reference at all to any national drivers - for example the Every Child Matters agenda and the "Be Healthy" outcome, with it's relevant performance indicators **[The Food Access Network A85]** The Food Access Network (FAN) is working to tackle diet-related ill health amongst the UK's most disadvantaged communities. By addressing the underlying causes of food poverty, we aim to ensure that everyone in the UK has access to healthy, affordable food – regardless of their income, age or social exclusion. The network currently consists of some 350 food projects working to improve the nutrition, health and wellbeing of their local communities. The Food Access Network –UK works closely with the North East Food Access Forum, and welcomes the opportunity to consult on the Better Health Fairer Health document, which we consider to be a challenging and ambitious contribution towards better health in the North East of England and of relevance to the UK as a whole. We support the aims and priorities of the strategy and applaud the inclusion of access to healthy and affordable food as a vital component of improving regional health and well-being in the North East. Finally, we hope, with our members, to continue to play a role during further development of this strategy. We agree that a regional health and well being strategy for the North East should exist and can add value. We would particularly welcome a forum to encourage people to work together across sectors and issues. **[Paul Hanson A89 - North Tyneside Council]** North Tyneside Council supports the development of a regional strategy aimed at improving the health and well-being of people living and working in the North East for areas where a wider approach adds value and results in economies of scale. However we also recognise that the regional strategy needs to be underpinned by local action in addressing the public health agenda using effective partnerships. Attached is the response from the Council on your response template. We are happy for you to post our response on your consultation website. We look forward to working with you on actions that will build on the vision set out in the strategy and result in improved health and well-being outcomes for the North East of England. North Tyneside Council are happy to support the regional strategy, recognising that improving the health and well-being of people living in the North East requires collaboration and economies of scale. However it also recognises that the regional strategy needs to be underpinned by local action in addressing the public health agenda using effective partnerships. **[Nonnie Crawford A90 - Individual]** Yes should exist…should focus on a few big areas where maximum benefit from working together strategically accepting implementation will be different and local (FRESH model)… I suggest alcohol, domestic violence, safeguarding children as three key areas **[Steve Brooker A91 - NE Sustainability Officers]** It is important that there is a document that identifies the health and well-being issues pertinent to our region – a national document won't do that. Once the sub-national review (SNR) has been implemented there will be a single integrated regional strategy (IRS) that pulls together the spatial and economic development strategies for the region. Health has a powerful influence on our economy and therefore needs to be picked up in the future IRS. It may be that the sub-regional health strategies do not pick up on all the key issues for our region in a cohesive way or do not clearly set out the need for regional partnership and cooperation to tackle the key issues. If so, it is important to have a regional health and well-being strategy that influences the content of the future IRS. If health and well-being are fully represented in the future IRS, at that point in time the health and well-being strategy will have fulfilled its role and can cease to exist. **[Peter Wright A92 - NE Public Protection Chief Officers Group]** Yes, there massive potential for the strategy to create radical improvements in health. **[Joyce Leeson A93 - Individual]** Yes, it needs to reach and involve as widely as possible – churches, football clubs, media etc. **[Nic Best A94 - Campaign to Protect Rural England]** The aspiration of the Strategy to be 'the piece of the jigsaw which links other regional strategies and objectives' is very appropriate. In this it echoes the aspirations

Q1	Should a regional health and well being strategy for the North East exist and how can it add value?
	of the emerging NE Strategy for the Environment which in a similar fashion seeks to put a valued and safeguarded environment at the heart of regional policy-making. Health and wellbeing, and a good quality environment are two sides of the same coin and appropriate linkages should be made. **[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96]** Yes it is vital that a regional framework exists to help co-ordinate activity at this level and create a reference point for sub regional health development. This is especially important in terms of a focus on inequalities. While this is identified as a principle on page 6 it would add value to work at a regional level if this principle was exemplified through all the aspects of the strategy. The relationship between this strategy and the Regional Economic Strategy, Housing Strategy, Transport Plan and Spatial Strategy is crucial. The strategy could be a vehicle for turning current indicators of being 'behind' other regions into strengths e.g. low car ownership. **[Jean Blair A97 – Individual]** This seems to have been pre-decided **[Nicholas Baumfield A98 - Arts Council England, North East]** The Arts Council welcomes the creation of a health and well-being strategy for the North East which focuses on the specific needs of people in the region and which seeks to use the combined resources of the region. The Arts Council and the arts sector have a long track record of working with North East partners to achieve regional outcomes. The arts have a strong contribution to make to the delivery of the intended outcomes outlined in the document and add value to the strategy. To do this the involvement of the arts needs to be at a strategic as well as delivery level. For example in local authorities the arts now customarily contribute to outcomes across the authority's priorities. This has been enabled through the process pioneered in the North East of Arts at the Strategic Centre and is now translated to Local Area Agreements and the work of Local Strategic Partnerships. The development of the strategy will certainly provide a forum in which there is collective action to pursue improved health and well-being and the arts should be part of this discussion. **[Cath Clark A99 - South Tyneside Local Engagement Board]** • Yes it should, it would enable people to have shared goals and objectives. • Useful as an overarching strategy – as a mechanism of collating each localities success allowing application in others – localities • Regional focus on public health will have more influence nationally • It should reflect local issues • May attract resources • Strategy – guidelines – for all agencies • Programme – communication with all agencies • Joined up working – information, bottom up approach, involvement of the public/individual • All agencies to sign up • Actions to be measured by university would be useful • Would add value, especially to tackle inequality • Should support better co-ordination of services • Will help to prioritise issues • Would we loose 'local focus? Local strategies might also be needed • Would facilitate better Campaigns – regional or national • 'Challenge' whether it will add value – Why? This middle level. Already with 'SOTW' merging there are services which suffer Other views Could add value by:- • Providing direction to local strategies • Inclusive of all agencies • Improve and link to services in existence • Improve the networks to help interventions work in local areas, i.e. joining up social care, police, PCT etc. • Work more closely with Youth Agencies to get over health messages i.e. Alcohol prevention **Areas missed** • substances misuse

Q1	Should a regional health and well being strategy for the North East exist and how can it add value?
	• stress level - mental health rephrase – broken down into something else, e.g. improving psychological/mental health issues • holistic areas of dentistry • housing **[Steve Ruffell A100 – HealthNet]** **Positive** Meet regional needs. Aggregate resources. Should exist but will it be adhered to? Yes - Need a regional strategy. Focus on our specific issues. Adds value because it addresses local issues. May attract local finance. Need to look at resources – best use. **Concerns** Need to focus on problems in our patch. Would anything be lost with a regional strategy e.g. smaller areas? Finance – costs. Power issues. Polarisation of services. What might work nationally might not work locally. If a regional strategy does not add value to local focussed initiatives then it will not be cost effective and good use of resources. A regional structure may prove costly and take resources away from local good practice. **[Alisa Rutter B01 - Fresh - Smoke Free North East]** Yes. Firmly agree that this is a necessary and very welcome development. It will help to focus a broad range of partners on key priorities for improving public health. It should also help to galvanise action and reinforce the substantial contribution that prevention will play to the improvement of health and wellbeing. Also believe that more could be achieved if there was greater emphasis on strategy across a regional level and not just through local activity. This strategy will help to ensure that there is a more coordinated, sustained and evidence based approach adopted across the whole region. It should also help to ensure that economies of scale are achieved through a more efficient use of local resources, if they are more effectively pooled **[Danny Ruta B03- individual]** There is no doubt that the North East needs a Regional Health & Wellbeing Strategy and this strategy should be warmly welcomed. It is right to emphasise the need for a regional strategy to add value to existing work and strategies; much greater clarification and consensus is required however on exactly how a regional strategy can add most value. Hopefully the full set of responses from the consultation will help achieve this clarity and consensus. The current document appears confused about how it could add value and is often contradictory on this issue. Specific examples with suggestions for improvement are included in the responses to questions 2, 3, 10, 12 & 13 below.

Q2	**Do you agree with the restrictions that have been placed around the development of this strategy, or is there a need to explore some of the pitfalls at greater length?**
	[Janine A Ogilvie A07 - North East Community Forests] A strategy should be a working document, with opportunity for review periods built in. Avoiding the temptation to restructure prematurely. **[Louise Wilson A08 - Individual]** Needs focus explicitly on agencies – health, education, social care/local authorities voluntary and private sector working together. The governance structure presented later might be adapted to reflect this. **[Mike Lauerman A09 - CSIP - individual]** Too often grand claims are made in drafting a strategy. A test must be as to how feasible are the aspirations.' Under promise and over deliver' should be the maxim. **[Louise Wilson A10 - Northern CFS/ME Clinical Network]** Pointing to where the information detailed in 1.3 would be useful. The caveat for the avoidance of describing structures must be that these are often inextricably linked with the 'how' for achieving solutions. **[Jan Welbury A12 - consultant paediatrician - individual]** I think there should be more work on child health, as it is well known that much adult ill-health and unhealthy life choices have their origins in childhood. The choices and lifestyles are cyclical and intergenerational – we must take the opportunity to act when these vulnerable children and their families are identified and act in a 'whole family' way diagnosing and managing holistically with the power of children's services the police and the judiciary behind us joining up the care and heath needs of children and adults in a sensible way. We should tackle the drug misusing, alcoholic and criminal sector who are parents and ensure that the services dealing with them remember the possibility that children are involved and are likely to be being adversely affected by their parent's difficulties. **[Brian Hedley A14 - Newcastle CC Strategic Housing Service]** I think that the Strategy needs to be as ambitious and extensive as possible and not be too restrictive in its aspirations to raise the standards of health and well-being. As such, it would appropriate to assess some of the perceived pitfalls in more depth. **[David Chappel A16 - NEPHO - individual]** Broadly Yes. However there will need to be a set of other documents alongside this strategy. For example the evidence-base for many suggestions is not explicit so this would need to be available and there need to be links to wider strategies. There may need to be different versions for different audiences. See Q12. Structure and process are necessary to make tangible these aspirations and must not be neglected. Leadership is most critical but needs the right structures to work While not disagreeing with 1.3.1.g I think it is phrased negatively, an alternative might be "We need to innovate and evaluate. Everything we do must have evaluation (and if possible research) built in. The exception is evidence-based interventions where simple monitoring may be sufficient." **[Karen Horridge A17 - consultant paediatrician - individual]** I think there should be more work on child health, as it is well known that much adult ill-health and unhealthy life choices have their origins in childhood. Also should address the needs for better health chances for disabled children. **[David Chappel A18 - NEPHO response]** Yes. See above **[Denise Orange A19 - Regional Health in the Workplace Group]** We feel that context is lacking in terms of the changing skills base in the region, including migration and the extended working life of the population **[Bharat Sibal A20 - Public Health Trainees Group]** On the overall, yes. However, it is imperative to ensure that the Health care / quality of care element of Public Health should not fall behind the health improvement agenda. **[Vivien Hollyoak A21 - North Tyneside PCT]** There is no evidence of 'excessive prioritisation of equality' and very little prospect that closing the gap will be resourced at the expense of population health improvement. For decades the NHS and public health have demonstrated a weak resolve when tackling inequalities. We must not be persuaded by our own rhetoric. We are a long way from realising the level of resource and effort required to make a difference, which is why we have not made any impact upon the life expectancy gap. Closing the gap is the number one priority for the North Tyneside LAA and Sustainable Community Strategy and it is essential that the Regional Strategy gives it full and unequivocal support to reducing health inequalities.

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	[John Woodhouse A25 - HPA] in general we agree with the restrictions that you have placed on the development of the document. It is of the utmost importance that such a document should be pragmatic and capable of execution. We strongly support the principle of equity. We would encourage some specific discussion of health protection issues and we would be happy to support the development of a health protection focused annex or specific section in the final document. **[Gwen Ellison A27 - Health Trainers Coordination]** It has been useful to be presented with a comprehensive strategy that allows agreement and disagreement. The pitfall is the extent to which it can be changed, once written and also the lack of participation mitigates against collective ownership and action. The pitfalls can be avoided if there is greater involvement and participation in planning implementation and action. **[Elaine Richardson A29 - Jobcentre Plus NE Region] Agree with the restrictions applied, as there is no negative impact on the message/context** **[Louise Wilson A30 – Sports England]** We understand the principles behind the omission of background information relating to the pitfalls. However, it is useful to provide a context for the strategy and assumptions cannot be made about the audience – some readers will not have an in depth knowledge of the region's health. Likewise, there are some areas which lack data, such as obesity, which it would be useful to include **[Barbara Harrison A33 - National Offender Management Service]** On the whole, the restrictions placed around the document are useful in the sense that they keep the work focused and succinct. In our opinion however, it is important to acknowledge the integral role played by small, often voluntary projects across the North East, in providing services for local communities. This particularly applies in areas where mainstream provisions are either sparse or weak (for example alcohol treatment services) and often in the most deprived and excluded communities in the region (such as the South Bank Women's Centre in Middlesbrough). Whilst it is essential to invest in mainstream service provision, it is also important to bolster the wide range of voluntary projects catering for individuals and communities in all areas of the North East. **[Jennifer Taylor A34 - Tees Public Health Dept]** "There seems to be a good spread of issues to work on, all of which will work towards improving health. Even if people make one change from the selection, it will be of benefit to their health i.e. not everyone smokes but they could make changes to their diet to improve their health or take more exercise." "There has to be some boundaries kept, otherwise the strategy will become too large and results unattainable. From mid term outcomes it will become apparent if further examination of some areas to improve results is appropriate" **[Kevin Rowan A35 - TUC]** It is the view of the TUC that there can be relatively little value in simply regurgitating the series of statistics that continue to expose the north east as a place where ill-health and health inequalities remain pervasive. An attempt to add value to current strategic frameworks, to shape and cohere public policy intervention around key aspirational outcomes over a longer term is welcome and, given the right response, a more sustainable and effective way to consider public policy. A focus on more aspirational quality of life outcomes is potentially an inherently cohesive dynamic, especially for the public sector. It is hard to argue against interventions that have this ambition as an outcome. It would not, however, diminish the necessary negotiations and wranglings over priorities for finite resources. **[Martin Shaw A36 - Natural England]** Useful idea to separate 'fact collection' from 'plans and strategies'. Suggest that more needs to be done to evolve the 'state of the region' report into an inclusive document that delivers for social, health, environmental AND economic data. We clearly need better data and evidence but we also need to better present the evidence we do have. A strengthened state of the region report could then form the reference document to a number of regional strategies. This involves the continued development and aligning of both NERIP and the Health Observatory. We then need a regional health strategy to set out a strategic vision and to develop actions that can make a difference. **[Leah Blacklock A37 - Community Action on Health]** CAOH believes that in terms of scene-setting it is useful to have a short contextual information section, namely facts and figures for the region in comparison to others and England. This would enable a baseline to be drawn and progress as a result of the strategy to be

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	measured. Although we agree that it is not necessary to document and describe each of the strategies it is important to acknowledge their aims and objectives so as to make sure the regional health strategy complements those already in existence and does not significantly contradict other strategies or overlook issues identified in these documents. We agree that concentrating improving upon an area which already has a 95% coverage should not necessarily be a target but urge strategists not to lose site of these areas and the fact that the other 5% may actually be within easy reach. CAOH feels that although excessive description about the process of developing the strategy is not necessary, it is important to provide a brief explanation of the process and particularly who was involved in the consultation process. In terms of suggesting an action for a particular problem just to show it has been identified, CAOH also feels this is not necessary but would suggest including such issues in the document with a caveat around further work in this area and possible inclusion in future strategies. Finally, CAOH does agree with the statement about absolute inequalities but again would urge policy makers not to lose site of the worsening inequalities in particular areas. If these are not addressed in the final document we would suggest an acknowledgement of them and an instruction around local policies picking up these issues. **[Janice McColm A40 - Tees Valley Rural Community Council]** This should not be another talking shop. If statements are made about what the intentions are then they should be followed through. The strategy should take into account the work that is already being undertaken by the voluntary and community sector and enhanced not replaced. **[Peter Heywood A41 - Middlesbrough PCT - Individual]** I agree – need boundaries and parameters otherwise becomes too unwieldy and looses it's focus **[Ann-Marie Gibson A42 - National Energy Action]** NEA concurs that the restrictions placed on the development of the strategy are valid and that there is no need to explore further the pitfalls outlined in this document. **[Chris Drinkwater A46 - West End Health Resource Centre]** Think g) and I) need further exploration. There are complexities about separating needs and wants, in terms of everyone gets the amount of treatment they need/want. There are also issues about absolute gain for the whole population in the presence of widening inequalities that mean some individuals are worse off. This is a particular issue for the North East because the inequalities gap is wider than in most other regions. **[Heidi Jobling A47 - Newcastle Healthy City Project]** Yes, this is such a massive issue we need to focus somewhere however it does need to link in with local and national funding streams and strategies. **[Karen Evans A49 - Age Concern and Years Ahead]** On the whole, yes, we agree with the restrictions that have been placed around the development of this strategy – however we consider that point i) 'Finally, we are keen to negotiate carefully the problem of excessively prioritizing equality, or even in some cases equity, over opportunities for improvements to the population's health as a whole' may benefit from some further exploration. This document has been produced at the same time the new Equality and Human Rights Commission has been launched and would benefit from prioritising the six diversity strands covered by the Commission if not 'excessively' but certainly to some degree. Whilst we agree that improvements to the population's health as a whole is a key issue, this is too general an approach. There are various experts in the region who have a wealth of information on particular strands of diversity and their priorities and issues in relation to health. These views should be sought in the development of action plans or working groups that may develop from this strategy. Age Concern in the North East and the Regional Forum on Ageing 'years ahead' would be more than happy to discuss issues around ageing and health in more detail. **[Ceri Mather A50 - Health Improvement Solutions / TPHN]** I think we do need to consider structures in terms of what can the region do, how will this effect functions at PCT/LA level and in turn communities.

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	We need to be clear about funding streams and STOP short termism. It is worse to start something, raise expectations and dependency and then withdraw at the end of that fund e.g. HAZ, NRF, SRB than it would be to do nothing at all. We should all by now be familiar with the evidence base and able to adapt to meet the expressed needs of the communities we serve through employing social marketing techniques. **[Richard Briggs A51 - Cruse Bereavement Care]** The reasoning in the section on Avoiding Pitfalls appears sound. **[Sue Gordon A53 - PH Consultant - Individual]** The wording of the text implies a pragmatic approach to reduction in inequalities when traded off against a net increase in health improvement for a wider population. Checking that developments should not further cause disadvantage would seem to be still a reasonable principle. **[Richard Pow A54 - Forestry Commission]** Yes. We agree that the strategy should focus on what should be done and not elaborate on the current health of the region when this information is readily available elsewhere. We also agree that the strategy should not be a list of current activity but this list does need to exist somewhere and be readily available as without reference to it the reader is not reassured that the strategy has identified the gaps in current activity that are most appropriate to for the strategy to fill. **[Andy Roberts A56 - Ncle CC Children's Services]** Yes **[Cynthia Games A59 – Living Streets]** Living Streets concurs with the VONNE response **[Tim Blackman A62 - Wolfson Research Unit]** It is unclear whether proposals for new initiatives in the draft strategy are bids for additional funding or would entail top-slicing existing local budgets. If the latter is the case, then decisions over these funding priorities would need to be made in the light of the potential impact on local priorities and service developments. All proposals in the document should make clear what levers of change will be used to achieve their implementation, how budgetary provision will be made, and how priorities will be agreed with local delivery partners in the light of existing national priorities and targets and resource constraints There is a need for a clearer statement of the evidence justifying specific proposals or a rationale for piloting the proposal, and a statement of how the costs and benefits will be evaluated. **[Madeleine Johnson A63 - PHNE - Individual]** I understand why this approach has been taken for the Health & Wellbeing Strategy. However, there is a need for a single plan that describes all the main strands of public health activity, and this does not currently exist in the North East. The availability of an overall plan is particularly important for members of staff working within Public Health North East who need to understand how their work contributes towards the delivery of the overall public health agenda. If this full range of activities isn't described in the Health & Wellbeing Strategy, then further internal work needs to be done to provide this clarity. As it is also proposed that the Annual Reports will be based on the content of the Health & Wellbeing Strategy, there is further opportunity for staff who do not work on these areas to feel disenfranchised. A separate planning & reporting mechanism is therefore required to ensure that this does not happen. **[VONNE A64]** In principle we agree with the majority of the restrictions however there are concerns with regard to the context and terminology of the language used, and possible negative interpretations. For example paragraph 1.3.1d, describes the need to avoid exhortations where there is only a marginal chance of improvement. It specifically states "if an action to improve health already has 95% coverage, there is limited value in seeking the other 5%." Although we recognise the sentiment behind the statement, it could be negatively interpreted to suggest that resources should be diverted away from actions to improve health in the area of the other 5%. We would point out that the 5% may represent the must critically significant part of the health improvement action, which would affect a sea-change in the regions health & well-being. In paragraph 1.3.1e, it states "we have also avoided excessive descriptions of structure and process." Whilst we welcome this statement, as it is too easy for a regional strategy to get bogged down in the process and lose sight of the vision, a clear statement of where these descriptions of processes and structures can be found needs to be included in the strategy, perhaps in an appendix or bibliography.

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	VONNE has great concern with regard to the wording and tone used in paragraphs 1.3.1f and 1.3.1g, which we believe needs further exploration and debate. It appears to suggest there should be a requirement for evidence of effective interventions before projects are commissioned and small projects "do not comprise a systematic approach to improving health and well-being." VONNE would welcome a regional debate as to what constitutes evidence of effective interventions. A large number of VCS projects are set up and developed because there is either a need to plug gaps in statutory provision, or there is a belief that better quality and more holistic services can be delivered. They are often started without firm evidence of whether it would be an effective intervention, as judged by statutory organisations, but quickly go on to establish their credentials and value. We would argue that it does not mean that they are any less worthy than projects delivered with a clear evidence base, and therefore should be welcomed. VONNE would also point out that one of the main reason the evidence base is often thin, and the evaluation is rarely adequately funded (para 1.3.1f), is due to the lack of appropriate levels of funding provided by commissioning bodies and statutory funders to the delivery of VCS projects. This often does not incorporate an amount to cover effective evaluation and reporting. We suggest ensuring appropriate and commensurate levels of funding are provided to the VCS for service delivery should be a core theme in the regional strategy. The wording of these two paragraphs (1.3.1f and 1.3.1g) seems to imply that the regional strategy should be risk averse. VONNE would contend that to achieve the desired change in the region's health and well-being, a regional strategy should encourage innovation and risk, where appropriate, and that it should be prepared for some projects to fail, but only if we can share and disseminate the learning. We would particularly welcome this emphasis in the commissioning and procurement of services from and with the VCS. VONNE have concerns with regard to the wording used in paragraph 1.3.1i and would seek greater clarification and discussion. Although we empathise with the predicament faced in delivering the desired change in the region's health, we can not agree with the following wording "…that a significant absolute gain for all, even in the presence of relative worsening of inequality, may be worth talking." The NHS was founded on the principles that health care should be free, available to all, and of uniform quality no matter where people lived or what their background. VONNE believes a regional strategy for health & well-being developed by NHS North East should reinforce these principles and ensure the focus is on improving the quality and access for all. We would suggest that any proposal which leads to a worsening of inequality would not be the correct one. However we recognise the dilemma, as outlined, and would welcome further discussion. **[Caroline Wild A65 - Northgate Hospital Ctte Group]** 'If you live in Hospital, it's really difficult to be healthy.' (service user) The strategy must not focus on helping most people if it misses out people who really need help **[Caroline Wild A66 - Learning Disability Directorate NTW NHS Trust]** There is a need to explore how people with a learning disability can be empowered to access public health programmes and initiatives and how specialist services, local authority learning disability teams and LD Partnership Boards can engage local Directors of Public Health in addressing the public health needs of people with a learning disability. **[Dave Parkin A67 - Wallsend Town Hall]** Agree **[Stephen Blair A70 - North of Tyne PEC]** The Strategy should be restricted with the emphasis being on the main public health priorities and closing the health inequalities gap **[Craig Duerden A71 - Middlesbrough Community Network]** The pitfalls are all valid, though when debating equality it will be important to ensure that representation at a local level is equal and occurrences of 'inequality' do not occur when funding is allocated. Here is it important that the links between regional and local are strong in order to maximise effectiveness. The focus on improving health opposed to highlighting the problems is welcomed and looking forward to 'getting better' is essential as the region is constantly reminded of its poor health. **[Angela Dinsdale A76 - St Cuthberts Hospice]** I agree with the restrictions and that the strategy should avoid description of the existing situation, that it should be concise and there should be measurable outcomes. **[Martin White A77 - Institute of Health & Society]** Yes, strongly agree. Congratulations on taking a robust approach to this.

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It is important to keep the ultimate document succinct and short, otherwise it will just sit on a shelf collecting dust (i.e. no deeper or further exploration is required, and probably less).

[Ruth Stevens A78 - NE Physical Activity Group] It would be useful to explore some pitfalls to set the context of the plan – headline statistics rather than reams of text. Some people picking up the document will not be aware of some of the region’s health issues

[J Chexal A81 - Soroptomist Society] Yes, we agree with the restrictions placed around the development of the strategy.

[The Food Access Network A85] We welcome the avoidance of using deprivation data to bulk out a strategy document. Statistics tend to alienate communities and discourage the kinds of forward thinking policies that this document advocates.

We also agree that supporting a range of under-funded, short-term community food projects is not an adequate long-term solution to the kinds of health and well-being inequalities which this document aims to tackle. However, many community food projects create and maintain a wealth of local knowledge about how to tackle many of the problems stated in the strategy. Many projects are effectively addressing public health issues, despite the difficulties of demonstrating this through a formal evaluation with quantitative methods, so the regional strategy would do well to draw on the insight of the communities under consideration.

[Paul Hanson A89 - North Tyneside Council] The strategy needs to include a built in review structure, time to reflect on progress and reaffirm priorities.

[Nonnie Crawford A90 - Individual] I agree with restrictions.although recognising not all who read will beas conversant with where to find info as PH staff…a good bibliography and/or web address list would be useful

[Steve Brooker A91 - NE Sustainability Officers] We agree with the restrictions and do not think there is a need to explore the pitfalls at greater length.

[Joyce Leeson A93 – Individual] The great Victorian Public Health pioneers had to defy vested interests and if no certainty existed, work on best guesses. The same is needed today.

[Nic Best A94 - Campaign to Protect Rural England] For maximum influence, the strategy needs to be accessible across a wide variety of sectors. A long, statistic-ridden strategy would not achieve this. Rather, the strategy should indicate activities and approaches that can be incorporated into a wide-range of action plans in different sectors. The language used should also be clear to a range of sectors.

[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] There is a need to tackle some of the ‘how’ questions once the direction of travel is clear. ‘Excessively prioritising equity’ is hardly possible: we think that aspirational targets encourage us to aim high. Given the pull of the inverse care law, the push should be always towards equity, without any such caveats.

[Jean Blair A97 –Individual] Local Level is very important to services offered to public.

[Nicholas Baumfield A98 - Arts Council England, North East] It is important to emphasize that the arts do not represent a ‘fig-leaf’ approach to health and well-being even if initiatives sometimes appear to be project-led and short-term funded. The joint publication with the Department of Health of A Prospectus for Arts and Health and the considerable body of research and evidence of the benefits of arts and health engagement reinforce the now widely shared agreement that the arts make a direct and valuable contribution to better health.

[Cath Clark A99 - South Tyneside Local Engagement Board]

Generally yes
Good death – should this not be dignified (re-phrase)
Innovative ways to include children in physical activities from nursery age up.
#5 achieving better health through broader aims through better health – school curricula – diet – exercise – life skills
perception of stigma – vulnerability – recognition
Yes for well being strategy
Don’t understand areas 5 + 6 how would Joe public interpret this statement?
A lot of focus areas seem to link into one
Diet and Obesity should not be seen as a separate entity to physical activity

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Q2	Do you agree with the restrictions that have been placed around the development of this strategy, or is there a need to explore some of the pitfalls at greater length?
	• All 8 objectives interlink • the word ‘diet’ should be “healthy living” or nutrition • Physical and mental health well being cannot be separated • the objectives will be achieved more easily by all agencies working in partnership, • drug/substance misuse is missing from key focus areas • people focused • Sexual health not given sufficient priority • More caring, considerate approach to health care • ‘Choice issue’ • Parenting skills should encompass educating parents around sexual health. **[Steve Ruffell A100 - HealthNet Consultation]** Place for evidence base, however time delay on outcomes. Recognition / capturing of voluntary sector positive impact on health and added value offered which may be difficult to capture with ‘evidence base. Additional research resource to measure impact of voluntary sector. Economic wellbeing / early intervention Long term aspirations – priority commissioning Evidence base interventions balanced with freedom to be innovative. Brief section on encouraging greater engagement, flexibility and creativity. More response to needs. Consistency is essential – 25 year SLA with +/- 3years revenue. No short-term solutions Replicate / build on existing good practice. VCS able to responds quickly and decisively, needs to be recognised and encouraged. There should be social interaction – maybe something to develop into engage with others. People know what to do but they don’t always do it. Need to liaise in confidence to encourage people to socialise and participate. Need to offer support to help people learn. Social resources at local level – i.e. community group. Need new ways to encourage people to engage 25 years was felt to be too long a stretch – however a vision of what South Tyneside could be in that length of time seems fair. Sustained approach across the initiatives and evidence based interventions do work – so this should continue with consistency. **[Danny Ruta B03 - individual]** It is right to restrict the remit and scope of the strategy; particularly with the intention of focusing on where we want to be, not including socio-demographic data and descriptions of current activities. I take issue with one restriction, and would like to propose an additional restriction. Section 1.3 places undue emphasis on experimental research evidence as a key ‘restriction criterion’ for deciding which health improvement priorities and actions should be included in a regional strategy; this reflects a very ‘biomedical’ paradigm, and consequently skews the whole strategy toward biomedical interventions and approaches. 1.3 g states that ‘in the absence of evidence … there is a temptation to fall into the trap of doing anything rather than nothing’ and that ‘this is often worse than doing nothing at all’. In the absence of so called ‘hard’ evidence from experimental research the whole point is we cannot be sure if our interventions are better or worse than doing nothing at all. I think we are now erring too much on the side of ‘inaction’ rather than ‘action’ in the policy arena of health improvement, where experimental study designs are not feasible or not appropriate for evaluating many complex multi-agency interventions aimed at behavioural change. Of course, wherever possible, health improvement actions should be based on evidence of cost-effectiveness; however lack of rigorous experimental evidence should **not** be confused with evidence of lack of cost-effectiveness. We should be much bolder in implementing health improvement actions where local pilots and evaluations give us good reason to believe that such actions will be effective, even where the hard research evidence is lacking. As it stands the strategy encourages the opposite; an example is in section 3.5.15 on page 30, where the strategy states ‘there is little if any persuasive evidence that additional curriculum-based sport and physical education has any effect at all on obesity. What evidence does exist is generally equivocal, negative, poor in design or based on levels of intervention that would be unsustainable in practice’. I would draw the opposite conclusion, i.e. that based on observational evidence from other fields such as tobacco control, regionally we should actively encourage the piloting of whole-system multi-intervention approaches to tackling childhood obesity, where increased curriculum based sport forms a key component. We should evaluate these (using non-experimental or quasi-experimental methods) and roll out the most cost-effective components across the

Q2	**Do you agree with the restrictions that have been placed around the development of this strategy, or is there a need to explore some of the pitfalls at greater length?**
	region. The strategy perhaps ought to be much more restricted in what it includes within the scope of health improvement. We struggled with this in the development of Newcastle's Wellbeing and Health strategy: our solution was to clarify the distinction and relationship between wellbeing/quality of life and health and to restrict our definition of health improvement explicitly. In Newcastle we agreed that when we talk about a person having a good quality of life or enjoying a high level of wellbeing, what we really mean is that a person has the capability to do and be the things that we value in life. In other words: 'Wellbeing (or quality of life) can be defined as the gap between what a person is able to do and be in life and what they would like to do and be' Achieving good health is really just the means to an end – that is being able to do all the things you want to in life – in other words health is just one of many means to achieving wellbeing (or quality of life). This semantic distinction and causal relationship between wellbeing and health explains why in Newcastle we opted for a wellbeing and health strategy and not a health and wellbeing strategy. Many social, economic and environmental factors can have a direct influence on a person's well being. For example having a good income means a person can afford a comfortable home, can get about to do the things they enjoy, the things that most people value in life. Local and regional regeneration, housing and other strategies impact directly on wellbeing in this way and a health and wellbeing strategy adds little value to these. However, income and other economic and environmental factors can also directly improve health by enabling people to make healthier choices about what to eat, where to live and what type of work to do. In our Newcastle strategy we therefore restricted our use of the term health improvement to mean: 'Any action taken to address the underlying factors and lifestyle behaviours that directly improve physical, mental and social health' This focus on action that exert a direct influence on health immediately restricts the priorities and actions in a strategy; it excludes some priorities and actions that are included in the regional strategy. The best example is the focus on educational attainment in section 3.5.12 on page 29. Yes, educational attainment has a huge direct effect on wellbeing. Yes, a sizeable part of the impact of educational attainment on wellbeing is achieved through the indirect effect of education on health (e.g. through improved employment opportunities). I would argue that a regional education strategy can add value here but not a regional health and wellbeing strategy.

Q3	Are the principles outlined the correct ones upon which to base a health and well being strategy? Are some over-restrictive? Are there other principles that should be observed?
	[Janine A Ogilvie A07 - North East Community Forests] j) Value for money/cost effectiveness. Might be better if we consider whole life cost, in order to measure triple bottom line (environment, economic, social) impact as these are all identified important elements of health. Whole life cost is less biomedical in line with the regional strategy and national public health guidance. **[Mike Lauerman A09 - CSIP - individual]** To build on strengths at individual, family, community, local authority and regional levels. To guard against the risk of assuming that what might appear to be 'malfunctioning' elements of the system do not have any capability and capacity. **[Louise Wilson A10 - Northern CFS/ME Clinical Network]** In general yes. We have recognised the need to collaborate across agencies and organisations to achieve care and service-objectives: making multi agency working explicit in the principles would be helpful, particularly as the inference from section 1.4 might be that this refers solely to health organisations and teams. Similarly, engendering the culture of sustainability is as important as the culture of flexibility and change. **[Jan Welbury A12 - consultant paediatrician - individual]** Drug misuse and violence cannot be ignored as having devastating consequences for the health and well being for children and their families. The nature of these issues and their inevitable linkage with judicial proceedings offers points in time where their difficulties can be addressed with the weight of statute behind it. We should not miss such points in time when people are more amenable to engagement. **[Brian Hedley A14 - Newcastle CC Strategic Housing Service]** Basic principles seem fine .They need to be seen as relevant and realistic and easily understood by the general public as well as the range of service providers. **[David Chappel A16 - NEPHO - individual]** Yes. See also Q2 and Q12 **[Karen Horridge A17 - consultant paediatrician - individual]** Few of the principles can be applied to disabled children **[David Chappel A18 - NEPHO response]** Yes. See above **[Bharat Sibal A20 - Public Health Trainees Group]** Yes – seem to be fine. **[Vivien Hollyoak A21 - North Tyneside PCT]** The principles are the correct ones but their expression is tentative. If we want a concerted and consistent approach across regional organisations the principles that underpin our priorities need to be clear, firm and focused. **[John Woodhouse A25 - HPA] we** agree with the principles outlined as a basis on which to establish a health and wellbeing strategy. We do not see them as being overly restrictive but we would encourage a process of regular review of the principles which should be accommodated within the response to question 28. **[Rachel Turnbull A26 - Northumberland CAB]** It would perhaps be useful to briefly summarise what the national commitments are and how this strategy fit s in with those. **[Gwen Ellison A27 - Health Trainers Coordination]** The principles outlined are about moving things on and not repeating. They are over-restrictive as it does not explain who's aspirations for the region are we working to. It could easily be the aspirations of those who have already make the decisions that have resulted in the current state. The strategy needs to expect more equality regarding identifying aspirations and ideas and set out who's responsible for creating healthier communities? If actions remain robust in the face of political change is this democratic? **[Angela Ellins A28 - C&L GONE]** You state that there is no point in including what is already in place; however TP as an example is a national strategy with regional and local sign up / commitment until 2011. What is the length of this strategy? What if other strategies end before this regional one resulting in gaps on major health and well being concerns Need to acknowledge what is already out there and they have impact on this strategy **[Elaine Richardson A29 - Jobcentre Plus NE Region] We agree , the principles are the correct ones** **[Louise Wilson A30 - Sport England]** Sport England broadly agrees with the principles outlined. **[Caroline Airs A31 - Gateshead Advocacy Information Network]** The Strategy itself and any proposals made within it should be carefully considered for their impact upon people from minority/disadvantaged groups.

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	(The current strategy includes proposals which discriminate against disabled people, and it would appear that the duties imposed upon public bodies by the Disability Discrimination legislation have not been fulfilled) **[Peter Wright A32 - NE Chief EHOs Group]** Local public bodies are currently grappling with the issue of delivering services in a way which ensures both better and fairer health The "Better Health, Fairer Health" strategy sets out a series of initiatives which, evidence shows, will improve public health. These are a combination of new interventions and proposed modifications to existing services. These services, both new and existing, will only be effective in delivering both better and fairer health if they are accessed equitably i.e. they are delivered in a way which ensures that services are being accessed by groups in the population with greatest need. The regional strategy has a role in supporting and encouraging public bodies in their drive to provide services that are accessed equitably. Important tools which will deliver this goal are: • Needs Assessment – giving an understanding of variations in health and social care need both within the community and between communities • Equity Audit – demonstrating if services are being accessed proportionately to need • Impact Assessment – assessing the impact on health of proposed developments or service modifications The regional strategy for health and well-being should propose regional initiatives that would support and encourage use of these tools across public bodies in the NE. This could include: • promoting and advocating their use delivering training programmes which would give officers the skills to use these tools. **[Barbara Harrison A33 - National Offender Management Service]** Overall, we concur with these principles, particularly the need to travel "further and faster than other parts of the country." It is essential that this document is ambitious and far reaching, with a clear focus upon outcomes and timescales. **[Jennifer Taylor A34 - Tees Public Health Dept]** "The time frame of 25 years is meaningless. Who now remembers the last 10 year NHS Plan even? Two parliaments (8 years) is about the furthest horizon in my book. Having said all that, the focus areas (p17) are probably right; it's just how we address them." **[Kevin Rowan A35 - TUC]** Adding value is certainly a key principle, without that it is hard to understand how radical change can be achieved. The TUC would certainly support the need to act quickly and affect change more effectively than other parts of the country to improve health and well-being rapidly. However, this should not be seen as a competition with the rest of the UK. Inevitably these comparisons will be made and will provide a relative yard-stick in terms of leverage for public sector investment, but the principle focus is to improve health and well-being in the region for its own sake. Having a sound evidence base for actions is important in securing support for investment and for changing behaviour. We must also acknowledge that there are things we don't know; science can be inexact, and we need to ensure there is sufficient flexibility in the actions that flow from this strategy to account for the unforeseen as much as can be reasonably practicable. Additional commitments should be determined by their effectiveness, including the possibilities and practicalities of delivery, cautioning that strategies should be ambitious but achievable. Ambitions that are too aspirational are never translated into action. It may be too that our understanding changes and priorities must change too. Future commitments may be necessarily achieved at the demise of current activity. **[Martin Shaw A36 - Natural England]** Recognise the principle in 1.4.1(a) but, for this strategy to succeed, it must embrace and engage a wider audience than the traditional health sector. It may therefore have a role to play in increasing understanding in order to evoke action. There is a danger in assuming that we all share a common understanding. We may also wish to cite how existing projects can be developed to add value. Re 1.1.1 (b) there could be merit in penning a short vision of what this region might look like in 2032. This has

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	been used to good affect in other strategies (e.g. Rural Action Plan) Perhaps a short; advocacy leaflet to connect new audiences to the strategy would be useful? We need to build a coalition of partners and knowledge; understand the data we have, why it's important and then focus on that which will make the most difference. **[Leah Blacklock A37 - Community Action on Health]** CAOH agrees with the majority of principles outlined within the consultation document; we have however made some observations: - Again CAOH agrees with adding value to local and national commitments but would suggest that where commitments have been made elsewhere, they should be identified within this document. - In terms of timescales CAOH agrees that it is important to look to the longer term but that the actions (and their timescales) of other regional documents such as the Regional Economic Strategy and Regional Spatial Strategy should be considered when looking to develop these actions. **[Neil Johnson A38 - CSIP - Individual]** The strategy could be based on the following model which includes what perhaps should be the underpinning themes of the strategy and examples of issues that would fall within them: mental health (e.g. individual, community and population levels); physical health (e.g. diet, exercise, smoking); biological health (e.g. folate); sociological or social wellbeing (e.g. work, education, social capital); and, environmental health (e.g. accessibility, environmental design) **[Janice McColm A40 - Tees Valley Rural Community Council]** The voluntary and community sector has a wealth of knowledge and is usually the 'expert' on the people and areas in which they work for example the Tees valley Rural Community Council already consult with the rural areas of the Tees Valley on health. Working in partnership and collaborating with the VCS would help to build on the evidence base and prevent time wasting. Whilst the principles are correct, there should be a greater emphasis on positive health rather than looking at the negative aspects in people's lives. The principles set out are the goals we wish to achieve but the language needs to be translated in a way that doesn't alienate and frighten people with health issues that need addressing. **[Peter Heywood A41 - Middlesbrough PCT - Individual]** I agree with the principles and restrictions. If we need to 'catch up' and travel further faster there undoubtedly will be some hard choices over priorities. One of our main problems is that we do too much and spread resources too thinly to be effective. Other principles that could be developed – As well as tackling aspirations, a regional strategy should try and address the broad (and deeper) area of achieving culture change. **[Ann-Marie Gibson A42 - National Energy Action]** NEA is in broad agreement with the principles outlined at 1.4. NEA employs a Regional Co-ordinator in the North East and part of this role is to ensure that there is commitment from key regional organisations to working to secure 'affordable warmth' (i.e. the obverse of fuel poverty) for every household in the region. Clearly, this represents a significant challenge and can only be achieved through ongoing cross-sectoral partnerships; consequently, the principle of considering a longer term view than would ordinarily be the case is rational and beneficial (1.4.1b). NEA is encouraged that the need for the strategy to provide "a broader view than would be taken by one organisation" is recognised (1.4.1d). Fuel poverty is a cross-sectoral issue and NEA strives in all of its work to engage with all relevant sectors to encourage them to recognise the importance of action to tackle fuel poverty and to commit to incorporating such action into their everyday practices and procedures as a priority. Ref: 1.4.1j: Whilst NEA would agree that cost-effectiveness and value for money are important principles; this should not be at the expense of meeting the needs of individuals. It is NEA's experience in achieving affordable warmth for health and comfort that there are occasions where solutions for certain households will be more expensive than for others but this is not to say that the more expensive option is not of equal value in meeting need. Therefore, NEA feels that there should be both equality and equity in service provision even where this means that similar solutions cost more for certain individuals. Clearly the beneficial outcome of interventions should be the measure of success and not the cost. **[Chris Drinkwater A46 - West End Health Resource Centre]** In addition to the stated principles, there should also be a commitment to sustainable development and to wider public and patient engagement in improving the

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	health of the population. **[Heidi Jobling A47 - Newcastle Healthy City Project]** It only focuses on obesity and as it is a health and wellbeing strategy, there are other food issues to address. It is important not to lose sight of the bigger picture – or how the work of this strategy fits in with existing ones. Also we believe that there needs to be clarity about what 'inequalities in behaviour' means in relation to food. **[Karen Evans A49 - Age Concern and Years Ahead]** Yes, Age Concerns in the North East and 'Years Ahead' consider the principles outlined in the strategy to be the correct ones. Considering point b) 'there should also be consideration of aspirations for the region over the next 25 years or more. What kind of region do we expect the North East to be in 2032? What will the style of life be?' Age Concern and Years Ahead would like to request that this strategy not only focuses on aspirations and expectations but also uses demographic projections and statistical data to inform action plans. Years Ahead has recently produced a report on demographic change in the region which shows that: 'The total population in the North East is expected to rise by 87,800 over the next 25 years. However, total growth in the population disguises variations in population growth and decline across different age groups. The 65 plus age group are expected to increase by over 200,000 individuals whereas the numbers of under 24s are expected to decrease by over 76,000.' Inter-related changes in income and wealth, employment, patterns of leisure and consumption, political engagement by older people, and the demands which demographic ageing is likely to put upon health and social care are considered in the demographic change report which is available upon request. Considering point i) Where evidence does not exist, we must collaborate to obtain it. This point should also include sharing evidence and good practice widely. **[Ceri Mather A50 - Health Improvement Solutions / TPHN]** a) agree in principle, but there are some things which are already commitments e.g. integrated children's services, where the current strategy is invisible and leadership absent, so we do need clarity re existing commitments b) agree c) agree d) strongly agree see comments in Q1 above e) agree f) but should avoid navel gazing g) Hear hear, but You must also make the case that ongoing organisational change is costly, stops anyone doing anything for 2 years and must stop. h) Completely agree i) It is terrifying how few people understand the necessity of evaluation and reporting, if we are not doing it effectively in health how can we expect others to do so. This is a training need j) Cost effectiveness should not be the principle driver, it should be quality of life, some things are expensive but the long term impact is worth the expenditure. k) Better workforce planning and partnership arrangements would release massive capacity to refocus and re-engineer existing services to better effect. (nab. recent district nurse review in Birmingham revealed that most staff members spent less than 10% of their time engaged in patient related activity) many current tasks delivered in the NHS are outdated and ineffective, we should review and reflect re outcomes achieved much more. We also need to get much better at health at work and keep NHS staff in work reducing absenteeism, presenteeism and removing incompetence. How many PCTs and LAs are carrying dead weight because the HR systems don't let us let people go. l) agree

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	[Richard Briggs A51 - Cruse Bereavement Care] We agree the principles set out **[Sue Gordon A53 - PH Consultant - Individual]** The evidence base for much partnership working may be lacking. The establishment of plans that include explicit assumptions about interventions and outcomes & defines associated risks would allow for ongoing evaluation. This may not be evidence of the RCT gold standard, but may still be useful. **[Richard Pow A54 - Forestry Commission]** Yes. This is an admirable set of principles for any strategy. But we suggest that the Strategy document could usefully be accompanied by a brief leaflet style advocacy document to reach out in an inclusive way well beyond the health sector and champion the aspirations of the strategy and identify how we can all contribute to achieving the strategies aims. **[Andy Roberts A56 - Ncle CC Children's Services]** The strategy must show benefits for the people of the North East. All stakeholders (including Children and young people) should be involved in the development of the strategy. **[Jan Bostock A57 - Northumberland Care Trust and NYW NHS Trust]** The principles are acceptable but need to include under (h) that there is a need for ongoing evaluation and the updating of evidence from practice. **[William Norman A58 – Newcastle Learning Disabilities Partnership Board]** we support the consistency over time principle We welcome the emphasis upon evidence based change. **[Cynthia Games A59 – Living Streets]** In as far as they go, the principles are appropriate. However, there is a need to consider more than economic growth and "reduction of the negative issues". The document should consider the positive, intangible and hard to measure factors in wellbeing: happiness as well as lack of depression; improved healthy choices as well as reduction in obesity levels; response to increased education as well as the increase in education on the subject of health and wellbeing; emotional literacy as well as reduction in domestic abuse. **[Ruth McKeown A60 – South Tyneside Strategic Partnership]** Regional action should add value and not duplicate existing work. We agree with the principle that actions should be evidence based but we have to be careful not to stifle innovation. We would define equality in terms of outcome (best possible outcome for each individual) and equity we define as equal access to treatment according to need. The Strategy should make explicit the importance of adherence to the Declaration of Human Rights. **[Tricia Cresswell A61 - Durham & Darlington PCTs]** The definitions of equity and equality are central to this strategy, and we question the ones selected. Section 1.3.1 h implies that inequality is the same as variation in health, but it has been argued that inequalities are unfair. Not all variations in health are unfair, such as the differences in average health status between older people and, say teenagers. The electronic library for public health defines health inequalities as "The gap in health status, and in access to health services, between different social classes and ethnic groups and between populations in different geographical areas". Across County Durham and Tees Valley, the following definition has been used for some years: "Health inequalities are disparities in health between population groups that are systematically associated with socioeconomic factors (social class, ethnicity, place of residence, income etc). Such disparities in health are avoidable and are therefore considered to be unjust." Fundamental to health inequalities work carried out across the north east is an appropriate definition agreed by all. Again in section 1.3.1h achieving an absolute health gain for all, in the presence of worsening inequalities, would be a very poor result. This contradicts the comment on p5 that tackling health inequalities is a fundamental and perhaps the most important, issue for our region. We concur with the latter view and believe that any regional strategy for health should have tackling inequalities as its focus. Encouraging others to think more long term. Currently NHS thinks in short tem cycles of three year LDP rounds. These curtailed by focus on annual budget rounds. **[Tim Blackman A62 - Wolfson Research Unit]** We fully support the need for long-term consistency and would like to see proposals for how this will be achieved in a governance landscape subject to change over quite short time periods. A range of possible options could be explored, such as an independent regional office or agency for health and well-being, or the Regional Health Forum having such a role.

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	[Madeleine Johnson A63 - PHNE - Individual] Yes, but there needs to be a commitment to follow up the strategy with proper planning in order to ensure delivery **[VONNE A64]** VONNE welcomes the majority of the principles as outlined, however we seek clarification on the definition of worthy as outlined in para 1.4.1h. Actions undertaken, which can be regarded as worthy, can have a significant impact on the perception of quality of life without providing evidence of improvement in health and well-being. For example, certain aspects of end of life care may be deemed worthy but have little or no impact on a patient's health or well-being, but have a significant impact on the perception by relatives of the quality of life of the patient, and therefore their own well-being. We would welcome greater regional debate on the definition of worthy. With regard to where evidence does not exist, (para 1.4.1i) we wish to see the inclusion of 'supporting and resourcing organisations to obtain it, as well as collaboration'. At present, the majority of monitoring and evaluation undertaken is either statutory or funder driven. We would like to see a commitment to provide adequate resources to allow organisations and projects to fully monitor and evaluate their services within a regional framework and context. VONNE would welcome clarity on the definition of value for money, and what constitutes cost-effective, para 1.4.1i. We would hope that any calculation would not solely measure the impact on statutory health services but would take a longitudinal view of potential improvements in the quality of life of the individual and the social capital of the community area. It would be beneficial if a principle of sharing and disseminating practice across the region, and beyond, is also included in the strategy. VONNE believes to achieve the level of change required it is important to develop a mechanism where all learning, good or bad, can be shared as quickly and efficiently as possible. This would have the aim of helping to improve service delivery. We would also welcome greater emphasis on multi-agency and partnership working, which encourages innovation and measured risk taking. This is especially pertinent with regard to commissioning new projects and services, as well as partnership development. **[Dave Parkin A67 - Wallsend Town Hall]** Agree. Item I – not only collect information but share it as well **[Stephen Blair A70 - North of Tyne PEC]** Many initiatives that target health inequalities are often based on short term funding and valuable experience and expertise are often lost when initiatives cease. A key challenge highlighted by the audit Commission competed by Deloitte and Price WaterhouseCoopers, November 2007, is to 'develop arrangements to evaluate projects and ensure continued funding of those that deliver tangible outcomes, and to embed this learning in project planning and performance management systems' Principles to be observed should therefore be to commission evidence based activities and to target services at those areas where there is unmet need. More effective strategies to target hard to reach groups need to be developed **[Craig Duerden A71 – Middlesbrough Community Network]** The principles outlined are acceptable and give recognition to the 'long term'. Though it should be noted that creating an evidence base can be difficult for short term funded projects, particularly those within the voluntary and community sector that may not have the other internal resources from which to draw. Within the principles of the regional strategy locality specific issues should not be forgotten or lost but should also be given recognition. Value for money versus cost effectiveness over the length of the 25 years will need to be recognised. Analysis of cost effectiveness can be a way that voluntary and community organisations aren't able to provide adequate evidence for. There is some confusion over principle (k) clarification of 'commitments' needs to be given. **[Kirsty Foster A75 - Health Protection Agency]** The breadth of approach, scope and vision of the strategy are encouraging – although there are gaps (see below). The collective emphasis is important – although it is not clear how this will be played out. The range of proposals (from direct intervention to lobbying for political change) is good. **[Angela Dinsdale A76 - St Cuthberts Hospice]** The strategy should include the results of this and other consultations. **[Martin White A77 - Institute of Health & Society]** Yes. A title/summary for each principle would be helpful.

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A point that some may take issue with is the seven unachievable ‘zero tolerance‘ aims on P6 (Para ix); a more realistic approach may be preferred by some – this could perhaps be couched in the language of ‘continuous improvement’ and maximising achievement across the 7 aims.
What about ‘working upstream’ as a principle - making prevention more of a priority, as it is arguably the most effective way to achieve population health gain. This chimes with national rhetoric, if not policy.
[Ruth Stevens A78 - NE Physical Activity Group] In addition to the stated principles, there should also be a commitment to sustainable development and to wider public and patient engagement in improving the health of the population.
[J Chexal A81 - Soroptomist Society] We generally agree with the principles but would ask whether the region is stable as an entity in the light of frequent reorganisation in both the NHS and local government. We would also question whether it is realistic to focus only on initiatives which are evidence-based as, in public health; evidence sometimes does not exist at present. Perhaps initiatives based on well-grounded theory could also be included?
[The Food Access Network A85] We welcome the principles outlined in this strategy for taking a longer-term view than is usually possible in regular institutional planning cycles. In addition, the regional health and well-being strategy should involve a ‘whole food’ approach, taking account of not only the direct public health effects of food, but also the environmental, economic and other social implications of the food system as a whole.
Principle “J” states the “we should not pursue change that is not cost-effective” – you need to define this in greater detail.
We suggest adding to the principles the need to engage with local authorities at a political level across the region.
[Paul Hanson A89 – North Tyneside Council] Principle “J” states the “we should not pursue change that is not cost-effective” – you need to define this in greater detail.
We suggest adding to the principles the need to engage with local authorities at a political level across the region
[Nonnie Crawford A90 - Individual] Principles outlined need to take account of LA as well as NHS sensibilities and requirements
[Steve Brooker A91 - NE Sustainability Officers] The principles are all relevant and of value.
Although equity is picked up elsewhere in the document we believe there should be a principle that equity underpins any actions recommended to improve the health and well-being in the region.
[Peter Wright A92 - NE Public Protection Chief Officers Group] Both professions have a strong role in improving health and well-being, principally by a basket of preventative measures that enable people to enjoy greater prosperity and a higher quality of life.
The professions have already taken steps to improve our Regional work:

NEPPCOG has been running for over a decade
A northern branch of the Trading Standards Institute has existed for many decades, providing support to members of that professional body.
The North East Trading Standards Association was formed over 10 years ago, and now has a regional coordinator and a coordinated work programme. NETSA differs from the Institute branch in being an executive body operated by the councils and involving all those working in Trading Standards, not just the members of the professional body.
5 years ago, NETSA undertook a project with NEPHO to determine opportunities to enhance the public health role of the Trading Standards profession. This initiative informed a national publication from the Trading Standards Institute
NETSA continues to engage in regional projects to protect consumers. An example of this is an operation to check the weight of deliveries of solid fuel.
NETSA has been the catalyst for the establishment of a regional part of the national consumer support

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	system, Consumer Direct, a regional pilot of "Scambusters" and a new, regional Illegal Money Lending team. All of these regional initiatives have their greatest impact on reducing poverty and exploitation in the poorest part of the population. • The Environmental Health profession has a similar regional structure to Trading Standards. The professional body, Chartered Institute of Environmental Health, has a regional branch for its members. • The Environmental Health equivalent of NETSA is less well developed, although funding has now been secured for a coordinator who will commence duties in 2008. Chief EHOs meet regularly at county level, plus once or twice a year before NEPPCOG meetings. Against this background, NEPPCOG broadly supports the principles set out in section 1.4. Better regional working can deliver a great number of improvements. We do believe that there will be a far stronger role for lobbying for national legislative changes than is intimated in this section. **[Joyce Leeson A93 – Individual]** Under 2.1.1 – wrong order. Behaviour derives from environment, which should be focus. **[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96]** Local public bodies are currently grappling with the issue of delivering services in a way which ensures both better and fairer health The "Better Health, Fairer Health" strategy sets out a series of initiatives which, evidence shows, will improve public health. These are a combination of new interventions and proposed modifications to existing services. These services, both new and existing, will only be effective in delivering both better and fairer health if they are accessed equitably i.e. they are delivered in a way which ensures that services are being accessed by groups in the population with greatest need. The regional strategy has a role in supporting and encouraging public bodies in their drive to provide services that are accessed equitably. Important tools which will deliver this goal are: • Needs Assessment – giving an understanding of variations in health and social care need both within the community and between communities • Equity Audit – demonstrating if services are being accessed proportionately to need • Impact Assessment – assessing the impact on health of proposed developments or service modifications The regional strategy for health and well-being should propose regional initiatives that would support and encourage use of these tools across public bodies in the NE. This could include: • promoting and advocating their use • delivering training programmes which would give officers the skills to use these tools. **[Nicholas Baumfield A98 - Arts Council England, North East]** The strategy rightly seeks a very clear focus for its proposals but it does not it does not exclude the necessity of taking a holistic view of the measures needed to create health and well-being where appropriate. It is important to be discriminating and intelligent about the interpretation of evidence. For example there are many examples of arts having beneficial impacts on people with mental health issues. But it is always recognised that a range of factors contribute to the effects. **[A99 South Tyneside Local Engagement Board]** • 1, Smoking – if this was prevented it would equal to better health across families, this would have an immediate effect • 2, mental health, diet and obesity and physical activity – all as important as each other – tackling all would have a great impact on other health issues • 3, achieving better health through broader action – strategy for the future – long term (action on drugs and alcohol important) • To find three key areas is difficult as the group found they were very inter- linked

Q3	Are the principles outlined the correct ones upon which to base a health and well being strategy? Are some over-restrictive? Are there other principles that should be observed?
	[A100 HealthNet Consultation] The 8 key focus areas listed in the draft strategy are: a. Smoking b. Specific action on diet and obesity c. Physical activity d. Alcohol e. Achieving better health through broader action and achieving broader aims through better health f. Receiving help at the earliest opportunity g. Improving mental health h. Achieving a good death. Family approach as well as individual. Sexual Health Self Esteem Equality in Health provision / opportunities Disabled people and carers. Social interaction – engage with others. Drugs Diabetes – which is losing services in South Tyneside and this can have additional conditions attached – including BME communities. Drug / substance abuse among local deprived communities M - – what does this mean? O – add Wellbeing P – change to Positive Death experience **[B01 Alisa Rutter – Fresh – Smoke Free North East]** Overall the outlined principles are correct. However Fresh would welcome further discussion on its relationship with this Strategy. It is difficult to articulate actions for this overarching Strategy in isolation of the Regional Tobacco Strategy. If the former is only to cover areas that aren't already encapsulated by work elsewhere this is quite tricky for tobacco control. If there are things not currently underway Fresh should be examining this. The relationship between the two strategies will need to e closely monitored and there must be a clear synergy between the two. We welcome the clear emphasis given to ensuring that evidence based activity is undertaken and there should be greater scrutiny of programmes carried out 'because they feel right'. A further discussion on the accountability to ensure that this happens will be necessary and to ensure that at both the regional and local levels this mandate is adhered to. **[Danny Ruta B03 - individual]** The strategy quite rightly establishes the principle that it should focus on actions that are best taken regionally, and that require a broader view than would be taken by any single organisation. The strategy is on firm ground here, although, as stated above, there is a biomedical slant which seems to have ignored two priority areas for action that I feel meet these criteria: these are sexual health and accidents. It then states that 'where existing actions by individual organisations or sectors falls short of regional aspirations it may be appropriate to identify these as regional priorities. The strategy is on far shakier ground here, as it then starts to stray into very detailed and specific actions that seem to reflect the particular hobby horses of the authors and their lack of local knowledge rather than the failings of individual organisations and sectors to meet regional aspirations. An example of this is the recommendation for actions to tackle diet and obesity, and to commission research on home delivery options of healthy food. If this principle is retained in the final draft, then the choice of actions needs to be clearly justified and have a wide constituency of support from those expected to implement them.

Q4	Are there other life course events, periods, processes or qualities of the life-course that should be considered?
	[Janine A Ogilvie A07 – North East Community Forests] WORK. In the north east we work more unpaid overtime than any other region **[Louise Wilson A08 – Individual]** Under Quality of Life, the role of community which is wider than family and networks and incorporates the need for a vibrant local community not undermined by large supermarkets and out of town retailing – local authorities/planning can have major impact on health in this area. **[Mike Lauerman A09 – CSIP – individual]** Transitions: womb to family; home to school, school to school, childhood into adolescence; youth into adulthood and so on. **[Louise Wilson A10 – Northern CFS/ME Clinical Network]** Consider the role of community alongside quality of life: this is wider than friends and networks, and takes into account access to local shops, a vibrant independent high street, access to local/fresh food and so on, which may be at odds with car-dependent, out of area supermarkets: this factor might at least be considered in the context of QoL. **[Jan Welbury A12 – consultant paediatrician – individual]** Childhood is a major period that needs separate and in depth consideration whilst acknowledging and addressing the crucial linkage to adults and their difficulties and needs. If they are not there to provide good care and good role models their children suffer and loose any opportunity to meet their potential and consider their health needs. **[Brian Hedley A14 – Newcastle CC Strategic Housing Service]** Access to good quality Housing, sustainable employment and welfare benefits advice as well as 'signposting ' of more general information and advice are important factors in contributing to good health and social well-being and need to be integrated into the inputs to the Health Strategy. **[David Chappel A16 – NEPHO – individual]** No. **[Karen Horridge A17 – consultant paediatrician – individual]** Childhood is a major period that needs separate and in depth consideration. Disabled children are too often forgotten. E.g. It is not just the ageing who deserve a 'good death'. **[David Chappel A18 – NEPHO response]** Good to look at life-course and base strategy around educational attainment. Greater focus school based preventative strategies/initiatives. Not clear why certain influences e.g. locus of control or treating strokes are highlighted. **[Denise Orange A19 – Regional Health in the Workplace Group]** The workplace is not covered in any depth in the document despite it being a key setting affecting most of the adult population and a major 'life stage' of most people **[Bharat Sibal A20 – Public Health Trainees Group]** It is too simplistic and the model does not allow for cross interactions. For e.g. the bio-psycho-social influences on the dynamic life course of an individual and also the interactions at a population level cannot be easily depicted. **[Vivien Hollyoak A21 – North Tyneside PCT]** We do not find the life course model helpful. A heuristic device in this context should support clear strategic thinking. It is an unnecessary layer of complexity. **[John Woodhouse A25 – HPA] the** life course events described are largely focused upon behavioural issues. We would encourage that other exposures, e.g. noxious environmental exposures should also be considered when developing and executing this strategy. There are particular issues of equity here because it is often the least well off and least healthy, also least able to influence their exposures to noxious agents. **[Rachel Turnbull A26 – Northumberland CAB]** The transition from childhood to adulthood. When things in life go wrong – relationship breakdown, debt, long periods of illness, **[Gwen Ellison A27 – Health Trainers Coordination]** The significant social factors influencing life-course should be considered such as where you live, social capital, peer group etc. particularly if the strategy is about spanning different organisations. **[Angela Ellins A28 – C&L GONE]** 2.1 reducing inequalities – need to mention aspirations in inequality of opportunity 2.2.3 – need to acknowledge 'transition' periods as a particularly time of risk for young people P16 – taking risks model – need to include sexual risk taking

Q4	Are there other life course events, periods, processes or qualities of the life-course that should be considered?
	Why is domestic violence under risk taking? **[Elaine Richardson A29 – Jobcentre Plus NE Region] A major life course event to be considered is the loss of employment, either through redundancy or physical ill health and the impact this can have on mental health** **[Louise Wilson A30 – Sport England]** The workplace as a setting for health improvement has been overlooked in the strategy. Employment in itself has the potential to impact on a wide range of health determinants, whilst workplace settings offer a unique opportunity for health promotion which has not been considered within the strategy. **[Caroline Airs A31 – Gateshead Advocacy Information Network]** Transition, into "adulthood", and from adult services to older people's services, is a significant, and often stressful, time in the life of anyone using health and social care services **[Peter Wright A32 – NE Chief EHOs Group]** The influences against the life course diagram at figure 2 are necessarily summarised, but we feel that the final strategy should contain a larger illustration, which is considerably more detailed, so that there are fewer gaps in coverage of some of the critical components. Whilst some of the life events come at a single point in time (e.g. birth and death), others can last almost the whole life of an individual (e.g. learning or quality of life). In the case of the former, there are limited opportunities for intervention to improve health, with the latter there may be over 80 years. The matter of inequalities in life, not just in health, need to be brought explicitly to the fore in this and later sections of the strategy. Our greatest challenges lie in raising aspirations to live a long and healthy life in the communities where generations before have taken life choices, and learned harmful behaviours, that make shorter, poorer lives inevitable. Reversing these beliefs, behaviours and low aspirations is even more critical than improving the medical preventive and protective measures available in these communities. **Events missing** • Poverty (and effects of the 'poverty premium' where poorer people pay more for goods and services, or must travel further to buy healthy produce more readily available in affluent areas.) • Community norms, beliefs and aspirations. • Forming beliefs, behaviours and aspirations Being 'happy' should be considered, the immeasurable is often ignored. **[Barbara Harrison A33 – National Offender Management Service]** The list of life course events, periods, processes etc. is fairly comprehensive, although it would be worth including 'offending' alongside smoking, alcohol, domestic violence and drug abuse (under the wider heading of 'taking risks'). **[Jennifer Taylor A34 – Tees Public Health Dept]** "Additional influences on health and well being across the life course for consideration in a regional strategy include: "Acquiring general life skills (e.g. food and cooking skills)" "Need more emphasis on teenage years (when tend to take risks)" "Income and poverty – there is no specific information on how these factors impact on the life course" "Financial inclusion/exclusion – can have impact on mental and/or physical well being" "Encouraging aspirations recognising that aspirations may change throughout the life course – health, work, etc" "Environmental pollution issues – as a wider determinant of health" "Key life/transitional events impacting on health and well being include the transition from primary school to secondary school, leaving secondary education, entering into adult life (can have significant impacts, in particular, for those with learning disabilities), starting work/retiring from work and bereavement" **[Hartlepool & North Tees Workshop A34 annex]** Additional influences on health and wellbeing across the life course for consideration in a regional strategy include: • Acquiring general life skills (e.g. food and cooking skills) • Need more emphasis on teenage years (when tend to take risks) • Income and poverty – no specific information on how these factors impact on life course • Financial inclusion/exclusion – can have impact on mental and/or physical wellbeing

Q4	**Are there other life course events, periods, processes or qualities of the life-course that should be considered?**

	• Encouraging aspirations recognising that aspirations may change throughout the life course – health, work, etc
	• Environmental pollution issues – as a wider determinant of health
	• Key life/transitional events:
	    o The transition from primary school to secondary school
	    o Leaving secondary education, entering into adult life (can have significant impacts, in particular, for those with learning disabilities)
	    o Starting work/retiring from work
	    o Bereavement
	
	[Kevin Rowan A35 – TUC] The TUC is of the view that within the regional public health strategy there should be a stronger focus on the workplace. 7.5% of the working age population are currently claiming benefits due to sickness or disability, a large proportion of these are suffering ill health due to work. This situation is compounded by an outflow from work to incapacity and economic exclusion and inactivity of around 600,000 people each year. This clearly has a significant negative impact on quality of life, very few people are better off living on incapacity and other benefits.
	
	Economically the case for tackling occupational ill health is equally weighty; 36 million days each year are lost to ill health related directly to a person's employment. The Health and Safety Executive states that 2.2 million people are suffering from an illness caused or made worse by their work, with 646,000 new cases in the last 12 months. Three quarters of these were musculoskeletal disorders or mild to moderate mental health problems caused by work-related stress.
	
	According to the Journal of Occupational and Environmental Health, "Never in history has there been so much occupational disease as exists in the world today."
	
	Perhaps the real tragedy is that much of these illnesses are totally preventable, they are unnecessary. Tackling occupational health is critical to improving people's health and well-being generally, to reduce the increase in workers moving to incapacity and to arrest the high numbers of people dependent on out of work benefits.
	
	The workplace also provides an opportunity for effective social marketing. Workers are a 'captive audience' for positive workplace initiatives, which could include health and lifestyle education, guidance and good practice. Drug and alcohol awareness could be focussed in the workplace, as well as healthy eating, the advantages of exercise and campaigns such as 'everyday sport' would benefit from a workplace focus.
	
	Essential to the effectiveness of workplace-based social marketing is the role and involvement of trade union health and safety representatives.
	
	Safety reps have traditionally contributed enormously to workplace safety and health. Independent research by the London School of Economics and Government shows that workplaces with organised trade union safety reps are literally twice as safe as those without. Through a systemic approach involving workplace inspections, consultations with workers and managers, well-trained union safety reps prevent accidents occurring, saving lives and preventing injury on a daily basis.
	
	Engaging union safety reps to promote effective occupational health and well-being strategies, including social marketing, would greatly enhance their role in the workplace and would increase the impact of any campaign in this area. The relationship of trust and respect that union reps have with their members distils negative concerns associated with health messaging and also ensures workers are more likely to engage, understand the concerns and to respond positively by changing behaviours.
	
	It must be stated, however, that merely talking good health will not be enough on its own to halt the persistent march of workers toward ill health. Sedentary work and long hours are a toxic combination contributing to lack of physical activity and obesity; workplace stress, consistently the number one concern of trade union safety reps in recent years, can be related to use of tobacco, recreational drugs and alcohol.
	
	Enabling workers greater control or influence over their work and working time can greatly reduce stress and can increase opportunity to balance activity and interests outside work with demands in work. Promoting flexible working is one key action that employers and workers can take, in addition to other more directly health related interventions discussed elsewhere in this response.
	
	[Martin Shaw A36 – Natural England] There should be a clear read across between Fig 2 and the key focus areas under 2.3.1. Quality of the environment is a key aspect of quality of life and should be included in Fig.2.

Q4	**Are there other life course events, periods, processes or qualities of the life-course that should be considered?**

Useful to recognise the role that the workplace can play in health promotion and improvement, particularly in encouraging an 'active' workforce (see Q6).

There needs to be a better analysis / clarification of the drivers and trends that are affecting the life course events – currently it's a bit ambiguous.

[Leah Blacklock A37 – Community Action on Health] We believe that all areas have been covered; however there could perhaps be a section on culture, although we do acknowledge that the issues related to culture could sit within a number of different areas.

[Janice McColm A40 – Tees Valley Rural Community Council]

Learning:	People with learning difficulties need their learning styles to be taken into account
Quality of Life:	Affordable, safe and comfortable living conditions, changing perceptions of mental health issues
Wear and Tear:	Back Pain Management (growing problem in the UK) Diabetes Recuperation/homecare after operations as hospital stays become shorter
Adding Life to Years:	Sustain and promote Independent living

[Peter Heywood A41 – Middlesbrough PCT – Individual] No – possibly too many and overly complicated.

I think the area of 'risk taking behaviour' is an important one to consider. Particularly with young people, there is a tendency to address the individual risks in isolation from each other and fail to explore, understand and influence the reasons why some people choose to take multiple health risks . . . . .often all in the same evening!

[Ann-Marie Gibson A42 – National Energy Action] The 'quality of life' and 'avoiding risks' sections make no acknowledgement of behavioural activity in the domestic environment that poses a risk to the health of the individual.

[Charlotte Clarke A44 – University of Northumbria] The connection between need and response was not particularly clear. Many of the interventions /issues highlighted could therefore be deemed potentially relevant and worthy, but their link to needs analysis was not clear, an illustration would be that a life span approach is adopted. But we felt that this needed to be layered with which needs, during the life span were particularly challenged or facilitated for different populations. One benefit of adopting the life-span approach is that a broad range of issues are therefore highlighted, for example end of life which is often neglected in the public health agenda. That said, the public health dimension of end of life care needs to be enhanced to clarify how for example it is distinguished from the primary care role

[Chris Drinkwater A46 – West End Health Resource Centre] One disadvantage of a life course approach is that it tends to focus on the individual and the medical model of health. It would help if the life course was balanced by a settings approach – family, community, schools and educational establishments, workplace.

[Karen Evans A49 – Age Concern and Years Ahead] Age Concern and the Regional Forum on Ageing 'years ahead' welcomes the point made in 2.2.2: 'If we aim to have the best health in the country, we need to consider actions affecting people of all ages.'

We consider that the 'quality of life' factor should be cross-cutting amongst the entire life course, not just placed in the middle section / middle age part of the diagram. We would also include Dignity under Quality of Life – this should be for everyone not just older people, it is a basic right.

It would be useful to mention of carers or supporting carers to maintain their health and well-being in the diagram.

It would also be beneficial to include a heading such as 'improve healthy life expectancy' or 'adding healthy life to years' replacing 'adding life to years'. This heading should be placed above the heading 'Frailty and illness' not below it where it sits currently. We know that life expectancy is gradually increasing, e.g. In 2003-05 life expectancy at the age of 65 for a man was 16.8 years and 19.6 years for a woman. This was an increase of 3-4

Q4	Are there other life course events, periods, processes or qualities of the life-course that should be considered?
	years over the previous two decades (Office for National Statistics, Life expectancy statistics, 19.12.06). Unfortunately healthy life expectancy has increased less. In 2002 a man aged 65 could expect to live 4.2 years in poor health and a woman 5.1 years (Office for National Statistics, Health Expectancies in the UK 2002. Health Statistics Quarterly 29 (Spring 2006) "Prioritising actions that impact on future health" should not at the expense of action to deal with the legacy of the past i.e. improving the quality of life for older people. **Changing perceptions of old age** This is a high priority for older people as the perceptions of others and the perceptions older people have of themselves are significant determinants to health. The perception that older people are forgetful, physically deteriorating, valueless to the economy, slow at walking, grumpy etc is one not only not based on reality, but not helpful to older people. At our recent consultation event which was attended by over 80 older people and people working with older people, we noted that it is acceptable to say things about older people and to produce images of older people that would not be acceptable around black people or women. An example was given of cartoon characters of older people designed in Gateshead that were not at all flattering. The only older person on the committee deciding the use of these images, when she strongly objected to them, found the rest of the people on the committee could not understand her viewpoint. Older people experience loss of status once they retire from work and are not valued for the non-paid activities they do, such as voluntary work and glueing the community together, and increasingly, looking after children to enable the parents to work. The pressure to look younger has a big impact on the design and sale of clothes; occupations mostly undertaken by young people designed for the younger people's market. Yet, older people are those with more disposable income and therefore would welcome clothes in which they felt comfortable and fashionable. One glaring example of negative images of older people is the road signs in this country for "elderly people". **Proposal** that the Strategy includes a section on changing the perceptions of old age which is something that can only be achieved by different agencies working together and working with older people to identify and promote images which older people would want to project themselves. **Proposal the monitoring of this strategy to look at the impact of the strategy on different groups to ensure that the generalist approach does not discriminate indirectly against particular groups.** **[Ceri Mather A50 – Health Improvement Solutions / TPHN]** Useful tool , alcohol should feature pre birth as well as half way up, delaying parenting/conceptions could usefully be included in the actions **[Sue Gordon A53 – PH Consultant – Individual]** A life course focus allows the complete omission of a key issue which is expected to be influential in the time frame of this strategy i.e. climate change. The devastation seen over the summer highlights the significance of this issue. A strategy that looks forward over the period suggested should not omit this. **[Richard Pow A54 – Forestry Commission]** We suggest that quality of environment is a key aspect of quality of life and should be included in this section of figure 2. Access to nature, including local green space, is an important part of this. **[Jan Bostock A57 – Northumberland Care Trust and NYW NHS Trust]** Qs 4 & 5 Under Quality of Life a number of important key influences need adding; There needs to be explicit inclusion of: Financial security; Living in a Safe Community; Gainful employment **or activity;** also something about satisfactory work conditions. Appropriate Welfare and Benefit support is important to adult quality of life (e.g. during hospital admission or chronic illness) in order to prevent out of control debts, homelessness etc. Also including domestic violence under "taking risks" seems inappropriate. There are public health arguments against inequalities in income and poverty to which this strategy could make reference. **[William Norman A58 - Newcastle Learning Disabilities Partnership Board]** We like the journey through life. However, we think it could have been a lot easier to understand. Perhaps learning to deal with death i.e. coping with bereavement – this is major life change /event in anybody 's lives but especially for people with learning disabilities

Q4	Are there other life course events, periods, processes or qualities of the life-course that should be considered?
	[Cynthia Games A59 – Living Streets] More emphasis should be placed upon a healthy and active old age. Living Streets has found (through consultation on our own regional Charter) that there is a need to cater for a generation of older people who are much more active and have a greater need for stimulus and recreation than their parents/grandparents did at that age. However, if older people are unable to enjoy that prolonged life in a manner that enhances their quality of life, this will become a source of difficulty in the future. There is a need to ensure that older people are more able to walk to local services, local activities etc. This means location of key resources and services at a local level **[Tim Blackman A62 – Wolfson Research Unit]** The lifecourse model presented appears to be too topic-based, linking topics to specific stages of the lifecourse when many are relevant – in different ways – to more than one stage of the lifecourse. It is unclear what actual 'added value' the model adds to a regional strategy. **[Madeleine Johnson A63 – PHNE – Individual]** I would like to see "screening" specifically included under "primary & secondary prevention in health care". **[VONNE A64]** Although we recognise the rational behind the use of life-course epidemiology, its use suggests individuals who do not fit into the prescribed age-related categories may experience inequality. The inclusion of building relationships and setting up a home would be beneficial, as these are two areas where we believe action could be taken to improve health and well-being. For example, the provision of affordable homes (which meet the lifetime homes standard) allowing for a family to grow and develop without the need to move, may have a positive impact on quality of life and emotional well-being. VONNE suggests that the life course event 'adding life to years' should be changed to read 'adding healthy and meaningful life to years'. This, we believe, would adequately reflect the rational behind the strategy. We would also wish to see greater acknowledgement that learning is a life long event and is not confined to children and young people. Also the inclusion of skills development would be beneficial, particularly with regard to quality of life and the impact on gaining meaningful employment. **[Caroline Wild A66 – Learning Disability Directorate NTW NHS Trust]** The life course is a useful was of considering public health in terms of people with a learning disability. There needs to be flexibility in the model i.e. carers are more likely to be young if they care form a child with a learning disability; their needs will be different to older carers. Also, palliative care may be needed at a younger age for some people with a learning disability – and may need to be provided differently **[Dave Parkin A67 – Wallsend Town Hall]** Two additions – Retirement and unemployment (if not covered under gainful employment) **[Angus Anderson / Arthur Probert A68 – Attend Rights to Warmth]** We would add "exposure to cold", or more generally exposure to temperature stress, as a key influence on health and well-being and would include it in the "avoiding risks" part of the life-course diagram on page 16. Specific adverse effects on health and well being that can be attributed to exposure to the cold include: • exacerbating long term conditions, such as cardiac and respiratory conditions; • triggering emergency episodes such as broken bones from falls; • impaired mental health; and • poorer educational attainment **[Craig Duerden A71 – Middlesbrough Community Network]** The Strategy uses a "cradle-to-grave" arrow to demonstrate influences along a life course. In doing so an unequal process of expectation is built in automatically opening gaps in service provision that marginalises those patients that do not fall into the prescribed age-related categories. The quality of any service is about a service-users perception of excellence, which obviously varies. Health and well-being and a patient centred perspective should involve a strategy for any health issue to have a serviced care pathway for a patient to follow, no matter the age of the person. Inclusive, cross-functional initiatives will have a greater impact on realising service improvements than maintaining the current rigid, secluded initiatives

Q4	Are there other life course events, periods, processes or qualities of the life-course that should be considered?
	or policies within each statutory agency. In terms of educational influences on the life-course it is important to recognise that there is a difference between children's learning in primary and secondary education. The importance of breast-feeding to long-term health outcomes e.g. Link to obesity cannot be underestimated. Being 'happy' should be considered, the Immeasurable is often ignored. The 50 – 70 year age gap has been largely ignored and is an overall weakness of the document. The issues 'frailty and illness' occur towards the end of life course, though individuals can be 'frail' or 'ill' at any time throughout their lives. The issues relating to disability and mental well being should have higher profiles in the strategy. The strategy should be considering adding life and this may be better described using mind map opposed to a vertical line giving a broad depiction of banding life stages. **[Joanne Lavender A74 – North East Chamber of Commerce]** Education and the ability to learn could be linked with gainful employment. This will become increasingly important as the new diplomas are introduced with compulsory element of work based learning. **[Martin White A77 – Institute of Health & Society]** Adolescence, gaining independence (leaving 'home'), entering the workforce, retirement – all important life transitions. There is no indication of time scale on the arrow; although difficult, it might be important to realise that working life could be 40 years, and is therefore a long time in which to find assessment opportunities. For example, it would be possible to put in an age related screen, say, at age 40, to pick up potential problems at an early stage (cf Finland). It might be worth considering putting this in occupational health to make it easier for people to access. Standardised risk data collection at specified age would be a good monitoring resource. Retirement and later life is an opportunity for people to have or develop wellness plans; it would be good to see this developed. As a region we need to consider: (1) the health and well being of the 65-90 group and how best we can promote health and disease free years; and (2) how health and social care services, particularly long term care, will need to be configured to accommodate the increasingly elderly population. We would like to see consideration of support to keep people in work as healthier, and better, for the North East economy. Child abuse, "looked after children", children with disabilities and perhaps parenting, should be mentioned in the section referring to childhood. Some things are missing from the figure, although some are the subject of sections in the report and it would be best to be consistent about things impacting on health. Under quality of life, special groups like prisoners should be mentioned. Under wear and tear, family history should be mentioned next to high blood pressure and cholesterol. **[Ruth Stevens A78 – NE Physical Activity Group]** One disadvantage of a life course approach is that it tends to focus on the individual and the medical model of health. It would help if the life course was balanced by a settings approach – family, community, schools and educational establishments, workplace. Early years and play should be included– jumps from baby to education The workforce as a setting for health improvement has been overlooked. This misses a setting with potential to impact on health, and employment in itself has the potential to impact on a wide range of health determinants. **[J Chexal A81 – Soroptomist Society]** The diagram on page 16 is confusing. We feel that this section should be re-addressed to separate life stages from influences on health at different stages. Life stages should include youth and the retirement years – which are now often quite long and active. The section on 'wear and tear' should include arthritis, a common and disabling condition. **[Gateshead Public Health Partnership A82]** In section 4.1 the matrix of action clearly identifies modes of implementation – there is a gap around capacity building. Capacity building to deliver health improving encounters (wider workforce development) needs to underpin all of the themes otherwise it will be seen as an add on

Q4	Are there other life course events, periods, processes or qualities of the life-course that should be considered?
	[Alma Laing A83 – Local Engagement Board Gateshead PCT] Issues affecting specific groups such as those with mental health problems or learning disabilities were raised because life course events have a different impact on these groups. **[Paul Hanson A89 – North Tyneside Council]** Suggest adding Diet **[Nonnie Crawford A90 – Individual]** No but may wish to focus more on specific parts of life course for specific gender issues? **[Steve Brooker A91 – NE Sustainability Officers]** We are not clear on how this section adds value when the key focus areas are listed separately in section 2.3 **[Peter Wright A92 – NE Public Protection Chief Officers Group] Events missing** • Poverty (and effects of the 'poverty premium' where poorer people pay more for goods and services, or must travel further to buy healthy produce more readily available in affluent areas.) • Community norms, beliefs and aspirations. • Forming beliefs, behaviours and aspirations • Being 'happy' should be considered, the immeasurable is often ignored. **[Joyce Leeson A93 - Individual]** Too individualised, where you are born – homeless, poor housing, harsh un-neighbourly traffic-ridden streets, nowhere to play, no books at home, no 'green spaces', no respect – these factors have major impact on our lives. **[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96]** The life course approach has many advantages, in terms of understanding the development of inequalities in health. However it does not fully represent the complexity of the socially created context in which lives develop, and so does not lead easily into an understanding of the interaction of culture, the built environment, educational and economic prospects etc. Further thought about how to include these aspects visually would be helpful, if this diagram is going to be the way in which the strategy is explained. The influences against the life course diagram at figure 2 are necessarily summarised, but we feel that the final strategy should contain a larger illustration, which is considerably more detailed, so that there are fewer gaps in coverage of some of the critical components. Whilst some of the life events come at a single point in time (e.g. birth and death), others can last almost the whole life of an individual (e.g. learning or quality of life). In the case of the former, there are limited opportunities for intervention to improve health, with the latter there may be over 80 years. The matter of inequalities in life, not just in health, need to be brought explicitly to the fore in this and later sections of the strategy. Our greatest challenges lie in raising aspirations to live a long and healthy life in the communities where generations before have taken life choices, and learned harmful behaviours, that make shorter, poorer lives inevitable. Reversing these beliefs, behaviours and low aspirations is even more critical than improving the medical preventive and protective measures available in these communities. For example, despite educational achievement at the GCSE stage in Gateshead placing the borough in the top 7 councils nationally, only 27% of our young people go on to further education, whereas the England average is 42% and in Scotland it is more than half. The 'locus of control' element needs to be expanded if this is where individual formation of beliefs, aspirations and behaviour is addressed. While not an event an important aspect of the life course approach is the 'discounting' of future benefits from current behaviour. In health economics language the value of 'not dying from lung cancer' is often discounted against the immediate satisfaction of a cigarette to address a nicotine craving. **Events missing** • Poverty (and effects of the 'poverty premium' where poorer people pay more for goods and services, or must travel further to buy healthy produce more readily available in affluent areas.) • Community norms, beliefs and aspirations • Sexual health • Patterns of physical activity

Q4	Are there other life course events, periods, processes or qualities of the life-course that should be considered?
	• Patterns of eating. **[HealthNet Consultation A100]** **Top three priority areas.** **Priority 1** Recognition of Voluntary Sector & Carers as equal partners Mental Health and Wellbeing Prevention – early diagnosis, education, awareness, self care. Obesity **Priority 2** Ensure vulnerable groups are explicitly receiving improved services. Alcohol Social inclusion Diabetes **Priority 3** Cancer Obesity Resources Joining up of existing policies **[Alisa Rutter B01 – Fresh – Smoke Free North East]** Would recommend the expansion of antenatal care to also include postnatal care.

Q5	What is missing from the 'menu' of areas in which we could act?
	[David Landes A05 - NESHA dental lead] Oral health and oral health services are a significant matter for health and well-being for the residents of the North East of England. There are large and unacceptable variations in the oral health of the population of the North East of England. In some areas, levels of dental decay amongst the population remain at a lamentably high level. This is contrasted with areas of affluence where dental disease has been eliminated, not only in one generation but increasingly in the second generation in the population. Primary Care Trusts in 2006 were given the budget for the delivery of all primary dental care services. This represented a fundamental shift in the delivery of primary care dental services which are the main platform for the delivery of all health care services to the population. Prior to 2006, primary care dental services had changed very little since the establishment of the NHS in 1948. Dental practices were established where practitioners wanted to provide services and hence there was a pull to provide services in better off, more affluent areas, where there had traditionally been a greater uptake of professional health care services. This, over a period of nearly 50 years, led to an inequitable distribution in dental services, with less utilisation from people living in the more deprived and less affluent parts of our community. The second area where the Region should be playing a key strategic role is the development of the oral health workforce, including both dental practitioners and other dental care professionals. There is a need to ensure that there is close liaison in order that the development and evolution of primary care training programmes meet the needs of the commissioning strategies being developed by primary care trusts to ensure that the workforce; has the necessary skill set to deliver services which are going to be commissioned in the future by Primary Care Trusts. This will have an increased focus on providing care which addresses the needs of the less affluent sections of our community and those population groups which require a more flexible and less traditional service delivery approach to meet their needs. There are also increased challenges in providing services which tackle the increasingly stringent targets set by Government for access to services, Primary Care Trusts will have to meet 18 week targets in secondary care for all the hospital dental specialities and a workforce must be available to deliver these targets. In order to achieve these aims, we need to ensure that we have the right workforce to provide specialist services. These practitioners are trained in posts which are established by the Deanery, it is important that we ensure that workforce development takes place in close alignment with the increasing and challenging demands placed upon all health services. **[Janine A Ogilvie A07 - North East Community Forests]** WORKPLACE. CULTURE. NATURAL ENVIRONMENT. **[Louise Wilson A08 - Individual] Town planning and impact of supermarkets on health, wellbeing and communities.** **[Jan Welbury A12 - consultant paediatrician - individual]** Childhood. Vulnerable children. **[Brian Hedley A14 - Newcastle CC Strategic Housing Service]** Area regeneration and attracting employment. Public transport. Provision of green recreation spaces for personal exercise. Education and training skills **[David Chappel A16 - NEPHO - individual]** No. **[Karen Horridge A17 - consultant paediatrician - individual]** Childhood. Disabled children. **[David Chappel A18 - NEPHO response]** More emphasis upon school based prevention initiatives / interventions would be welcome. While the focus upon improving educational attainment is very welcome, the needs of those who are not able to achieve such improvement need to be addressed. **[Denise Orange A19 - Regional Health in the Workplace Group]** Action in the workplace has the potential to impact on several key issues such as tobacco, alcohol & obesity as well as economic development and regeneration and as such should be included in the matrix and the strategy itself as a cross cutting issue It is an important setting in which health interventions can be delivered and we would like 3.6.9 delivering health-improving encounters to reflect this i.e. that health service encounters are not the only means of providing health promotion encounters A specific action that has the potential to raise the profile of workplace health, and which we would like to see included in the strategy, is the development of a regional accreditation standard, supported by key agencies in

Q5	What is missing from the 'menu' of areas in which we could act?
	the region, to recognise the achievements of employers in relation to workplace health. **[Bharat Sibal A20 - Public Health Trainees Group]** See response to above i.e. Q4 **[Vivien Hollyoak A21 - North Tyneside PCT]** If the strategic aim was clearer then this question would be easier to answer. The reference point for the menu of actions appears to be a vision statement for the NHS which is unlikely to inspire the broader leadership community which has to buy into this Strategy if it is to work. **[John Woodhouse A25 - HPA]** We note that within the document some of those areas that relate specifically to health protection are not emphasised perhaps as strongly as we would like. We understand the need for a balanced approach towards addressing these wider public health issues. We would particularly emphasise the importance of taking action in relation to sexually transmitted diseases which is an increasing problem in the North East, and also to the impact of the wider environment on health, particularly those that are consequent on the region's industrial history. **[Rachel Turnbull A26 - Northumberland CAB]** Gainful employment is not possible for some – gainful support for those unable to join the labour market for whatever reason is of just as much importance – not just financial, but social, mental, etc What about housing – where does that fit in? Not sure that domestic violence should be included in taking risks – it seems to suggest that it is something that victims have more control over then is possibly the case. Should it not be in quality of life as it does affect esteem, friends and networks, leisure, etc? There appears to be a general lack of recognition of the effects of poverty and deprivation on health, which is staggering considering that the document, is looking at health inequalities – health and poverty is inextricably linked and this cannot be ignored and must be tackled. Until social and financial inequalities are addressed, then health inequalities will continue. **[Gwen Ellison A27 - Health Trainers Coordination]** The Tackling Health Inequalities: 2004 -2006 data and policy update (DoH December 2007) stated that change can come from empowering disadvantages communities to aspire to good health. There is a great deal of experience within the community and voluntary sector in the north east of effective organisations and processes for doing this which need to be supported and implemented. Health Trainers provide some support for this. **[Angela Ellins A28 - C&L GONE]** Sexual Health – particularly onset of being sexually active – keeping safe, having adequate negotiation skills, aspirations, self esteem to negotiate safer sex and right time **[Louise Wilson A30 - Sport England]** Whilst 'Leisure, relaxation and sport are included as key influences, they are not highlighted as being areas that 'fall particularly within the ambit of a regional strategy..'. We feel strongly that sport and leisure, linked to increased physical activity should be given equal weight to the other topics that have been singled out. **[Caroline Airs A31 - Gateshead Advocacy Information Network]** 1. Issues around diet, alcohol, and lifestyle are important at the pre-conception stage 2. Healthy eating is an issue throughout 3. It is difficult to see why domestic violence is included against "Taking Risks" – this is more a Quality of Life issue – but is also relevant in relation to Birth, Infancy and Parenting 4. To Quality of Life add: effective community engagement/social inclusion; independence; and support for carers – these are all key issues in relation to quality of life, and avoidance of stress 5. To Avoiding Risk add: effective personal support – for many disabled people personal support can enable them to go out and engage with their communities in situations which would otherwise carry significant risk 6. To Adding Life Years add: Independence, Choice and Control 7. Add Advocacy into each section, as advocacy support is essential to ensure that all people are able to access the services they need to achieve health, emotional wellbeing, independence and choice. **[Peter Wright A32 - NE Chief EHOs Group]** Continuing the theme from the above response to Q4 1. There are a tremendous number of skills that could be taught at school which would help raise a childs ability and will to lead a long and healthy life.

Q5	What is missing from the 'menu' of areas in which we could act?
	• Self esteem and assertiveness are critical at an early stage to limit the influence of harmful peer pressure If we are to invest in social engineering in the population, we need to invest heavily in passing on those messages through the education system. **[Jennifer Taylor A34 - Tees Public Health Dept]** "Suggested additional areas for consideration at regional level and inclusion in a regional strategy are sexual health and problematic substance misuse (rather than just alcohol)." **[Kevin Rowan A35 - TUC]** The TUC believes there is a case for further research into the impact of occupational ill health and health and well-being generally. The increasingly fragmented workforce and workplace means that the capacity to understand, over time, the health of workers through the impact of work has been gradually diminished. There is a dearth of occupational health services reaching workers. TUC analysis shows that only 20% of workers enjoy any kind of access to professional occupational health services and support. Only 3% of workers receive comprehensive services and support in this area. Good quality occupational health services will: • identify cause or contribution to ill health; • determine actions to prevent ill health; • introduce appropriate control measures. A clear focus of a health and well-being strategy must be to improve and increase access to comprehensive, professional occupational health support. A further area relevant to a regional public health strategy and occupational health is effective sickness and absence management by employers, an area where the TUC would wish to acknowledge the effective interventions of the Engineering Employers Federation. Most employer approaches to sickness and absence management focus exclusively on getting employees back to work as quickly as possible. This is both a missed opportunity to pinpoint work-related health issues and also is potentially increasing the risk of further and greater ill health to the workers concerned. There is currently no legal duty on employers to consider rehabilitation, even when a worker is injured or made ill directly by their work. A lack of rehabilitation services and support is a key factor here, as is the focus on rehabilitation driven by an ambition to minimise compensation claims in serious injury cases, rather than by a policy focus to keep workers in work and healthy. HSE guidance on managing return to work is excellent, but is not replicated in the actions of enough employers. There is an almost absolute absence of rehabilitation of workers in return to work policies and practices. The UK, as a result, is lagging behind in enabling workers with ill health to stay in the labour market. In Sweden rehabilitation return to work rates are at 50%, in the USA it is 1/3, in the UK the rate is only 1 in 6. Little is known about future health risks from emerging technologies. Nanotechnology, for example, is a rapidly emerging sector of the north east economy, growing out of the pharmaceutical and chemicals clusters in the region. There are clear concerns about the potential impact of nanoparticles on the cardiovascular system of workers, particularly in the process elements of nano industries, as well as on the wider environment and on users of nano products. The Institute of Medicine and the Health and Safety Executive have both expressed concern about the lack of occupational health intelligence about this sector. Yet, in the UK, 150 times more is spent on developing the commercial potential of nano products than is spent on developing an understanding of the occupational health impacts. Trade union organisations are increasingly concerned that we are working toward another industrial epidemic on the scale of asbestos. Action is needed now to develop much greater understanding of the occupational health risks involved in nanotechnology processes and products and to identify hazards and appropriate control measures. **[Martin Shaw A36 - Natural England]** We would welcome explicit reference to diet, exercise and exposure to nature. We need to define 'environmental design' but it is important to make the link between 'quality green space' and

Q5	What is missing from the 'menu' of areas in which we could act?
	encouraging / enabling people to take more exercise. **[Leah Blacklock A37 - Community Action on Health]** In terms the menu of areas in which to act again specific actions around the cultural aspects of different groups in society could be acknowledged. Financial stability could help in many of these areas and we feel that in terms of quality of life diet and transport could be added here. **[Janice McColm A40 - Tees Valley Rural Community Council]** Mental Health, Housing **[Ann-Marie Gibson A42 - National Energy Action]** As indicated in Figure 5 (page 32) targeted winter warmth and energy efficiency activity will have an impact across most of the identified life stages (pre-conception, conception, birth, quality of life, wear & tear, frailty & illness, adding years to life, and death). NEA would recommend that "housing" be included in Figure 2 (page 16) under the "Avoiding risks" heading because, as noted in Figure 5, any action to improve the energy efficiency standards of a home is likely to have health benefits for and/or minimise health risks to the household. NEA recognises that the life course model is overly simplistic and risks compartmentalising the influences on the individual. NEA believes there is an item missing which might equally fall into 'quality of life' or 'avoiding risks', which is 'behaviour'. The current schematic does not recognise the influence of where someone lives, i.e. their home and the quality of that home. If someone lives in poor housing and adopts certain behaviour because they are poor e.g. lacking gainful employment, that person is likely to be at a higher risk of poor health than other individuals. NEA recognises that it is not the responsibility of the health sector to provide good housing. However, as housing and health are inextricably linked the health sector does have an interest in ensuring that housing does not adversely affect the health of occupants and that personal behaviour within the home does not result in negative health outcomes. **[Charlotte Clarke A44 - University of Northumbria]** This cannot always be anticipated, therefore a stronger reliance on needs analysis would identify issues and allow changing needs to be exposed thereby allowing the strategy to be 'live' **[Chris Drinkwater A46 - West End Health Resource Centre]** Healthy living – mental and emotional wellbeing, food and nutrition and physical activity are not made explicit in the list. **[Heidi Jobling A47 - Newcastle Healthy City Project]** Derek Cox - Medical Officer for Dumfries and Galloway has done work on how to assess peoples 'well being' based upon the work of Max-Neef with the Model of Human-Scale Development. **[Karen Evans A49 - Age Concern and Years Ahead] The Life Course Model** Whilst the life course model is a useful one, we found that presenting it as a linear model left out important factors. For example, learning is deemed to undertaken near the beginning of the arrow, i.e. in younger years. **Proposal**: to change the model such that learning is portrayed as life long. Similarly, knowledge and education of sex is deemed to be something to be undertaken in younger years. However, there are an increasing number of people in their 50s with sexually transmitted diseases who, due to marital break up and other factors, are having unsafe sex.. Older people (and not only those in their 50s) should be included in sex education, not just younger people. **Locus of control** – this is about independence i.e. about not feeling totally dependent on others. Staying in your own home should not necessarily mean the one you live in now. To some extent we are all dependent on others but the issue as we age is avoiding unnecessary dependence i.e. being a prisoner in your own home unable to get out, meet people etc - as someone said, not being able to nip out to buy a loaf of bread when you need it. **Retirement** This is not mentioned in the model at all, yet, it has significant impact on opportunities, income, education and status of people retiring and therefore a big impact on their health. **Grandparenting / Great Grandparenting** Would it be possible to include the heading of 'Grandparenting' and Great Grandparenting as life course events? (to follow on from the 'parenting' theme listed on the arrow part of the diagram) Often the discussion around an ageing population focuses on older people as dependent on others and a drain on society. This neglects the huge contribution that people over fifty make to society through unpaid work: caring for sick or disabled people; caring for grandchildren and other voluntary work. Age Concern have estimated that the value

Q5	What is missing from the 'menu' of areas in which we could act?
	of unpaid care for sick and disabled people by people over 50 is worth around £15 billion a year. (Source: 'The economic contribution of older people' Report for Age Concern England by Pamela Meadows, Volterra Consulting January 2004) **Proposal:** to amend the life course model to include the above issues A lot more could be done around treating people with dignity and respect no matter who they are by improving basic practices through education and training. **[Ceri Mather A50 - Health Improvement Solutions / TPHN]** alcohol should feature pre birth as well as half way up, diet is missing from actions delaying parenting/conceptions could usefully be included in the actions access to services **[Sue Gordon A53 - PH Consultant - Individual]** Climate change is a major omission. **[Richard Pow A54 - Forestry Commission]** See previous answer. It would be better if there was a more clear read across from figure 2 to the proposed key areas for the strategy (3.1-3.8) **[S.C.Paske A55 - Regional STI Action Group]** We are very concerned that sexual health is left out of the menu. It is a clear national priority and there is strong evidence that sexual health in the north east is poorer than the national average. There is also evidence of much good practice in the area, particularly in the field of men who have sex with men. We are concerned that if this does not continue to be seen as a top priority that funding may be reduced. **[Tricia Cresswell A61 - Durham & Darlington PCTs]** Advocacy Taking risk – sexual health Quality of life – environmental sustainability **[Tim Blackman A62 - Wolfson Research Unit]** Three points: 1) More attention could be given to linking acute services into the effort to improve health, such as auditing admissions for what they reveal about public health failures and commissioning acute services to include public health and health promotion services as part of their in-patient and discharge responsibilities. 2) There could be scope for a regional role in 'adding value' through building on the experience of local service developments and regeneration initiatives in key areas, within an evaluative framework. This could help develop the evidence base in key areas such as reducing premature mortality and narrowing the health gap and facilitate the spread of good practice. 3) There could be more explicit recognition of the role of the health sector as itself a source of economic regeneration, employment and training capacity, of the importance of a healthy skilled workforce as a necessary precondition for successful economic regeneration, and of a supply of decent jobs as itself an important determinant of health and well-being. This includes the need to tackle the link between ill-health and worklessness and a key component of a strategy to tackle health inequalities. **[VONNE A64]** It may be included in friends and networks; however VONNE recommends the specific inclusion of access to services as a menu area under quality of life. We would also welcome the inclusion of education and the ability to learn, and mental health and emotional well-being throughout the life-course as we believe they should be included as life-long areas. **[Caroline Wild A66 - Learning Disability Directorate NTW NHS Trust]** A major area for people with a learning disability is in Oral Health promotion. This could be addressed in the strategy **[Angus Anderson / Arthur Probert A68 - Attend Rights to Warmth]** Action should be taken to address the impact of the cold. The proposals recognise the extreme impact of cold, and excess winter deaths in particular, but the impact of the cold is much more widely experienced and has a much greater impact on health service delivery than currently perceived. Rights to Warmth, in conjunction with the Kings Fund and the Wolfson Institute at the University of Durham, has reviewed the existing literature looking at the impact of cold conditions, which suggest that as many as 2 million people in England may suffer from mild hypothermia on an ongoing basis, and that as many as 400,000

Q5	What is missing from the ‘menu’ of areas in which we could act?
	emergency admissions and readmissions each year across England may be triggered by living in conditions that induce mild hypothermia. The strategy should, therefore, also develop actions for mitigating and addressing the less extreme but more significant effects of exposure to cold outlined in our previous answer. **[Stephen Blair A70 - North of Tyne PEC]** A key focus should be to identify the most vulnerable groups and the people who don’t engage with mainstream services **[Craig Duerden A71 – Middlesbrough Community Network]** The private or commercial sector is missing, e.g. private sector companies who provide public na other services e.g. nursing homes. School dinners, gyms and care services. These can have a positive impact on health and well-being; for example, care homes can promote healthy eating for their residents. Mental health and overall emotional health should be considered throughout the life course. **[Vera Bolter A72 – Elders Council of Newcastle]** Preventing accidents and falls is an important issues for older people, where a comprehensive strategy is required to cover all aspects of risk, e.g. falls and accidents in the home and in the street, as well as diagnosis and early treatments of causes of falls because of deteriorating health, sensory loss, etc. **[Kirsty Foster A75 - Health Protection Agency]** Two key areas that we have identified that are missing from the strategy are 1. **Sexual health** – considering sexual health in its broadest sense, this is one of the key areas that will impact both on the life course of residents of the North East (from teenage pregnancy and the impact that can have on life chances, through to morbidity and mortality from STIs, and the health inequalities we know exist in sexual health). Although rates of STIs in the region are not as high as other parts of the country, numbers of cases of HIV and AIDS, as well as the more common STIs, are increasing and the underlying factors need to be tackled at a regional level. Services for HIV and AIDS (preventive and treatment; health and wider aspects of care) need to be addressed at a regional level. 2. **Migrant health** – from a health protection perspective, the increase in migrants in the region pose particular problems with regard to infectious disease risk. On a broader scale, these new arrivals into our region are potentially a vulnerable group – with a wide range of problems and barriers (health, social, language barriers) to good health. We have seen specific problems relating to migrants with TB (an increasing problem in healthcare workers) and HIV (the massive rise in HIV in black African women in the NE), but surveillance data also show other health problems occurring. We are aware of work being undertaken by the PHO on migrant health but feel that this is a public health problem that can only be solved with a multidisciplinary and multiagency approach. In more general terms, there is no mention of infectious diseases or health protection as an aspect of public health that needs a coordinated approach across the region. Now that we are one health protection unit for the North East, a more consistent approach will be possible. **[Martin White A77 - Institute of Health & Society]** Ultimately, this needs to be based on epidemiological needs assessment, focusing on the biggest problems, widest inequalities etc. Some potential issues are missing (e.g. contraception/planned pregnancy; sexual health; injury prevention; diet/nutrition; physical activity, healthy ageing and later life, mental health). Primary prevention of CVD: this is going to become increasingly important as obesity and Type 2 diabetes epidemics kick in. Deaths due to CVD, in the North East, are double that of the general population. Type 2 diabetes prevention: a good evidence base; burdensome disease which can be prevented; risk assessment of ‘likelihood of developing’ easy by risk scoring; ethnic and socio-economic pattern, with different risk parameters for ethnic groups. With regard to diabetes, obesity treatment would be equitable. We would like to see mention of child abuse, looked after children, and domestic abuse. Given the emphasis on life course influences on health, there is some disappointment in the lack of content around pregnancy, and lifestyle interventions during this time (Contacts Drs Judith Rankin and Ruth Bell) ‘Traffic and transport’ should be highlighted in red, especially since the growth of cars on our roads is expected to rise more quickly compared to other parts of the UK. More pressure should be put on local on national government to improve public transport, which has deteriorated in the last few years. Reductions in public transport services can have a detrimental effect on access to health services for people who prefer not, or are not able, to drive a car. Local air quality and global climate change may also be affected negatively by reduction

Q5	What is missing from the 'menu' of areas in which we could act?
	in public transport. The quality and comfort one is granted by the use of public transport services, especially bus services, is no longer appropriate for 21st Century standards. In this respect, the North East Region falls behind many other parts of the UK and mainland Europe. The focus should not be placed on "gainful" employment, but on "meaningful" employment, which may have greater potential to improve health. **[Ruth Stevens A78 - NE Physical Activity Group]** Healthy living – mental and emotional wellbeing, food and nutrition and physical activity are not made explicit in the list. Physical activity is a key determinant of health throughout life and should be reflected on the diagram **[J Chexal A81 - Soroptomist Society]** Housing and employment should be included as priorities which are fundamental to standard of living. **[Alma Laing A83 - Local Engagement Board Gateshead PCT]** Building capacity among front line workers, including the voluntary sector, and raising the aspirations of the public. **[Paul Hanson A89 - North Tyneside Council]** Actions linked to diet – education and information, skills development **[Nonnie Crawford A90 - Individual]** Emotional health and wellbeing approaches for children, young people adults and older people **[Steve Brooker A91 - NE Sustainability Officers]** We are not clear on how this section adds value when the key focus areas are listed separately in section 2.3 **[Joyce Leeson A93 – Individual]** Public health impact / health promotion needed where every decision are taken which influence items – LA's, Housing Associations, Regional and local traffic, other planners, regeneration staff, schools, employers etc. **[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96]** Continuing the theme from the above response to Q4 There are a tremendous number of skills that could be taught at school (and out of school) which would help raise a child's ability and will to lead a long and healthy life. • Self esteem and assertiveness are critical at an early stage to limit the influence of harmful peer pressure • If we are to invest in social engineering in the population, we need to invest heavily in passing on those messages through the education system and others working with young people. **[Jean Blair A97 – Individual]** Think obesity should be included in "taking risks" **[Alisa Rutter B01 – Fresh – Smoke Free North East]** Very comprehensive list. **[Hartlepool & North Tees Workshop A34 annex]** Suggested additional areas for consideration at regional level and inclusion in a regional strategy: • Sexual Health • Problematic Substance Misuse - (rather than just alcohol) **Additional modes of implementation/support from regional level**: • Workforce development • Exchange of effective practice

Q6	Are these the most significant and the alterable of areas that influence health and well being? What others would you advocate?
	[Mike Lauerman A09 – CSIP – individual] Must ensure close link with anti poverty and economic regeneration agendas **[Louise Wilson A10 – Northern CFS/ME Clinical Network]** The key focus areas do not distinguish between children/young people, adults, the severely affected and so on. **[Jan Welbury A12 – consultant paediatrician – individual]** Childhood needs separate consideration in terms of what factors are alterable that might improve life chances. I came because Karen Horridge came across this document by accident – what consultation has there been, or publicity, with those involved in children's health? **[Philip Wynn A13 – Durham CC Occupational health service]** The Key Focus areas should recognise the role of work in achieving and maintaining favourable health outcomes. **[Brian Hedley A14 – Newcastle CC Strategic Housing Service]** Housing and personal economic circumstances. **[David Chappel A16 – NEPHO – individual]** This looks fine at this stage. **[Karen Horridge A17 – consultant paediatrician – individual]** Childhood needs separate consideration in terms of what factors are alterable that might improve life chances. I came across this document by accident – what consultation has there been, or publicity, with those involved in children's health? **[David Chappel A18 – NEPHO response]** Where do they link to evidence base? Not clear which politically expedient. While the focus upon improving educational attainment is very welcome, the needs of those who are not able to achieve such improvement need to be addressed. **[Bharat Sibal A20 – Public Health Trainees Group]** Sexual health, Teenage Pregnancy, HCAIs seems to be omitted **[Vivien Hollyoak A21 – North Tyneside PCT]** The Regional Strategy and the key focus areas should be seen to emerge from a strategic needs assessment conducted and articulated jointly with key stakeholders and provide an exemplar for Joint Strategic Needs Assessment across the region **[John Woodhouse A25 – HPA]** please see comments for Q4/5 above. We recognise that those issues outlined in paragraph 2.3.1 are all of particular relevance to the population of the North East. We have a particular interest and concern about promoting psychological health and wellbeing through the proper understanding of risk and the appropriate response of individuals and communities. **[Rachel Turnbull A26 – Northumberland CAB]** Increasing access to free, impartial and confidential information, advice and guidance. **[Gwen Ellison A27 – Health Trainers Coordination]** Self –efficacy, well-being, satisfaction with life and achievement of potential, educational attainment **[Angela Ellins A28 – C&L GONE]** Sexual health. Prevention of U18 conceptions **[Elaine Richardson A29 – Jobcentre Plus NE Region] Yes , agree** **[Louise Wilson A30 – Sport England]** We broadly support the key focus areas listed. **[Caroline Airs A31 – Gateshead Advocacy Information Network]** As discussed at the Third Sector Consultation event, mental and emotional health and wellbeing underpins most of the areas identified, and should be at the core of any strategy. A key element of mental and emotional health is Independence, Choice and Control. **[Peter Wright A32 – NE Chief EHOs Group]** In our most deprived neighbourhoods the significance of norms and beliefs cannot be underestimated. These are alterable, but this is a long process and needs to be undertaken largely outside the NHS. There is a strong role for the Strategy to influence themes for future LAA and MAAs to tackle this issue across the region. Sexual health is missing. There are inequalities in sexual behaviour and in sexual health outcomes which are

Q6	Are these the most significant and the alterable of areas that influence health and well being? What others would you advocate?
	wider than the teenage pregnancy agenda **[Jennifer Taylor A34 – Tees Public Health Dept]** "The Regional Tobacco Control Strategy is a very important tool to maintain the high profile of smoking cessation and tobacco control in the North East. Extra aid to areas struggling with targets and possibly small teams to go in to and help in these areas. There has to be adequate and sustainable resources available to all stop smoking services and an acknowledgement that 'one size does not fit all' with each service approach, but rather to embrace varied methods of delivery." "Coordination at a regional level already in place is working well, but there needs to be good two way communication and consideration given to the differences and requirements at a local level to enable services to concentrate on inequalities and target local need. **3.1.9** It is important that 'shock tactics' are not used in this area as we have had used previously, as this is counter productive. It should be done by increasing awareness and highlighting/reinforcing the dangers and risks. **3.1.11** Campaigns should be assessed for added value. There was an example of a campaign directed by Fresh recently which must have been costly and had **no value** to the Middlesbrough area (the Big Quit) Approach to future campaigns should be considered carefully and involve local services more closely. **3.1.14** 'Smoking prevalence' – There is a concern that 'smoking prevalence' is considered to be down to Stop Smoking Services. The recent NHS Stop Smoking Service Monitoring and Guidance document states that 'Stop Smoking Services should not be regarded as the main driver for a reduction in prevalence and that National Policies and Local Tobacco Control Strategies affect this more! I think this point needs to be clear. **3.1.17** I have some concerns that to have a regional smoking prevalence target may not take into account variations at a local level. This is not a fine enough tool to monitor activity at a local level and if set regionally it may mask problems at a local level. **3.1.18** There is a whole new debate around the area of the QOF in relation to Smoking. This recording process should be looked at in relation to the requirements requested. It would improve matters considerably if there was a requirement for GP Surgeries at least to signpost to Specialist services or to provide stop smoking treatment, before the 'point' was given! Stop Smoking is everyone's business and every health professional should see it as an integral part of their role!" "Regional action would facilitate easier and better comparison of practice and subsequent sharing of best practice throughout the region. We need to know what has worked elsewhere and what provides the best value for money. For instance, following development of a toolkit in Hartlepool we are now looking at what should be our next action and regional support would be very useful. Regional support around early interventions is also desired" (Please see consultation event document attached for further comments) **[Martin Shaw A36 – Natural England]** Strongly support the inclusion of diet, obesity, physical activity and mental health. Need to add employability and workplace health. **[Leah Blacklock A37 – Community Action on Health]** CAOH believes that these are significant priorities for the strategy to focus upon and would also suggest action on drugs to be considered. **[Janice McColm A40 – Tees Valley Rural Community Council]** Education **[Peter Heywood A41 – Middlesbrough PCT – Individual]** This is fine. Again, tendency to focus on too many 'priorities', which dilutes the whole meaning of what a priority is! **[Ann-Marie Gibson A42 – National Energy Action]** One omission here is 'cold-related morbidity and mortality' although 'excess winter deaths' is covered in section 3.5 there is no mention of cold-related morbidity. **[Charlotte Clarke A44 – University of Northumbria]** The document appeared to be predominately informed by a medical model and illness focus rather than a social model of health. The need for a mixed model approach to allow greater like hood of being able to more accurate identify problems and create appropriate solutions is desirable **[Chris Drinkwater A46 – West End Health Resource Centre]** Employability and workplace health need to be added to the list. The North East still has high numbers of people who are workless and/or on incapacity

Q6	Are these the most significant and the alterable of areas that influence health and well being? What others would you advocate?
	benefit. We also need to do more on using the workplace to improve health. **[Karen Even A49 – Age Concern (North East)]** Age Concern and the Regional Forum on Ageing 'years ahead' would agree with the key influencers of health and well being listed in the strategy. We would also advocate a priority to reduce age discrimination in health care. For point 3.2 'specific action on diet and obesity' we would also like to see 'specific action on diet and malnutrition' included. Age Concern has been promoting a national, regional and local campaign called 'Hungry to be Heard' since August 2007 regarding the malnutrition of older people whilst in hospital. We know that 4 out of 10 older people are already malnourished upon arrival to hospital and that 6 out of 10 older people are malnourished when they leave hospital (source: Malnutrition within an Ageing Population: A Call to Action, European Nutrition for Health Alliance, August 2005). Age Concern has several recommendations for specific action to be taken by NHS Trusts and staff to tackle this problem. Please refer to the Age Concern England Website: www.ageconcern.org.uk to locate the document 'Hungry to be Heard, The scandal of malnourished older people in hospital' (August 2006). Offering choice is also very significant. Older people need to be helped and supported in making appropriate choices. Measures to give due weight to the needs and aspirations of older people , as the main users of most health services should be implemented **[Ceri Mather A50 – Health Improvement Solutions / TPHN]** Delaying conceptions/parenting **[Richard Briggs A51 – Cruse Bereavement Care]** We wholeheartedly endorse the "Key focus areas" put forward and most especially sub-paragraphs 3.6 Receiving help at the earliest opportunity, 3.7 Improving mental health and 3.8 Achieving a good death. **[Sue Gordon A53 – PH Consultant – Individual]** The Regional Strategy and the key focus areas should be seen to emerge from a strategic needs assessment conducted and articulated jointly with key stakeholders and provide an exemplar for Joint Strategic Needs Assessment across the region. Multisectoral approach to prevention and protection from the effects of climate change, accidents & sexual health are specific issues. **[Richard Pow A54 – Forestry Commission]** The consultation document and evidence that it draws on suggests that these are the right areas to focus on. **[Andy Roberts A56 – Ncle CC Children's Services]** Drug abuse. **[Tricia Cresswell A61 – Durham & Darlington PCTs]** Clarity on point 3.5. Does this mean the strategy seeks to influence/impact on the wider determinants of health? Other areas that should be considered are: • Sexual health omission. The reference to 'sex' in the timeline is inappropriate as sexual health is integral to an individual's health from preconception to death. Sexual health contributes to the overall mental, physical and social health of individuals and communities. • Education impact on health. • Health inequalities should be identified as an overarching point • Oral health and dentistry. **[Tim Blackman A62 – Wolfson Research Unit]** Drug abuse should be included, and could be grouped together with alcohol and smoking as addiction issues. Allergies should be included. Long-term conditions should be included as a well-being issue. **[VONNE A64]** At the, VONNE organised, regional consultation event for the Third Sector on the proposed strategy, there was much discussion on whether the eight areas identified were the right ones. The majority of people agreed that these were areas where action was needed, however the debate centred on if they were too symptom focused and whether the action areas need to have greater focus on cause and preventative approaches. The cross cutting nature of a number of the key areas was recognised, with the argument put forward that the

Q6	Are these the most significant and the alterable of areas that influence health and well being? What others would you advocate?
	areas forming the core of the strategy should be broader in their focus. Overall there was no firm consensus on what constituted the most significant areas upon which a strategy should focus, however the following themes did emerge and are included for consideration. • Mental health and emotional well-being is a key cross-cutting component effecting everyone's health & well-being. The under-pinning role it plays across all areas needs to be given primary focus. • Specific action on diet and obesity needs to include specific reference to malnutrition. This is particularly relevant given the North East's population forecast over the next 25 years. • Access to services should be a key focus area of its own. • Receiving help at the earliest opportunity should also include specific reference to receiving help as long as it is required. • Achieving a good death is welcomed. • There should be a specific focus on partnership development and the commissioning framework, ensuring funding is directed to organisations and services delivering at a community and local level where it is most needed. • Drugs and sexual health should merit inclusion. • Carers should have a specific cross cutting focus. Recognising that the impact on individual's health and well-being can be caused by a wide array of issues and they will respond differently to treatment and support, it may be more beneficial if the strategy focused on the broad core areas of; children and young people, older people, women, men, carers and the environment. **[Dave Parkin A67 – Wallsend Town Hall]** Yes. Nothing to add **[Angus Anderson / Arthur Probert A68 – Attend Rights to Warmth]** We would advocate that exposure to cold be added to the list. Definite actions can be taken to improve the situation, such as social marketing programmes to raise awareness and the development of intervention strategies for those at risk, particularly among the elderly, that help them maintain independence, so reducing levels of admission and readmission to hospital. The benefits from including exposure to cold are not only improved health and well being for a significant number of people, but also a consequential release of resources for use in other parts of the health and social services. **[Stephen Blair A70 – North of Tyne PEC]** Some focus on accident prevention **[Craig Duerden A71 – Middlesbrough Community Network]** The Planning and Environmental governance structure can be important to health and well-being and the encouragement of healthy lifestyles. For example local authorities have to ensure the right mix of retail outlets in an area and can potentially limit fast food shops. Drug and alcohol misuse should be a key area – both drug and alcohol misuse is a priority. **[Vera Bolter A72 – Elders Council of Newcastle]** As far as older people are concerned a different approach may be needed. For instance rather than concentrating on reducing obesity, it is preferable to promote healthy diets, especially as there is evidence of malnutrition in this age group. We would also see merit in promoting healthy lifestyles that would include both exercise and healthy eating in a single programme. Maintaining social networks is an important part relating to healthy ageing and contributes directly to promoting mental health. **[Joanne Lavender A74 – North East Chamber of Commerce]** Health and Safety awareness training. **[Martin White A77 – Institute of Health & Society]** Teenage pregnancy; health behaviours in pregnancy (see above). Systematic approaches to intervention generated inequalities, which are pervasive in health care and public health. Stroke: the National Strategy for stroke has just been published. This needs integrating with this strategy. Although we have one of the highest levels of adherence to national standards in the national stroke audit, there is still a great deal to be done to implement the known evidence base. There is a strong argument for the proposals to develop and raise stroke awareness, and clearly we are supportive of this through the NIHR funded DASH stroke research programme grant that we are involved with. Nonetheless, the potential at a

Q6	Are these the most significant and the alterable of areas that influence health and well being? What others would you advocate?
	population level to make a big difference is still likely to be limited with hyper-acute treatment at the moment. Furthermore, the section on surviving stroke implies that the problem exists with the public. There is also a need for a shift in professional perception to see stroke as a medical emergency. Whatever the plans are for stroke, it will be good to see them addressed alongside the DASH research programme. It would be a shame to see rapid implementation of interventions prior to the development of the evidence base that we are pursuing (Contacts: Prof Richard Thomson, Prof Gary Ford, Prof Martin White, Dr Helen Rodgers, Dr Madeleine Murtagh). Primary prevention of CVD (see also response to Q5) Prevention and management of mental illness could be given greater prominence **[Ruth Stevens A78 – NE Physical Activity Group]** Employability and workplace health need to be added to the list. The North East still has high numbers of people who are workless and/or on incapacity benefit. We also need to do more on using the workplace to improve health. **[J Chexal A81 – Soroptomist Society]** We would advocate the inclusion of housing and employment. **[Gateshead Public Health Partnership A82]** Key focus areas in section 2.3 3.5 " achieving better health thro' broader action and achieving broader aims thro' better health" is a clear statement 3.6 Should read receiving the right help at the earliest opportunity We need to ensure that older people's needs are met within these areas. Leisure, relaxation and sport is an area which has potential to impact on a number of different issues for people at all stages of life: alcohol use, physical activity, well-being, social isolation, lifelong education. **[Anne Simpson A84 – Redcar & Cleveland Partnership, H&WB LIT]** Sexual Health (and not just young people but in general); Substance misuse (ditto). Emotional as well as mental health **[Paul Hanson A89 – North Tyneside Council]** A stronger focus on educational attainment and housing quality to support improved health, and joined up action / intervention between health agencies and local authorities **[Steve Brooker A91 – NE Sustainability Officers]** Mental health should include confidence and self-esteem, two significant influences on individual contentment. The text surrounding the list would benefit from an explanation of the importance of education in contributing to tackling these issues **[Peter Wright A92 – NE Public Protection Chief Officers Group]** In our most deprived neighbourhoods the significance of norms and beliefs cannot be underestimated. These are alterable, but this is a long process and needs to be undertaken largely outside the NHS. There is a strong role for the Strategy to influence themes for future LAA and MAAs to tackle this issue across the region. **[Joyce Leeson A93 – Individual]** See 5. Suggest link health of North East with health of planet. Poorer people here and throughout the world are the first victims of climate change – floods, temperature rises etc. Promoting health eating, walking and cycling, reduced tobacco use, less vehicle (and air) carbon emissions link in here. **[Nic Best A94 – Campaign to Protect Rural England]** Tranquillity is a key component in mental health and well-being. CPRE has been promoting the concept of tranquillity over the last fifteen years. In 2004-5, CPRE North East and others commissioned a study[1] which assessed ordinary people's concepts of rural tranquillity and developed a planning methodology to protect and develop environments conducive to generating feelings of tranquillity **[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96]** In our most deprived neighbourhoods the significance of norms and beliefs cannot be underestimated. These are alterable, but this is a long process and needs to be undertaken largely outside the NHS. There is a strong role for the Strategy to influence themes for future LAA and MAAs to tackle this issue across the region.

[1] Mapping Tranquillity CPRE March 2005 ISBN: 1902786777

Q6	**Are these the most significant and the alterable of areas that influence health and well being? What others would you advocate?**
	For consistency if alcohol and smoking are to be included as issues, so should sexual health, patterns of eating and patterns of physical activity. All of these are directly intertwined with efforts to tackle inequalities in health. **[A98]** The Arts Council believes that participation in cultural activity is a direct contributor to well-being. Increasing the volume and the quality of cultural participation in the North East will be central to Arts Council strategy in the next three years. **[B01]** Perhaps a more formal acknowledgment on cancer prevention would be welcomed. There is no reference made to sun exposure and skin cancer, and there is a clear need for advocacy and legislative action around the area of the proliferation of unregulated, irresponsibility promoted solariums. **[Danny Ruta B03 – individual]** Sexual health and accidents (see response to question 3 above)

Q7	What other regional action should be taken on smoking?
	[Jan Welbury A12 – consultant paediatrician – individual] Specific programmes and strategies to support children to quit smoking. Many of the L:AC children have been smoking since around 10years of age and they are very dependent – their care situation which often has many uncertainties makes a cessation programme almost impossible particularly as many carers smoke – the latter needs to be addressed and we need to participate more actively in resolving the care needs of children. **[Brian Hedley A14 – Newcastle CC Strategic Housing Service]** Actively discourage smoking in **all** public spaces which are not covered by the current ban i.e. pedestrianised streetscapes, outside schools and hospitals. More use of role models (i.e. local sportsmen, entertainers) and popular media to support anti-smoking campaigns. **[David Chappel A16 – NEPHO – individual]** Given there is already a regional strategy under the aegis of Fresh there is little need to add anything here. **[Karen Horridge A17 – consultant paediatrician – individual]** Specific programmes and strategies to support children to quit smoking. **[David Chappel A18 – NEPHO response]** Given there is already a regional strategy under the aegis of Fresh there is little need to add anything here. **[Bharat Sibal A20 – Public Health Trainees Group]** Combined response with Q8 (next question) **[Vivien Hollyoak A21 – North Tyneside PCT]** Establish an evidence base for primary prevention. School based smoking initiatives are ad hoc and ineffective. However, preventing the uptake of smoking is of strategic importance and local areas should be given a regional steer. **[Rachel Turnbull A26 – Northumberland CAB]** If people have chaotic lifestyles and low income, they are more likely to smoke. It is a way of controlling stress. Until these underlying themes are tackled, it is going to be very hard for some people to stop smoking. **[Elaine Richardson A29 – Jobcentre Plus NE Region] LSP's and employers to work together to support employees/colleagues to quit. Joint promotional work in the workplace.** **[Peter Wright A32 – NE Chief EHOs Group]** The Region should robustly campaign for data on smoking status to be gathered by GPs, backed by the QOF. We must have accurate, timely information about smoking rates to track progress on various strands of work. We believe that this should be a national requirement, rather than relying on the regional arrangement proposed in 3.1.18. We believe that the region should champion "tobacco poverty" as a means of showing the wider effects of companies selling addictive substances for profit. There is a danger that tobacco companies manoeuvre the government into accepting oral tobacco as a safer alternative to smoked products – whilst this would have substantial health benefits it would do nothing to alleviate some of the other effects of nicotine addiction in removing people's choice over how to spend their income, and in reducing their control over other life choices which impact on health. (If we can get them off the fags, why don't we maintain them on NRT at public expense rather than Snus) The Region should champion the raising of the age to purchase tobacco to 21. Regional publicity must continue at the current (or better) high levels. We believe a significant component of the regions position in having the best compliance with Smoke free laws is due to the population having a better understanding of the dangers of ETS than the rest of the country, largely due to the high quality TV adverts. The position of the region's stop smoking services as the best in the country is commendable, and we need to take action to ensure that they remain well ahead of the field for the next 25 years. We need to adopt different approaches to service improvement and commissioning to achieve this. The region should lobby government for substantial increases in the funding and staffing of the HMRC anti-smuggling teams so that they can make a significant impact on the supply of smuggled tobacco. The chapter needs an inequalities focus. The interventions it describes are universal and could increase inequalities **[Hartlepool & North Tees Workshop A34 annex]** Regional action would facilitate easier and better comparison of practice and subsequent sharing of best practice throughout the region. We need to know what

Q7	What other regional action should be taken on smoking?
	has worked elsewhere and what provides the best value for money. For instance, following development of a toolkit in Hartlepool we are now looking at what should be our next action and regional support would be very useful. Regional support around early interventions is also desired. **[Kevin Rowan A35 – TUC]** The introduction of a comprehensive ban on smoking in workplaces and enclosed public places was a milestone achievement in improving occupational health and was strongly supported by the TUC. Evidence would show that smoking is a root cause of much ill health and smoking cessation is accelerated by a workplace ban. However, we do know that smoking continues to see high prevalence in certain groups in the community. People living in deprived communities and young people are disproportionately highly represented in smoker statistics. Future efforts should focus on prevention and cessation among these groups. The north east enjoys high compliance rates following the introduction of new duties and regulations related to smoking at work and in enclosed public places, which demonstrates that it is evidently possible to radically change culture and behaviours. Within the workplace the TUC will continue to support efforts to reduce smoking, through formal policing of the regulations and through supporting social marketing initiatives to promote good health. **[Leah Blacklock A37 – Community Action on Health]** CAOH feels that the smoking priority area suggests a number of important and useful action points. However, we believe it will be difficult to gather statistics on smoking during pregnancy. People are often reluctant to tell their doctor that they smoke and particularly so when they are pregnant. The proposals also do not make any mention of counterfeit tobacco/cigarettes and how this issue can be overcome. There is also no target around under-age smoking. Finally, we would also suggest monitoring the price of black market cigarettes as an indicators of smoking prevalence. **[Janice McColm A40 – Tees Valley Rural Community Council]** Education in schools, smoking cessation self help group in schools. A campaign highlighting the positive aspects of not smoking rather than just looking at the negative aspects of smoking. **[Peter Heywood A41 – Middlesbrough PCT – Individual]** Comprehensive list of actions at regional level . . . . • Need strong leadership at regional level • Need to utilise QOF more to achieve our goals. Better use of IT so that automated invitations are generated to SSS whenever a smoker is identified. Why ask (and pay) GPs simply to record smoking status rather than deal with it? • Mandatory stop smoking training for all midwives and paediatric staff plus compulsory brief training for all Drs at induction Leadership to ensure that employees at every part of the system where a smoker 'turns up' knows what to do and direct them to the best available support. **[Ann-Marie Gibson A42 – National Energy Action]** Recognition of the link between poor housing and potentially harmful behaviour e.g. smoking. Psychological distress resulting from poor living conditions and associated social exclusion may predispose the occupant(s) to such behaviour. Consequently, action to tackle fuel poverty may lead to positive action on smoking. **[Charlotte Clarke A44 – University of Northumbria]** Continued prevention rather then stopping smoking. Questioning to what degree any individual lifestyle behaviour should be focused on in isolation to whole lifestyle choices and the choice processes **[Chris Drinkwater A46 – West End Health Resource Centre]** Need to explore more effective ways of targeting groups D & E, perhaps through health trainers and peer support. Social marketing approaches could be used to explore this issue. **[Karen Evans A49 – Age Concern and Years Ahead]** At our recent consultation event for older people to inform this strategy on the 6th December, the overall feeling was that older people were glad that 'smoking' was included in the strategy. Further comments revealed however that smoking cessation was not a priority issue for older people. The perception was that older people were not going to change their habits and that the damage had already been done. It was felt more important to target resources at educating and encouraging

Q7	What other regional action should be taken on smoking?
	young people to stop smoking, although these comments may be a manifestation of older people having lower expectations. It is important to note that that this view of older people really relates to 'older' older people and 50 year olds giving up smoking will improve their life chances and health. This is an important point to make in terms of the great span of age covered by the term "older people" and the danger in assuming that issues are applicable to 50 year olds as well as 90 year olds. It appears that the North East is doing well in reducing smoking and 2032 seems a long way off to reduce the overall regional prevalence to 10%, could this be brought forward a few years? **See further comments on this question at Appendix 1** **[Ceri Mather A50 – Health Improvement Solutions / TPHN]** Think this is covered well **[Alison Nichol A52 – Northumberland Stop Smoking Service]** Proposal 3.1.7 There needs to be a structured forum in order to discuss and develop quality standards regarding key interventions rather than concentrating solely on quit rates etc. Proposal 3.1.9 There needs to be support to encourage Acute Trusts to complete discharge data as this is a problem area. This data needs to be validated as opposed to self-reported. Proposal 3.1.17 it should be clearly recognised that stop smoking services alone cannot influence smoking prevalence. Whilst there is a need to monitor quit rates, there needs to be acknowledgement that by targeting traditionally hard to reach groups the quit rate could drop. Initially there may be a greater need to increase activity and access to services with an understanding that: These quitters may need longer and more intensive support together with more medication for a longer period. These quitters may relapse and return to services more frequently. These quitters may lower quit rates. There needs to be greater emphasis on smokers obtaining support in primary care and explore reasons why this support is not always available. Proposal 3.1.18 There needs to be greater monitoring of smoking status as it frequently changes. There also needs to be CO validation. There needs to be greater links developed between dietary, exercise and quitting support so that the stop smoking services have more opportunity to refer quitters directly. This would lead to a seamless holistic approach to the care required by many smokers. One final general comment would be that for many of these lifestyle choices be they smoking, alcohol diet or exercise we need to address the lack of self-worth and hopelessness that many young people feel which can contribute negatively to the choices they make. **[Sue Gordon A53 – PH Consultant – Individual]** Given the recent publication of the new radon maps, it would be worth exploring geographically targeted interventions based on those areas at greatest risk. **[Andy Roberts A56 – Ncle CC Children's Services]** How will the strategy address the cultural issues involved in areas of deprivation? **[Tricia Cresswell A61 – Durham & Darlington PCTs]** Tackling inequalities in outcome of people accessing the services to support those from lower socio economic groups Life course needs to include a more prominent focus on the impacts of smoking e.g. pre conception impact of smoking on reduced fertility levels for males/females. Target in relation to GP practice registers may not be feasible, unless the strategy implies there is a role for influencing QOF at national level. Agreement on referral processes including carbon monoxide monitoring or better still cotinene testing at booking is needed first, so an accurate prevalence of smoking pregnant women can be identified. Stronger performance monitoring for training health professionals in brief interventions, and implementation of the intervention with pregnant women and their families. Like wises, stronger performance management on implementation of the 10 High Impact Actions for pregnant women.

Q7	What other regional action should be taken on smoking?
	The targets identified do not fit with the very low progress that has been made in the last seven years with the current smoking cessation service. Service redesign issues via a stronger commissioning process and tighter performance management could assist the step change required. Support for smoke free mental health trusts- ensuring stop smoking services are accessible to individuals with mental health problems and staff confident in providing support **[Tim Blackman A62 – Wolfson Research Unit]** There should be more attention given to establishing the extent of cigarette smuggling and basing interventions on this research. Funding for smoking cessation services needs to be visible and the volume of services plausible compared to the prevalence targets. Regional priorities for health and well-being should be reflected in local strategies, and preventive services should not continue to provide a soft target for cost savings. A systematic approach to targeting disadvantaged groups and areas at local levels should be encouraged. A key strand is the creation of additional regional targets. This needs to be supported by an implementation strategy aligned with finance and commissioning strategies, with regional support for investing in longer term health. How will PCTs and others be supported in meeting regional targets, which are to be commended but which are additional to national targets? **[VONNE A64]** VONNE would welcome an action which uses education to challenge and change perceptions of smoking. This is suggested over and above the proposed broader marketing campaign. We would also welcome specific action which supports / assists children who grow up in household where one or both parent / guardian smoke. With regard to the proposed lobbying and campaigning on content of cigarettes, VONNE would welcome further regional debate and research into whether this is a key priority. We have concerns that lobbying on this issue may divert valuable resources away from frontline delivery. EU Directive 2001/37/EC already provides legislation on the content of cigarettes and it is questionable what impact lobbying will have. There may also be a potential knock on effect with regard to an increase in smuggling and the availability of counterfeit cigarettes. If proposed lobbying on content is successful and is coupled with a likely increase in taxation, we are concerned that more smokers may turn to smuggled and counterfeit cigarettes to save money and achieve the same 'taste'. At present it is estimated 1 in 6 cigarettes and about half of hand-rolling tobacco smoked in Britain are illicit (New responses to new challenges: Reinforcing the Tackling Tobacco Smuggling Strategy. HM Treasury, March 2006). We propose that further research is commissioned into why people purchase counterfeit and smuggled cigarettes, coupled with regional specific research looking at potential social and economic factors influencing why North East people continue to smoke after the recent legislation. The results of which can be used to focus the relevant social marketing and lobbying. **[Caroline Wild A65 – Northgate Hospital Ctte Group]** Staff who know us (in Learning disability services) should have training to help us stop smoking. Staff should encourage you to be healthier in all ways. It's good to have things to look at and touch that help you understand about why smoking is bad for you. Information and leaflets need to be easy to read and with pictures. Staff that don't smoke should have training about how hard it is to stop. Staff who do smoke should try to stop too **[Caroline Wild A66 – Learning Disability Directorate NTW NHS Trust]** People with a learning disability have largely been unable to access any of the existing action on smoking because information is not accessible, and they have not been targeted for specific support. Further work must address this and ensure that vulnerable groups who already experience health inequalities are not left behind further. **[Stephen Blair A70 – North of Tyne PEC]** More emphasis on primary prevention and more specific action to reach the hard to reach groups **[Craig Duerden A71 – Middlesbrough Community Network]** Education should be a priority – focus should be given to initiatives that attempt to change perceptions. It is suggested that the cost of NRT should be reduced / subsidised and availability should be widened. Targeted work towards the hard to reach groups e.g. people with

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	mental health needs may well prove beneficial. **[Vera Bolter A72 – Elders Council of Newcastle]** With regard to reducing smoking, future policy should combine enforcing existing regulations with help to individuals to change behaviour. **[Martin White A77 – Institute of Health & Society]** Limit point of sale promotions Enforce law on sales to under-18s. Make bolder attempts to prevent teenagers from starting smoking (e.g. targeting of young people with a "truth campaign", similar to that run in the USA, and/or some of the excellent work done by Health Scotland (about which the Chief Executive of FORREST remarked that he was completely against it; one of the best complements for tobacco control work!). Making smoking unpopular among kids). Some targeted social marketing on stop smoking services is needed for men and ethnic minorities, who are less likely to use services, and think they can give up on their own. Many people smoke and drink, and it may be worth while exploring the delivery of brief interventions on alcohol at the same time as level 2 interventions. **[Ruth Stevens A78 – NE Physical Activity Group]** Need to explore more effective ways of targeting groups D & E, perhaps through health trainers and peer support. Social marketing approaches could be used to explore this issue. **[J Chexal A81 – Soroptomist Society]** Would it be possible to work towards the elimination of tobacco from duty-free allowances? **[Gateshead Public Health Partnership A82]** The Region should champion the raising of the age to purchase tobacco to 21 The Region should robustly campaign for data on smoking status to be gathered by GPs, backed by the QOF. We must have accurate, timely information about smoking rates to track progress on various strands of work. **[Paul Hanson A89 – North Tyneside Council]** Additional focus on school age smokers, with prevalence targets Need to ensure that we don't loss focus as other public health agendas take priority **[Nonnie Crawford A90 – Individual]** Specific work around schools and young people particularly girls? **[Peter Wright A92 – NE Public Protection Chief Officers Group]** The Region should robustly campaign for data on smoking status to be gathered by GPs, backed by the QOF. We must have accurate, timely information about smoking rates to track progress on various strands of work. We believe that this should be a national requirement, rather than relying on the regional arrangement proposed in 3.1.18. We believe that the region should champion "tobacco poverty" as a means of showing the wider effects of companies selling addictive substances for profit. There is a danger that tobacco companies manoeuvre the government into accepting oral tobacco as a safer alternative to smoked products – whilst this would have substantial health benefits it would do nothing to alleviate some of the other effects of nicotine addiction in removing people's choice over how to spend their income, and in reducing their control over other life choices which impact on health. If people can be encouraged to stop smoking, but cannot break their nicotine addiction, they should be provided long term smokeless nicotine alternatives at public expense. Tolerating a transition to snus, and other tobacco industry smokeless products, will perpetuate tobacco poverty. The Region should champion the raising of the age to purchase tobacco to 21. The Region should champion the elimination of cigarettes being openly on sale, as shop displays are a subliminal form of advertising. The Region should champion the **Positive** Licensing of tobacco sellers. There should be numerical controls on the numbers of licensed sellers in an area. An addictive, harmful product should **not** be freely available in most shops. Regional publicity must continue at the current (or better) high levels. We believe a significant component of the regions position in having the best compliance with Smokefree laws is due to the population having a better understanding of the dangers of ETS than the rest of the country, largely due to the high quality TV adverts. The position of the region's stop smoking services as the best in the country is commendable, and we need to take action to ensure that they remain well ahead of the field for the next 25 years. We need to adopt different

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approaches to service improvement and commissioning to achieve this.

The region should lobby government for substantial increases in the funding and staffing of the HMRC anti-smuggling teams so that they can make a significant impact on the supply of smuggled tobacco.

The chapter needs an inequalities focus. The interventions it describes are universal and could increase inequalities

[Joyce Leeson A93 – Individual] Don’t put pressure on pregnant women. Expectant fathers, grandparents, friends, work mates etc should all be targeted to ‘protect that baby’ and support the pregnant woman.

[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] The Region should robustly campaign for data on smoking status to be gathered by GPs, backed by the QOF. We must have accurate, timely information about smoking rates to track progress on various strands of work. We believe that this should be a national requirement, rather than relying on the regional arrangement proposed in 3.1.18.

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[Alisa Rutter B01 – Fresh – Smoke Free North East] Overall the priority given to smoking is very welcome and this section is a good summary of areas of action going forward.

It is vital that there is a clear link between this section and that of the Regional Tobacco Strategy 2005-8 and new one to be developed in 2008 to cover the period to 2011. Linked to this will be regional action plans produced in 2008 (with requirement for locally accountable delivery plans) on: Reducing smoking to improve reproductive, maternal and child health; Reducing the demand and supply for cheap tobacco; Tobacco campaigns and communications.

In addition as part of the Cancer Reform Strategy there will be a consultation on a new National Tobacco Strategy and in 2008 there is a process underway to review Smoking Skills 1998 and update it for a new Revisited Strategy.

Fresh has expanded/amended the specific text as recommended below. We have also provided a ‘wish list’ of future legislation that should be pursued over the next few years and which clearly will have an impact on reducing smoking rates- vital in consideration of the fact that many of the key drivers for reducing smoking have already been implemented in the UK and with stagnating overall rates, and stubbornly high rates amongst routine and manual smokers, a long term strategy must propose some radical actions.

Reducing exposure to secondhand smoke

- Whilst the whole of the UK has now implemented comprehensive workplace and enclosed public places smokefree legislation, some sections of society remain vulnerable exposed to the lethal effects of exposure to SHS.

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- Work will continue to ensure that compliance with the law remains high and that ongoing evidence is collected to influence the planned three-year review of the law.

- Work will continue to support and guide those areas, which are currently exempted, from the law to ensure that non-smokers are protected from SHS as much as possible

- Ongoing education and media awareness of the health impacts of SHS will continue to build up further public acceptance of the health risks and support for future protective measures

- A region side training programme for health professionals on SHS, including within the acute sector should be implemented to ensure patients are given accurate information on protection from SHS

- Work will be undertaken to develop evidence-based approaches to addressing exposure to SHS in domestic and car settings. Ultimately there will be a need for legislation to ban smoking in cars when children are inside.

Help for smokers to stop

- At least 70% of smokers indicate they would like to stop smoking and work continue to ensure that all smokers have access to evidence based support through out the region

- Smoking rates are substantially higher (double that of professional groups) in routine and manual worker groups and in order to reduce health inequalities priority should be given to these groups. This means that locally, services need to ensure that they are not just focussing action on the most deprived wards as this in itself will not necessarily achieve the key inequalities targets for routine and manual smokers- where the greatest proportion of smokers can be found. Sub-groups warranting additional attention and priority are women of child bearing age (because of impact on maternal and child health) and mental health service users (given high levels of smoking related illness and death).

- The NHS offers a range of support to smokers and further action to actively promote the availability of these is important and such promotion should be undertaken by a the wide range of partners involved in tobacco control activity
- The North East as a whole has the best performing NHS Stop Smoking Services in the country. But this hides a large variation between areas within the region.

- We propose that there should be regional standards for levels of service that require the less well performing areas to increase their activity to match those achieved by the best, and to continue improvement in all services to ensure that the North East continues to have the most effective Services in the country.

- It is important that the evidence base on smoking cessation is fully implemented and vital that key government directives, for example NICE guidance is adopted across the whole region.

- It is also important that the wide range of regional and local partners with a public health role all play an active part in promoting the benefits of a smokefree lifestyle and ensure that appropriate signposting procedures are in place to the range of NHS support to quit,

- The current plans for the development and implementation of a Harm Reduction Strategy for Nicotine Addiction will be examined as this has the potential to assist those smokers most heavily addicted to smoking to reduce the harm from tobacco and it is vital that the region is full prepared for this.

- There should also be ultimately legislation in place to oblige tobacco companies to pay for the costs of smoking cessation in anyone wanting to quit.

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Impact of smoking before, during and after pregnancy

- Addressing the issues of high smoking rates in women is a key priority. At present around 25% of babies in the North East are born to mothers who have smoked throughout pregnancy. As a consequence, birth weights are lower, and infant mortality is higher than it would otherwise be.
- To most successfully protect both mother and child, more attention should be given to a whole systems approach to help women of child bearing age (and their partner and family) to stop smoking.
- Through Fresh, the region will develop a shared and consistent approach to ensure best standards are applied across the region involving all partners. This will include the strategic adoption of high impact changes to address the issue, including media and communications programmes, training for health professionals and easier access to effective cessation support and aids.
- Key priorities to successfully monitoring the success of this approach will include improvements in the collection of key data by lead partners

Media, communications and education

- Communicating the risk of tobacco smoking and the rationale for action to reduce smoking will remain at the heart of all tobacco control activity. This is vital to further motivate smokers to quit, help to prevent the uptake of smoking and to build up the rationale for further legislative action (advocacy).
- Evidence based media campaigns incorporating social marketing principles have been proven to be very effective in addressing smoking and have been central to those programmes most successful in the world in substantially reducing smoking rates.
- Work will continue to ensure that there is a coordinated approach to ensuing that smoking issues are communicated effectively and that national and regional initiatives are amplified at a local level, adding value to any activity
- Regional media and communications programmes will be developed following the evidence base and in conjunction with national activity. These will be assessed formally to test for added value over and above implementation elsewhere in the country
- Further priority should be given towards the prevention of uptake of youth smoking by ensuring that the most evidence based holistic education approach is adopted region wide. Youth advocacy programmes have been particularly successful elsewhere and will be explored in the region.

Reducing the supply of smuggled and counterfeit tobacco products

- The North East suffers from high levels of very cheap tobacco from illegal sources. High price of tobacco products is globally one of the single most effective means to reduce smoking (and the region should lobby strongly for this) but the free availability of illegal sources within this region will have a detrimental effect by keeping smokers heavily addicted for much longer and also increasing the availability of cheap tobacco to young people
- Much more coordinated activity is required to reduce both the supply and demand for these products which have the potential of impacting upon the success of many of the other tobacco control efforts
- A strategic multi agency approach will be developed to identify the high impact changes to reduce both the demand and supply.

Reducing the availability and supply of tobacco products to children

- Work should be undertaken to ensure the successful implementation of the age of sale regulations of The Health Act 2006 which will raise the age of legal sale of tobacco products to 18 from 16 on 1 October 2007
- However as many children obtain tobacco products from other sources other than retailers further lobbying should be undertaken to restrict these sources. Through Fresh, work will be undertaken to lobby for the prohibition of all vending machines and also to outlaw the sale of packs of ten
- To further restrict the overall availability of tobacco products research and subsequent lobbying activity should be undertaken to severely restrict the sale of tobacco products by the development and

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	implementation of a comprehensive positive licensing system which would have strict criteria to allow sales and would set a geographical quota for outlets. • There should also be efforts undertaken to determine tobacco industry earnings from under-age sales and requirement that that all these earnings be fully repatriated to an independent trust dedicated to reducing youth smoking. • Advocacy to be undertaken to commit the government to allocate all tobacco tax earnings to youth sales to the same independent trust, to run world's best practice youth prevention campaigns • There should also be the establishment of independently audited youth smoking reduction targets and associated punitive taxes on the industry if target reductions are not met. **Reducing tobacco promotion** • Ongoing priority will be given to further reduce the impact of tobacco promotion, especially to children. • Gathering the evidence base and subsequent lobbying on key areas including: point of sale adverting (to ultimately remove all tobacco products to below the counter with no display allowed) and media portrayal of smoking is important and legislation around these could have a significant impact on youth smoking rates. • There should be advocacy to aim for legislation which will adopt generic plain packaging in addition to the forthcoming graphic pictorial warnings (from October 2008) • Legislation to ban mail order sales of tobacco (via internet marketing) **Regulating tobacco** • Work should be undertaken to ensure that the UK adopts Reduced Ignition Propensity (RIP) cigarettes, which would reduce the impact of smoking related fires and cut down on northeast deaths and severe injury • An advocacy campaign focussing on price is vital with the ultimate aim that progressive increases in the retail price of cigarettes (in conjunction with a fully implemented strategy to reduce the demand and supply of cheap illicit tobacco) to the point that they become 'special occasion' commodities rather than hour by hour consumables. • Through Fresh, the region should be actively engaged in the development of a Nicotine Regulatory Framework as given this region has the highest numbers of smokers; it has the most to gain from such a development as it could substantially increase access to effective cessation aids and restrict those products which cause most harm. Note- it is important the current term in the draft- this is not about tobacco regulation and making tobacco products safer but about nicotine regulation. Please don't talk about alterative delivery methods of tobacco BUT instead of nicotine. Note also this is mentioned in the Cancer Reform Strategy. **Research, monitoring and evaluation** • A comprehensive regional research programme will be implemented to ensure that programmes are well developed and subsequently evaluated to assess their effectiveness • A regional monitoring framework should be developed and implemented to ensure that there is an ongoing annual tracking process to monitor the impact of activity

Q8	**Is it appropriate to set a regional smoking prevalence target? Is this the right level and timescale? Should we also set a long term regional target for the reduction of lung cancer deaths as an indicator of overall smoking prevalence?**