Wellbeing and Health Partnership
Healthy Lifestyles Strategic Board

Meeting to be held Thursday 25 August 2011, 1pm – 3pm, Swan Room, Civic Centre

**Contact Officer:** Liz Robinson, Strategic Partnership Coordinator  
Tel: 0191 211 6361  
Email: liz.robinson@newcastle.gov.uk

**Membership:**  
M Khaw, H Lamont, D Robinson, H Golightly, J Adams,  
T Durcan, C Drinkwater, R Forth  
J MacMorran, M Mordue, J Fraser, D Stobbs  
In attendance: L Robinson

## AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Lead</th>
<th>Paper</th>
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<tbody>
<tr>
<td>1.00</td>
<td><strong>Introductions and apologies for absence</strong></td>
<td>Chair</td>
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<tr>
<td>1.05</td>
<td><strong>Smoking Joint Strategic Needs Assessment</strong></td>
<td>Judith MacMorran</td>
<td>Yes</td>
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<td>1.25</td>
<td><strong>Health Inequalities</strong></td>
<td>Meng Khaw</td>
<td>Yes</td>
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<td></td>
<td>Reaching Out Understanding the health attitudes of harder to reach groups in the North West</td>
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<td>2.00</td>
<td><strong>Healthy Lifestyles Board Next Steps</strong></td>
<td>Meng Khaw</td>
<td>No</td>
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<tr>
<td>2.30</td>
<td><strong>What’s new?</strong></td>
<td>Liz Robinson</td>
<td>Yes</td>
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<tr>
<td></td>
<td>- Research and data</td>
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<td>- Policy and guidance</td>
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<td>- Conference opportunities</td>
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<td>2.50</td>
<td><strong>Minutes of meeting held 14 July 2011</strong></td>
<td>Chair</td>
<td>Yes</td>
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<td>2.55</td>
<td>AOB</td>
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| 8. | 3.00 | **Date and Time of Next Meeting:**  
|   |   | 6 October 2011, 1pm – 3pm |
NEWCASTLE JSNA: SMOKING

WHAT IS THE DATA TELLING US?

Smoking is one of the most important risk factors for preventable death, ill health and health inequalities in Newcastle. Smoking is a major contributory cause of coronary heart disease, lung cancer, other cancers and respiratory diseases particularly chronic obstructive airways disease. It is estimated that up to half the difference in life expectancy between the most and least affluent groups is associated with smoking. Deaths attributable to smoking are 45% higher in Newcastle than the national average (based on data for 2006-08).1

It is estimated that the average number of deaths per year attributable to smoking in Newcastle is 556. Whilst mortality rates are generally falling the decline is slower in Newcastle compared to the national average. Between 2003-05 and 2006-08 the England rate fell by 11.8% whereas Newcastle’s rate declined by only 4%.

As the chart below indicates, Newcastle’s rate is in the middle of the range for the cities in the Core Cities Health Improvement Collaborative2. Manchester and Liverpool have rates that are statistically significantly higher whereas Birmingham, Leeds, Bristol and Sheffield have rates that are significantly lower.

FIGURE 1

Mortality attributable to smoking, persons aged 35+ (2006-08)
Newcastle compared to England and other core cities

2 A network of the 8 largest cities outside London established to improve public health, based on the original Core Cities group.
**Key Indicators**

There are a number of national and local targets and ambitions associated with smoking;

**National:**
- The three national ambitions to focus tobacco control work across the whole system are:
  - To reduce adult (aged 18 or over) smoking prevalence in England to 18.5% or less by the end of 2015.
  - To reduce rates of regular smoking among 15 year olds in England to 12% or less by the end of 2015.
  - To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at the time of giving birth).

It is important to note that these are not centrally driven targets but represent an assessment of what could be delivered as a result of the national actions described in the National Tobacco Control Plan, together with local areas implementing evidence based best practice for comprehensive tobacco control.

- HMRC are responsible for implementing the World Health Organisation’s Framework Convention for Tobacco Control (FCTC) protocol to tackle the illicit tobacco trade in the UK.

- The Fire Service have a number of relevant targets to reduce the number of;
  - deaths from accidental fires in dwellings (target set at ‘0’)
  - injuries from accidental fires in dwellings.
  - accidental dwelling fires.

**Regional:**

Better Health, Fairer Health
- To achieve regional smoking prevalence for the North East of 20%, or a level below the national average, by 2015.
- To achieve an absolute regional smoking prevalence level of only 10% by 2032.
- To achieve an absolute regional prevalence level which is the lowest in the country whilst narrowing the gap in prevalence between social groups.

**Local:**

- Smoking quitters - The Strategic Health Authority Vital Signs target (monitored via the NHS North of Tyne Integrated Strategic and Operational Plan or ISOP) uses a proxy measure of 4-week quitters to assess performance on smoking. This indicator does not show a reduction in prevalence and can only capture activity facilitated and monitored via the NHS Stop Smoking Service.

**ISOP target 2011/12:**
- 2516 4-week quitters

**The NHS North of Tyne Strategic plan 2010 – 2014** has set out the following target:
- 600 more 4-week quitters by 2014

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The Smoke Free Newcastle Plan sets a number of annual local targets relevant to the eight strands of tobacco control (see page 22).

Tyne and Wear Fire Service sets annual district targets based on the previous year’s performance.

Prevalence (including trends and benchmarking)

At national level, data from the General Lifestyle Survey is used to assess smoking prevalence in adults (aged 16 years and over). Table 1 shows that national smoking prevalence has declined steadily over the last decade from 27% in 2000 to 21% in 2007 and has been relatively static since then. Smoking prevalence for the North East was relatively static between 2000 and 2005; but between 2005-6 a four percentage point drop occurred which was followed by a further three percentage point drop between 2006 and 2007 and a one percent drop between 2007-8 to 21%. However, the most recent General Lifestyle Survey has shown an increase to 22% for the North East region. These regional figures are based on relatively small samples (e.g. 580 individuals within the North East in 2009), and so results are not reported below regional level.

Table 1: Estimated smoking prevalence (% of population aged 16 and over), England and the North East of England 2000-2009

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<td>33</td>
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<td>2006</td>
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<td>2007</td>
<td>21</td>
<td>20</td>
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<td>20</td>
<td>30</td>
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<tr>
<td>2008</td>
<td>21</td>
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<td>20</td>
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<td>20</td>
<td>21</td>
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<td>2009</td>
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<td>30</td>
<td>20</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: Smoking and Drinking amongst adults, 2009, General Lifestyle Survey 2009, Office for National Statistics © Crown Copyright

It is expected that the new Integrated Household Survey will be capable of producing more robust local authority level data on smoking prevalence in the near future. The ‘experimental’ data recently released in the 2009-10 Integrated Household Survey measures smoking prevalence in adults aged 18 years and over (GLS measures smokers aged 16 plus). It indicates the following prevalence rates for smoking:

Table 2: Smoking Prevalence for Adults 18+, England, the North East of England and Newcastle 2009-10

<table>
<thead>
<tr>
<th>Location</th>
<th>Average</th>
<th>Routine and Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>21.4%</td>
<td>29.8%</td>
</tr>
<tr>
<td>North East</td>
<td>24.4%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Newcastle</td>
<td>27.3%</td>
<td>38.1%</td>
</tr>
</tbody>
</table>

5 Smoking and Drinking amongst adults, 2009, General Lifestyle Survey 2009, Office for National Statistics © Crown Copyright
6 www.lho.org.uk
Until the above data are more widely available, it is recommended that synthetic estimates based on the Health Survey for England are used to compare smoking prevalence in adults in local authorities or for areas within local authorities.

According to the synthetic estimate in the 2010 Health Profiles, Newcastle’s smoking prevalence is estimated to be considerably higher (28.6%) than the national average (22.2%), although, with the exception of Birmingham, it does not appear to be significantly different to the other Core Cities (Figure 2). These figures have recently been updated in the 2011 Health Profiles showing a comparative slight decline in both the national and Newcastle rates.\(^7\)

**FIGURE 2**

<table>
<thead>
<tr>
<th>Estimated % of the population aged 16+ who are current smokers-2006-08</th>
<th>Newcastle compared to England and other Core Cities</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>22.2%</td>
</tr>
<tr>
<td>Nottingham UA</td>
<td>31.6%</td>
</tr>
<tr>
<td>Manchester MCD</td>
<td>30.3%</td>
</tr>
<tr>
<td>Newcastle upon Tyne MCD</td>
<td>28.6%</td>
</tr>
<tr>
<td>Liverpool MCD</td>
<td>28.1%</td>
</tr>
<tr>
<td>Bristol UA</td>
<td>25.6%</td>
</tr>
<tr>
<td>Sheffield MCD</td>
<td>24.3%</td>
</tr>
<tr>
<td>Leeds MCD</td>
<td>24.0%</td>
</tr>
<tr>
<td>Birmingham MCD</td>
<td>22.5%</td>
</tr>
</tbody>
</table>

Estimated prevalence of smoking


Smoking by Age Range and Occupation

There are some groups that are important in our work around tobacco control, whether defined by age and/or occupation, due to the smoking habits and prevalence of these groups.

In 2009 according to the Health Survey for England, 24% of men and 20% of women aged 16 and over were current cigarette smokers. As in previous years, cigarette smoking was associated with age. Among both men and women, cigarette smoking was highest among younger adults and lowest among older adults. Among those aged 16-24, men and women were equally likely to smoke cigarettes (24% for men and 25% for women). However, among those aged 25 to 44, male smoking prevalence overtook that of their female counterparts. Among men aged 25-34 and 35-44 smoking prevalence was 32% and 28% respectively. Equivalent estimates for women were 26% and 20% respectively.

\(^7\) Health Profile Newcastle 2011 [www.healthprofiles.info](http://www.healthprofiles.info)
Smoking is strongly associated with social disadvantage, and higher levels of prevalence and tobacco addiction are often found in the most disadvantaged areas. National smoking statistics from 2008-09 show that those people in routine or manual occupations are more likely to smoke than those in managerial or professional occupations (30% compared with 15%). This is true for men (32% compared with 17%) and for women (27% compared with 14%) and is similar to findings from previous years. Those in routine and manual occupations were also more likely to smoke (30 per cent) than those in intermediate occupations (22 per cent).

As mentioned previously (see reference 6), the prevalence of smoking amongst the routine and manual (R&M) occupational group in Newcastle is higher than our general population at 38.1%.

**Smoking and Ethnicity**

While smoking rates have decreased within the general population, this pattern does not seem to be reflected among black and minority ethnic communities. Smoking prevalence varies greatly between ethnic groups. Whilst overall smoking rates among minority ethnic groups are generally lower than those of the general population there is great variation in smoking rates between different BME groups and between men and women within them. Adherence to religious traditions, which discourage tobacco use, may account for part of these differences. Lower socio-economic status which also influences tobacco usage, may account for the prevalence of smoking among some BME groups.

Findings from age-standardised analyses of combined data from the Health Surveys for England 2006, 2007 and 2008 suggest that among men, Black Caribbean’s (37%) and Bangladeshis (36%) have the highest smoking rates, followed by Chinese (31%) and Other White men. Indian (15%) and Other Black men (12%) had the lowest smoking rates among the ethnic groups explored (Health Survey for England1999, 2004, 2006, 2007, 2008). Rates of smoking for female Bangladeshis are very small.

Smokeless tobacco is a broad term that refers to over thirty different tobacco products, which include chewed, sucked or inhaled products. Chewing tobacco is a popular form of smokeless tobacco that is particularly prevalent among South Asian and Asian communities. These products traditionally contain tobacco, areca nut, betel leaf, flavourings and spices. In England, the highest proportion of self-reported use of chewing tobacco products is among Bangladeshi women (19%), followed by Bangladeshi men (9%), Indian men (4%) and Pakistani men (2%)11. However, it is important to note that there may be a degree of underreporting among these groups. Chewing tobacco is embedded in many aspects of South Asian culture and traditions. It has many symbolic implications at social and religious ceremonies. However, there are many misconceptions regarding the health risks associated with using chewing tobacco.

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Also used by BME communities, and increasingly by the wider population are shisha waterpipes. It is relevant then, to work with these communities and to tackle all tobacco use, not just smoking.

Smoking and young people

Smoking rates among young people are declining. The NHS Information Centre’s annual ‘Smoking, Drinking and Drug Use among Young People’ survey\(^{12}\) is the data source used nationally to track changes. In 2009, 29% of pupils taking part in the survey had tried smoking at least once. This proportion is the lowest measured since the survey began in 1982, when more than half of pupils (53%) had tried smoking. The prevalence of regular smoking among 11 to 15 year olds has halved since its peak in the mid-1990s – 13% in 1996. In 2009, 6% of pupils aged 11-15 years smoked regularly (at least once a week), with prevalence increasing with age to 15.5% by age 15 years. This proportion has remained stable since 2007. However in the North East the number of 11-15 year smokers is the highest of any other region in England standing at 10% (6% boys and 14% girls). It is important to note that smoking rates in the adult population peak between the age of 20-24 years at 30% and are 22% in the 16-19 year age range. Young people’s smoking prevalence mirrors that of adults in terms of its link with social disadvantage.

Reducing adult prevalence remains key to reducing that of young people. The availability of cheap and illicit and counterfeit tobacco is seriously undermining efforts to reduce smoking prevalence further among young people. A recent North of England study\(^{13}\) on illicit tobacco has revealed that half of all young smokers access their cigarettes from illicit sources.

No data on prevalence among young people at city wide level currently exists.

Secondhand Smoke

In terms of the effect of secondhand smoke on young people the Royal College of Physicians\(^{14}\) estimate that approximately 2 million children under the age of 16 years are exposed to secondhand smoke in the home/car. Whilst the number exposed to secondhand smoke did decline with the introduction of the smokefree legislation in 2007, such levels of exposure continue to contribute significantly to the number of unplanned admissions to hospital each year for breathing difficulties, in-patient episodes for other conditions and visits to primary care practitioners for conditions such as asthma.

The table below estimates the incidence of disease in Newcastle children caused by passive smoking, by applying the UK incidence rates to the local population. It should be noted however that this figure is likely to be an underestimate given the likely higher prevalence of smoking in Newcastle.

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\(^{12}\) Smoking, Drinking and Drug Use among Young People in England 2009. NHS Information Centre

\(^{13}\) Understanding the illicit tobacco market in the North of England. 2010. NEMS Market Research

www.illicitobacconorth.org

**Table 3: Estimated Incidence of disease in children caused by passive smoking in the home**

<table>
<thead>
<tr>
<th>Disease Incidence</th>
<th>Age range in years</th>
<th>UK population (in 000s)</th>
<th>UK cases attributable to smoking</th>
<th>Newcastle Population (in 000s)</th>
<th>Newcastle population as a % of UK population</th>
<th>Estimated number of new cases in Newcastle attributable to smoking each year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower respiratory infections</td>
<td>2 and under</td>
<td>2,276</td>
<td>20,500</td>
<td>9.70</td>
<td>0.43%</td>
<td>87</td>
</tr>
<tr>
<td>Middle ear infections</td>
<td>0-16</td>
<td>12,310</td>
<td>121,400</td>
<td>48.71</td>
<td>0.40%</td>
<td>480</td>
</tr>
<tr>
<td>Wheeze</td>
<td>2 and under</td>
<td>2,276</td>
<td>7,200</td>
<td>9.70</td>
<td>0.43%</td>
<td>31</td>
</tr>
<tr>
<td>Asthma</td>
<td>3-4</td>
<td>1,424</td>
<td>1,700</td>
<td>5.79</td>
<td>0.41%</td>
<td>7</td>
</tr>
<tr>
<td>Asthma</td>
<td>5-16</td>
<td>8,611</td>
<td>600</td>
<td>33.22</td>
<td>0.39%</td>
<td>53</td>
</tr>
<tr>
<td>Meningitis</td>
<td>0-16</td>
<td>12,310</td>
<td>165,100</td>
<td>48.71</td>
<td>0.40%</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total incident cases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>660</strong></td>
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</tbody>
</table>

1. Mid-2008 population estimates, Population Estimates Unit, Office for National Statistics © Crown Copyright
3. Mid-2009 population estimates, Population Estimates Unit, Office for National Statistics © Crown Copyright

By looking at hospital admission data in Newcastle it is possible to estimate the number of children aged 0-14 years who are admitted each year from specified diseases attributable to passive smoke exposure. This is given in Table 4 for the period 2008-10.

**Table 4: Estimated number of hospital admissions in children aged 0-14 years in 2008 - 2010 from specified diseases attributable to passive smoke exposure**

<table>
<thead>
<tr>
<th>Newcastle Residents</th>
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</thead>
<tbody>
<tr>
<td>Primary diagnosis (ICD-10)</td>
<td>Age group</td>
<td>Number of Admissions</td>
<td>Population attributable fraction</td>
<td>Admissions attributable to smoking</td>
<td></td>
</tr>
<tr>
<td>Lower respiratory infections (J20, J21 &amp; J22)</td>
<td>&lt;=2</td>
<td>619</td>
<td>10%</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Middle ear infections (H65 &amp; H66)</td>
<td>0 - 14</td>
<td>519</td>
<td>7%</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Wheeze (R062)</td>
<td>&lt;=2</td>
<td>109</td>
<td>8%</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Asthma (J45 &amp; J46)</td>
<td>3 - 4</td>
<td>69</td>
<td>4%</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 - 14</td>
<td>193</td>
<td>10%</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Meningitis (A390 &amp; G00)</td>
<td>0 - 14</td>
<td>18</td>
<td>22%</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>1,527</strong></td>
<td></td>
<td><strong>133</strong></td>
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Geographical Information

 Whilst the Newcastle upon Tyne overall smoking prevalence rate has been discussed earlier in this document, more specific data for the city are available. The smallest geography for which synthetic estimates are available is at the level of Middle Layer Super Output Areas (MSOAs). According to the synthetic estimates (Figure 3) the prevalence of smoking ranges from less than 14% in parts of the Gosforth/Jesmond area to 49.3% in the Walker area.

FIGURE 3

A local alternative to the synthetic estimates is the Residents’ Survey. Data from the 2009/10 Newcastle City Council Residents’ Survey reported that 20% of participants were smokers (the equivalent figure from the 2008/09 survey was 21%), with prevalence ranging from 7.3% in East Gosforth to 34.4% in Elswick. However, this survey may not be providing a completely accurate picture. There is a tendency for response rates to surveys of this type to be lower among men, younger people and those of lower socio-economic status, all groups where smoking rates are likely to be relatively high, which may lead to bias in prevalence estimates of lifestyle risk factors, such as smoking. On the other hand, the synthetic estimates seem to be suggesting a smoking prevalence which is perhaps inflated. If we compare the synthetic estimate for the North East overall (27.9% in 2006-08) with the data in Table 1 from the General Lifestyle Survey it is apparent that the synthetic estimate for the North East is several percentage points higher. However, caution should be exercised in interpreting the regional data from the General Lifestyle Survey, which as already indicated, is based on a small sample. The other point to note is that the synthetic estimates refer to 2006-08 whilst the Residents’ survey was undertaken in 2010.
It might be reasonable to assume that the true prevalence is somewhere between that reported by the Residents’ Survey (20%) and the synthetic estimate (28.6%).

Geographical data is also collected and used by Tyne and Wear Fire Service to map accidental dwelling fires where the cause is smoking related. This includes any deaths or injuries resultant of each fire. Mapping demonstrates that smoking related fires closely relate to smoking prevalence distribution in the city, with fires more likely to occur in areas where smoking rates are highest. The east end of the city is a particular hotspot for dwelling fires caused by smoking.

**Trends**

**NB: For details of prevalence trends please see page 3**

**Smoking quitters**

Table 5 shows that Newcastle Primary Care Trust, through its services to help people stop smoking, has maintained smoking quit rates above the England average but below the regional average over the period between 2003/04 and 2009/10.
Table 5: Trend in the number and rate (per 100,000 population aged 16 and over) of self-reported 4 week smoking quitters, Newcastle compared to the North East and England, 2003/04 to 2009/10

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<tbody>
<tr>
<td>NEWCASTLE</td>
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<td></td>
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</tr>
<tr>
<td>No. of quitters</td>
<td>1,588</td>
<td>1,929</td>
<td>2,342</td>
<td>2,442</td>
<td>2,352</td>
<td>2,150</td>
<td>2,462</td>
</tr>
<tr>
<td>Rate</td>
<td>753</td>
<td>882</td>
<td>1,054</td>
<td>1,065</td>
<td>1,048</td>
<td>951</td>
<td>1,059</td>
</tr>
<tr>
<td>NORTH EAST</td>
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</tr>
<tr>
<td>No. of quitters</td>
<td>18,511</td>
<td>22,421</td>
<td>23,648</td>
<td>23,900</td>
<td>24,441</td>
<td>22,325</td>
<td>25,485</td>
</tr>
<tr>
<td>Rate</td>
<td>901</td>
<td>1,086</td>
<td>1,145</td>
<td>1,147</td>
<td>1,171</td>
<td>1,063</td>
<td>1,208</td>
</tr>
<tr>
<td>ENGLAND</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of quitters</td>
<td>204,876</td>
<td>298,124</td>
<td>329,681</td>
<td>319,720</td>
<td>350,800</td>
<td>337,054</td>
<td>373,954</td>
</tr>
<tr>
<td>Rate</td>
<td>512</td>
<td>739</td>
<td>817</td>
<td>785</td>
<td>854</td>
<td>813</td>
<td>895</td>
</tr>
</tbody>
</table>


In interpreting patterns in smoking quit rate, it should be remembered that there is a relationship between the number of quitters and the underlying prevalence of smoking where areas with higher smoking prevalence generally see more smoking quitters.

In Figure 5 the numbers setting quit dates are examined in the context of smoking prevalence, as measured by synthetic estimates for PCTs. The PCTs which are part of the Core Cities Health Improvement Collaborative are shown in blue on the chart. Birmingham is represented by three PCTs. The prevalence estimate from Newcastle’s Residents’ Survey is also shown (grey triangle).

FIGURE 5

Number setting a quit date per 100,000 population, ages 16+, 2009-10 versus estimated prevalence of smoking by PCT, ages 16+, 2006-08

In Figure 6 the relationship between quit rates and estimated smoking prevalence is shown.

Depending on whether the synthetic estimate or the Residents’ Survey is viewed as the most accurate estimate of smoking prevalence, will influence opinions as to the contribution of the Newcastle Stop Smoking Service in helping to reduce health inequalities. Ideally the number of smokers quit at four weeks needs to be above the trend line in order to ensure good progress in reducing health inequalities. Figure 6 shows it to be below the trend line.

![Figure 6: Successful quitters per 100,000 population aged 16+, 2009-10 versus estimated prevalence of smoking by PCT, ages 16+, 2006-08](image)


### Smoking in pregnancy

Data is collected from hospital trusts on the prevalence of smoking among pregnant women at the time of delivery. It supplements the national information available from the quinquennial (once every five years) Infant Feeding Survey.

As Figure 7 below shows, the prevalence of smoking amongst women at time of delivery is higher in Newcastle than in any of the other Core Cities, although it is only slightly higher than Liverpool and Nottingham City. Following a year-on-year decline in prevalence over the period between 2005/06 and 2007/08, the proportion of Newcastle women continuing to smoke throughout pregnancy increased in 2008/09 and 2009/10. However, 2010/11 has seen a drop in the rate. Newcastle’s prevalence in 2010/11 was 18% compared to the England average of 13.5%. In the other PCTs that are part of the Core Cities Collaborative, prevalence in 2010/11 ranged from 6.1% (Heart of Birmingham Teaching PCT) to 17.3% (Liverpool PCT). It should be noted that Birmingham is represented by three different PCT’s. As a whole in 2010/11 the smoking at time of delivery rate for the three combined Birmingham PCT’s was 12.4%.
FIGURE 7

% of women smoking at time of delivery
Newcastle compared to England and other PCTs in Core Cities Collaborative

[Graph showing % of women smoking at time of delivery for Newcastle compared to England and other PCTs in Core Cities Collaborative.]

Source: Department of Health statistical release. [Link to source]
Note: Data are not available for all PCT's / England for all years due to PCT’s failing to submit data that complied with the Department of Health’s data quality criteria.

Whilst there are no data published on the proportion of pregnant smokers who access NHS Stop Smoking Services, the data that are available (Figure 8) show that of those that do access the service, the percentage who are successfully quit (self-reported) at four weeks is lower in Newcastle that in most of the other Core Cities. Only Manchester PCT reported a lower success rate.

FIGURE 8

% of the pregnant women that accessed NHS Stop Smoking Services who were quit at 4 weeks, 2009/10
Newcastle compared to England and other PCTs in Core Cities Collaborative

[Graph showing % of pregnant women quit at 4 weeks for various PCTs.]

Source: The Health and Social Care Information Centre, Lifestyles Statistics, Copyright © 2010. [Link to source]
Accidental Dwelling Fires

Overall the trend in accidental dwelling fires in Newcastle where the cause is smoking related is downward over the last 4 years, as shown in Table 6 below.

Table 6: Accidental dwelling fires attended in Newcastle when the source of ignition was cigarettes/cigar/tobacco.

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of smoking related accidental dwelling fires</td>
<td>27</td>
<td>22</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Number of injuries from smoking related accidental dwelling fires</td>
<td>3</td>
<td>5</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Number of fatalities from smoking related accidental dwelling fires</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Tyne and Wear Fire and Rescue Service.

The Fire Service benchmarks its performance in Newcastle with the core cities in terms of primary fires caused by smoking, including the number of deaths and injuries caused.

Regulatory Services and Public Protection

The Regulatory Services and Public Protection Division (RSPP) of Newcastle City Council are responsible for a range of services relevant to tobacco control. This includes for example; compliance monitoring for the smoke free legislation and enforcement activity concerned with the implementation of tobacco related regulations such as tobacco advertising, the sale of tobacco products to minors and sale of illicit tobacco.

The Division was instrumental in preparing the city for the 2007 smokefree legislation and used geographical information identified within the Neighbourhood Renewal Strategy to offer additional support to businesses in certain wards. This work continues with a robust programme of compliance monitoring and inspections that include smoking-related legislation.

Smoke free compliance visits have been embedded into the routine work of RSPP and the vast majority of business premises do comply. The numbers of complaints about breaches of the legislation and requests for information received by the department have remained constant at approximately 20 each quarter. The trend for the numbers of fixed penalty notices issued is increasing in the last year. This reflects a change of approach to enforcement of the legislation with taxi drivers.

In terms of age of sale legislation RSPP undertakes test purchasing visits to retail premises each year. The number of non compliant premises has decreased over the few years. Activity focusing on illicit tobacco has increased with the increasing availability and use of such products.
Forecasts

The population make up of Newcastle is one factor which influences projected smoking rates. The population of Newcastle was estimated at 284,257\textsuperscript{15} in 2009 (the ‘mid year estimate’). This represents an increase of just under 6,500 from 2008. The proportion of the population which is non-British (11\%) and born outside of the UK (14\%) are higher than the average across the North East at 3.4\% and 5\% respectively. (See charts in Figure 9 below). While net migration to Newcastle was around 7,330 in 2009, future net migration is expected to be much lower as immigration decreases and emigration rises. However, as the number of new migrant workers from EU accession countries has shown a decrease recently, there is a steady increase in workers from other countries arriving each year, with more people coming from India and China, where smoking prevalence rates are increasing overall. There would also appear to be a shift from working to educational migration as a result of the economic downturn.

**FIGURE 9**

<table>
<thead>
<tr>
<th>3.1 Nationality: non-British</th>
<th>3.2 Country-of-Birth: non-UK</th>
</tr>
</thead>
</table>

The projected population for Newcastle is expected to rise over the next 19 years, as shown in Table 7. Overall the trend for smoking prevalence in Newcastle currently is downwards although we have reached a hiatus where prevalence in most population groups and age ranges has become somewhat static. However if we ‘take our foot off the pedal’ there is a risk that prevalence may rise again.

If the migrant population from areas with high smoking prevalence should increase significantly there is a potential danger that this will contribute to a rise in prevalence in adults for the city as a whole. Equally it can be argued that with strong tobacco control activity in Newcastle, where the social norm is not to smoke, new migrants will adopt this behaviour. It is important therefore that future work on tobacco does involve and support BME groups and communities to reduce tobacco use.

\textsuperscript{15} North East Strategic Migration Partnership. Newcastle upon Tyne. Local Migration Profile Quarter 3 2010-11
TABLE 7: Projected population of Newcastle by age group and gender (2008 based population projections) 16

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>2010</th>
<th>2012</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons 0 - 19</td>
<td>64,400</td>
<td>64,100</td>
<td>64,900</td>
<td>67,400</td>
<td>71,100</td>
<td>72,500</td>
</tr>
<tr>
<td>Persons 20 - 39</td>
<td>98,400</td>
<td>102,700</td>
<td>106,500</td>
<td>109,700</td>
<td>108,500</td>
<td>109,800</td>
</tr>
<tr>
<td>Persons 40 - 64</td>
<td>79,600</td>
<td>79,100</td>
<td>77,400</td>
<td>75,400</td>
<td>75,800</td>
<td>76,800</td>
</tr>
<tr>
<td>Persons 65 +</td>
<td>41,000</td>
<td>41,900</td>
<td>43,600</td>
<td>46,000</td>
<td>50,100</td>
<td>54,900</td>
</tr>
<tr>
<td>Persons TOTAL</td>
<td>283,400</td>
<td>287,800</td>
<td>292,400</td>
<td>298,500</td>
<td>305,500</td>
<td>314,000</td>
</tr>
</tbody>
</table>

| Males | 0 - 19 | 33,100 | 33,100 | 33,400 | 35,000 | 36,900 | 37,500 |
| Males 20 - 39 | 50,800 | 53,400 | 56,000 | 58,000 | 57,500 | 58,100 |
| Males 40 - 64 | 39,700 | 39,500 | 38,800 | 38,300 | 39,300 | 40,700 |
| Males 65 + | 17,300 | 18,000 | 19,200 | 20,800 | 23,100 | 25,300 |
| Males TOTAL | 140,900 | 144,100 | 147,500 | 152,100 | 156,600 | 161,700 |

| Females | 0 - 19 | 31,200 | 31,100 | 31,500 | 32,600 | 34,400 | 35,000 |
| Females 20 - 39 | 47,700 | 49,300 | 50,500 | 51,700 | 51,000 | 51,700 |
| Females 40 - 64 | 39,800 | 39,600 | 38,600 | 37,100 | 36,400 | 36,100 |
| Females 65 + | 23,700 | 23,700 | 24,100 | 24,900 | 27,200 | 29,500 |
| Females TOTAL | 142,400 | 143,800 | 144,900 | 146,500 | 148,900 | 152,300 |

Source: Subnational Statistics Unit, ONS: Crown Copyright

The increasing availability of cheap, smuggled, bootleg and counterfeit tobacco is making tobacco more affordable for young people and those living in disadvantaged communities. This is seriously undermining work to reduce smoking rates further. The large percentage of current young smokers aged 20-30 years is cause for concern in terms of adult and pregnant women’s prevalence, if they fail to stop smoking in large numbers. Changing social norms in local areas and communities where smoking is so deeply ingrained and a cultural norm is a challenge and requires new approaches to be used. Local communities need to be engaged more effectively in tobacco control activity, with improved targeting and communication within those areas and communities identified as in greatest need.

16 NOTES: 2008-based Subnational Population Projections by sex and age;
Long term subnational population projections are an indication of the future trends in population by age and sex over the next 25 years. They are trend based projections, which means assumptions for future levels of births, deaths and migration are based on observed levels mainly over the previous five years. They show what the population will be if recent trends in these continue. The projections do not take into account any future policy changes that have not yet occurred. They are constrained at a national level by the national projections published on 21 October 2009. These projections, for areas in England, published on 27 May 2010 are based on the revised 2008 mid-year population estimates (published 13 May 2010).
WHAT IS THE STORY BEHIND THE DATA?

Stakeholder views

A range of methods of public engagement has been employed on tobacco control issues.

Newcastle Residents Survey

The views of local people are captured via the Newcastle Residents Survey\(^{17}\). As already stated, 20% of residents reported that they were smokers. It was encouraging to note that almost a third of respondents stated that they used to smoke either daily (22%) or occasionally (11%), but did not smoke at all now. There was little change in comparison to 2009/10.

Significantly of the ex smokers, more men (24%) than women (16%) said that they used to smoke daily. More women (52%) said that they had never smoked than men (46%). Comparatively more respondents (25-59 years old) smoked daily than younger (under 24 years old) and older (60 years old and over) age groups. It was encouraging to note that the younger the age group the more respondents claimed that they had never smoked and almost two thirds of under 24 year old respondents claimed that they had never smoked.

Among the respondents who smoked daily, 76% stated that they had tried to give up smoking. At the time of the survey 11% of respondents who smoked were trying to give up smoking with no significant difference between men and women. However, comparatively more men (21%) than women (15%) stated that they were thinking about giving up smoking now. 41% of respondents thought about giving up smoking but were not ready yet and there were significantly more women (47%) in this group than men (33%). Another 31% of respondents had no desire at the present time to give up smoking.

Newcastle and North Tyneside NHS Stop Smoking Service

The Newcastle and North Tyneside NHS Stop Smoking Service routinely collects user feedback on its services and alters local provision accordingly, where possible and appropriate.

Social marketing / insight gathering

In 2009/10 NHS North of Tyne commissioned a social marketing programme which included focus group research and questionnaires with routine and manual workers (a key target group for smoking cessation given their high smoking prevalence). The aim was to ascertain their motivations to quit and identify barriers to accessing NHS Stop Smoking Services. The results were used to inform a campaign that targeted workplaces and to shape the planning and locations of Stop Smoking Service sessions and drop-ins. However learning has demonstrated that this type of approach at best may raise awareness of services, but has not yielded many actual quitters from the target audience.

Citizens Assembly

Newcastle Citizens Assembly held an event in 2010 at which local groups identified issues of importance to them and discussed solutions to these. One group, Tyneside Women’s Health identified “considerate smoking” as their issue for action. They wanted to develop a ‘campaign’ to address the issue of smokers gathering in doorways causing issues concerned with exposure to second hand smoke, noise, litter and anti social behaviour.

\(^{17}\) The 2009/10 Newcastle Residents Survey, Newcastle City Council (May 2010)  
http://www.newcastle.gov.uk/condiary.nsf/all/4052B6D132A100388025777DD004E3A05
Smoke Free Newcastle has been working with the group to address these concerns within the Byker Shields Road area.

Community Action on Health
In 2008 Community Action on Health\textsuperscript{18} carried out consultation exercises with people living within disadvantaged areas of inner West and Outer West of Newcastle and a group of Community workers to ascertain their knowledge about the NHS Stop Smoking Services. Findings included the following:
\begin{itemize}
  \item Participants felt that a 10-20 minute consultation (in intermediate level services, mostly in General Practices) was not long enough to be effective.
  \item Some respondents felt that providing stop smoking services in pharmacies may not work because of privacy issues in an enclosed environment. However others thought that pharmacists were more approachable than doctors.
  \item Information leaflets need to be more relevant and available in a variety of languages and on video.
  \item Community-based specialist stop smoking services were supported, but should not be called ‘clinics’. Advice should also be incorporated into ‘well person clinics’.
  \item For BME communities, the need for the service to be culturally aware was mentioned e.g. having the same sex advisers and interpreters.
  \item It was felt that people should be able to access support without having to commit to giving up smoking completely.
  \item Nicotine Replacement Therapy (NRT) should be free to all.
\end{itemize}

Newcastle Smoke Free Project
The evaluation of the NRF funded Newcastle Smoke Free Project\textsuperscript{19} involved a number of focus groups and one to one conversations with service users on the provision of stop smoking support in community venues and ‘routine and manual’ workplaces. The findings have since been mainstreamed into the NHS Stop Smoking Service.

Newcastle City Council
Since the introduction of smoke free legislation in 2007 the City Council Regulatory Services department has undertaken engagement to communicate changes to regulatory approaches and to promote best practice. Various methods of engagement have been used including advisory letters, press releases, newsletters, meetings, visiting trade forums and websites.

Fire Service
One of the issues discussed with local residents during Tyne and Wear Fire Service home safety checks is smoking, in relation both to fire safety and brief interventions for stopping smoking.

Fresh; Smoke Free North East - Social Marketing Programmes\textsuperscript{20}
Fresh have undertaken a large amount of engagement activity with local communities as part of wider social marketing programmes. This engagement has occurred across the region, including Newcastle on a number of issues such as:
\begin{itemize}
  \item Secondhand smoke – used in the Smoke Free Families programme (including ‘Take 7 Steps Out’)
\end{itemize}

\textsuperscript{18}http://www.caoh.org.uk/site/images/resource_bank/area/west/a%20report%20to%20establish%20peoples%20awareness%20and%20use%20of%20accessing%20nhs%20stop%20smoking%20services%20in%20inner%20%26%20outer%20west%20newcastle%202008.pdf
\textsuperscript{20}www.freshne.com
• Tackling illicit tobacco – used in the ‘Get Some Answers’ programme
• Stop Smoking Service – used in the ‘People Like Me’ and ‘Around the Corner’ programmes

Newcastle LINk Research 21
In 2010 -11 Fawdon Community Association carried out a piece of qualitative research with 47 local residents aged 18-64 years on ‘Changing people’s behaviour around diet, exercise, smoking and drugs or alcohol’ on behalf of Newcastle LINk. 68% of the sample were smokers (regular and occasional). Differences between the age groups were revealed in the study. Younger participants felt they were young enough to cope with the consequences of smoking and could easily stop smoking and get fitter in later life. Older participants felt it was too late to make changes now and so that it did not matter anymore. The non smokers in the study, particularly those who had never smoked, were very anti-smoking and at times were quite aggressive in the focus groups. Many of the smokers felt persecuted and could not understand what they were doing wrong. Few smokers were concerned about the cost of smoking, with some saying that they would make sure they had enough money for their ‘ciggies’. 50% of the smokers had tried to quit smoking at some point, the most common reasons for not succeeding were ‘lack of will power’ and ‘stress’. Younger smokers who regularly socialised frequented pubs and clubs that offered the best environment for smoking, such as covered areas, patio heaters.

Health and Race Equality Forum (HAREF) 22
Health and Race Equality Forum (HAREF) conference in 2010 identified that BME communities wanted health information taken to them, appropriately, to where people already meet. This included information on smoking.

Residents Ward Charters 23
In 2011 neighbourhoods in Newcastle were asked to identify their neighbourhood needs in drawing up a Ward Charter for their area. A number of wards identified smoking specific issues as follows;
• Blakelaw – Identified that they would like more help to give up smoking and more health services available within central Blakelaw.
• Elswick – Wishes there was better promotion of existing support and services.
• Kenton – Wants support to help people to give up smoking
• Lemington – Wants help for mothers to stop smoking in pregnancy
• Fawdon – Wants more initiatives to help people to give up smoking
• Newburn – Wants more help for people who want to stop smoking

The work is being followed up by NHS North of Tyne in conjunction with ward coordinators.

Particular groups affected by this issue
A number of groups can be identified as having the highest smoking rates. These are routine and manual workers, pregnant women, young people aged 18-30 years, those with mental illness and specific BME populations such as Bangladeshi men.

21 Changing people’s behaviour around diet, exercise, smoking, drugs or alcohol. 2011. The Social Work Co-operative and Fawdon Community Association on behalf of Newcastle LINK.
22 McNulty Ann. 2010. HAREF Conference Report. 2010
23 Newcastle City Council www.newcastle.gov.uk
The Fire Service use ‘Mosaic’, past incident data and signposting schemes to identify the most at risk and vulnerable households within Newcastle. These are currently the elderly, high rise blocks and those living in rented accommodation.

Whilst not holding specific data on smoking Your Homes Newcastle holds demographic data on six equality strands i.e. gender, race, age, sexual orientation, religion and disability. This potentially could be utilized to identify target groups more effectively, provided information sharing protocols are agreed.

Causal factors

Smoking is the major cause of health inequalities in the UK accounting for two thirds of the difference in risk of premature death between social classes. There is a strong link between cigarette smoking and socio-economic group. Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off. In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).  

FIGURE 10

Long-term smokers bear the heaviest burden of death and disease related to their smoking. Long term smokers are disproportionately drawn from lower socio-economic groups. People in poorer social groups who smoke, start smoking at an earlier age. Of those in managerial and professional households, 31% started smoking before they were 16, compared with 45% of those in routine and manual households. Professor Sir Michael Marmot in his review of health inequalities noted that smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking related deaths are two to three times higher in low income groups than in wealthier groups.

Living in disadvantaged circumstances not only increases the likelihood of someone smoking but they are also more likely to smoke more and to be exposed to second hand

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Young people living in a household where smoking occurs are more likely to smoke; with those from lower income families more heavily exposed.\textsuperscript{26} It is important to note that evidence shows that reducing adult smoking prevalence is the most effective way of reducing smoking rates among young people as non smoking becomes the social norm.

\textbf{FIGURE 11}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure11}
\caption{Smoking among children in England aged 11–15, by number of smokers they live with, 2008\textsuperscript{7}}
\end{figure}

\section*{WHAT ARE THE GAPS IN DATA?}

A number of gaps in the data are evident which would help us to improve the effectiveness of the programmes developed and delivered. For example;

- Robust local prevalence data by ward is not available. Estimates based on a relatively small sample only currently exist.
- The Newcastle Residents Survey provides prevalence rate much lower than other available data and could be further improved in terms of sampling.
- No current data is available on the number of young people who smoke. Regional data is available but this is based on a national survey with a small sample size.
- No data exists on the number of children and young people exposed to secondhand smoke in the home in Newcastle.
- No data exists on the number of children seeking primary care advice resultant from exposure to secondhand smoke in the home.
- There are gaps in our understanding about why key target groups such as pregnant women do not access services to help them quit and when they do their quit success is lower and post natal relapse high. The social marketing initiative working with routine and manual (R&M) groups, confirmed some of our knowledge and gave us insight into what R&M workers want from a Stop Smoking Service, and provision is being shifted to accommodate these views.

Whilst smoking at the time of delivery data is collected and reported, maternity services are not as yet required to report on the number of women smoking at time of booking. Therefore we do not have an accurate picture of the percentage of pregnant smokers in Newcastle and those who go on to quit. It should be noted that smoking status at booking is recorded but is not required to be reported.

**WHAT ARE THE NATIONAL AND LOCAL DRIVERS?**

**National**

- NHS Stop Smoking Services. Service and Monitoring Guidance 2011/12
- NICE guidance on smoking (various) [www.nice.org.uk](http://www.nice.org.uk)

**Local**

- North of Tyne Strategic Plan 2010-2014 [www.northoftyne.nhs.uk](http://www.northoftyne.nhs.uk)
- Smoke Free Newcastle Tobacco Control Action Plan 2011/12 [www.freshne.com](http://www.freshne.com)
- Newcastle Health Improvement Strategy [www.newcastle.gov.uk](http://www.newcastle.gov.uk)

**WHAT IS CURRENTLY WORKING HERE OR ELSEWHERE?**

**Fresh, Smoke Free North East** - the regional tobacco control office is commissioned by NHS North of Tyne and other primary care organisations (PCOs) in the region to implement a comprehensive business plan to reduce smoking prevalence and develop a smoke free region.

**Smoke Free Newcastle** – a multi-disciplinary and cross-agency alliance, coordinated by Newcastle Hospitals Community Health and chaired by Newcastle City Council, which oversees tobacco control issues across the city. Smoke Free Newcastle is responsible for delivering the tobacco control strand of the local Health Improvement Strategy. It is ultimately accountable to the Newcastle Wellbeing and Health Partnership Executive, through the Healthy Lifestyles Board.

Through its action Smoke Free Newcastle plans and delivers a range of evidence based individual, family and community interventions to enable people of all ages and backgrounds to enjoy a smoke-free life. It employs an eight strand plan27 for tackling tobacco;

1. **Build the infrastructure, skills and capacity** for local tobacco control across partner organisations in Newcastle.
2. **Reduce exposure to second hand smoke** (SHS) by leading on a ‘Smoke Free Families’ programme of training for professionals working with parents/carers, to reduce SHS exposure in the home.
3. **Continue to provide free NHS stop smoking support** to people wishing to quit through the Newcastle and North Tyneside NHS Stop Smoking Service, focusing particularly on workplaces, routine and manual workers and other priority groups.

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27 Found at [www.freshne.com](http://www.freshne.com)
4. **Support and develop public education and media campaigns** which aim to give the public more information on the dangers of SHS, stop smoking support and to prevent the uptake of smoking among young people.

5. **Reduce the availability and supply of tobacco products** and address the supply of tobacco to children. Working with Fresh and HMRC, Newcastle Trading Standards department are implementing the North of England Action Plan on Tackling Illicit Tobacco at a local level.

6. **Monitor tobacco regulation** to ensure relevant laws relating to tobacco are effectively enforced. This includes legislation on tobacco advertising.

7. **Reduce the promotion of tobacco** by working with Fresh and trading standards to monitor point of sale legislation.

8. **Undertake research, monitoring and evaluation** of the plan to ensure that Smoke Free Newcastle delivers an effective programme of action which is based on sound evidence.

In terms of developing stop smoking work with **BME populations** a pilot programme involving four mosques has been implemented with the Health Improvement Service for Ethnic Minorities (HISEM), HealthWORKS, HAREF and the Stop Smoking Service. Preparatory work involved engagement with religious leaders, who announced well in advance that ‘Health checks’ including stop smoking advice, diabetes checks and blood pressure readings would take place in each mosque after Friday prayer. The backing of the Imams was key to getting the message across that the sessions were bringing in useful information. Following the pilot all the mosques have asked for follow-up sessions and one has asked for a session for women involving female Islamic scholars. Over 40 men have accessed information in the 4 pilot sessions.

The service specification between NHS North of Tyne and Newcastle Hospitals Community Health, for the Health Improvement Service includes delivery of a comprehensive tobacco control programme.

The Newcastle and North Tyneside NHS Stop Smoking Service has contributed to a North of Tyne Stop Smoking Service Delivery Plan 2011/12 which includes measures to improve performance monitoring, training and support of ‘Intermediate’ level advisors in other settings, and offer drop-ins and closed group support in workplaces.

**WHAT SHOULD WE BE DOING NEXT?**

The overall downward trend in adult smoking prevalence among the whole population in the UK and Newcastle would suggest that the multi component eight strand approach to tobacco control delivered in partnership with clear measurable outcomes in place is effective. International evidence supports the approach being taken. However it is of concern that prevalence rates are not improving in the city, further demonstrating the importance of maintaining a comprehensive tobacco control programme in Newcastle.

Newcastle Stop Smoking Service has failed to achieve the 4-week quitter Vital Signs target for the last two years following a record of over-achievement since inception of the NHS Stop Smoking Service 11 years ago. The challenge now is to continue to encourage people to access the service against a background of falling prevalence and to help these people become long term non-smokers. It should be noted that the 4-week quitter proxy measure captures a small element of Newcastle’s overall tobacco control programme and only then the smokers who quit by undertaking the structured programme offered by the NHS service.
Do we reach the people in most need?

Highest smoking rates are found in the most disadvantaged areas of the city. It is thus essential that activity for tobacco control is focused more heavily in these areas in the future if any inroads into reducing health inequalities are to be made. Likewise specific population groups such as pregnant women and Bangladeshi males require a more targeted approach in addition to universal provision to better meet needs. Smoke Free Newcastle will continue to provide a universal tobacco programme across the city, but in addition in 2011 will start to develop a more focused geographical approach in one agreed ward, where it will seek to add value to provision and better understand and engage with ‘harder to engage’ communities. Programmes specifically for pregnant women and BME communities will be further developed.

Such a geographical focus will link into existing networks and services in the agreed ward, trying to engage them in the broader tobacco control agenda. Intelligence on the ward and key stakeholders will be identified at an early stage to help develop a local programme of activity. For example ward coordinators, community development organisations, community groups, health trainers, Your Homes Newcastle, NHS service providers, schools, youth groups and the community itself will be crucial to developing such an approach. Staff from Your Homes Newcastle have access to large numbers of tenants, meet with them and residents associations regularly, thus having the potential to pass on information to large numbers and signpost them appropriately to local services. Credit unions could also be crucial to engage with as many smokers are living in disadvantaged circumstances and quitting can be one route to helping them out of debt.

The NHS Stop Smoking Service currently collects some data from its clients such as postcode, ethnic status and pregnancy status, which could also be better used to target interventions to particular hotspots for smoking and key clients groups. The areas which are more predominantly occupied by routine and manual smokers have already been mapped to ensure that local Stop Smoking Services are provided at suitable times and in suitable venues to meet this population groups’ needs.

Can people access the right service in the right place for their needs?

By piloting a geographical approach to tobacco control Smoke Free Newcastle will assess the value of uplifting generic activity in local communities. This will include a range of measures, for example looking at the merits of bringing the NHS Stop Smoking Service and illegal illicit tobacco awareness campaigns further into the heart of neighbourhoods through services and venues already established but not traditionally associated with activity on tobacco control. For example this potentially would include community groups, customer service centres, housing offices and credit unions. Such an approach potentially could provide direct access to hard to reach groups who otherwise do not engage in services.

Are we shaping services so that they are fit for the future?

Following an improvement review of the NHS Stop Smoking Services in North of Tyne, it was discovered that almost half of all people who use their local service either fail to attend, fail to quit or are ‘lost to follow-up’ meaning their quit outcome is unknown. The
Stop Smoking Service needs to communicate with their clients in a more systematic way to encourage engagement with the service, and to attract people who have gone back to smoking to re-access the support and treatment service in order to try again. It is well documented that smokers take a number of attempts before they achieve a positive outcome when stopping smoking. The NHS Stop Smoking Services are based on robust evidence of effectiveness and people who use them are four times more likely to quit smoking than ‘going it alone’. It is crucial that we re-engage with them each time, giving the people of Newcastle the best possible opportunities to achieve their goals. This process has already begun.

**Gaps in data/information**

A great deal of intelligence already exists on smoking and localities. However it is not always shared and analysed locally in a way that will better inform how we target services and interventions at a very local area basis. By pooling data there is potential to target populations and local areas more effectively with tailored messages and interventions.

**What should we be doing next?**

Smoke Free Newcastle should continue its multi component evidence based eight strand approach to tobacco control, providing a universal programme of activities whilst also developing a targeted programme in one ward. It should seek to collect and use intelligence related to local communities and their health behaviour more smartly, to devise and implement targeted interventions aimed at health improvement. Data mapping tools such as Mosaic could help to facilitate this process. It needs to link more effectively into existing services and groups within local areas where smoking rates are above average. Community engagement is essential so that communities and key population groups feel more empowered not to smoke. Community assets need to be identified and utilised more effectively.

In terms of stop smoking the recommendations from the Stop Smoking Service improvement review should be implemented in full and further development of the service undertaken. It is important that best value for money is gained from the investment into stop smoking support and treatment for Newcastle. Local services should be continually reviewed to ensure that they are provided in locations and at times most accessible to the key target populations. The Stop Smoking Service will continue to monitor the proportion of its clients in the routine and manual (R&M) occupational group and ensure this appropriate targeting.

Commissioners of services including NHS North of Tyne and Clinical Commissioning Groups need to continue to prioritise tobacco control and support its implementation through the service contracts for delivery that it has with a range of partners. For example, The Newcastle upon Tyne Hospitals NHS Foundation Trust should be embedding the provision of stop smoking advice and tobacco control messages into everyday practice for relevant staff across its Community Health and Acute Services. Health trainers and community development organisations likewise should routinely provide advice, support and signposting on smoking to the clients they come into contact with. It is important that such messages incorporate the wider tobacco control approach as well as stop smoking, such as illicit tobacco, secondhand smoke protection and social norms.

Engagement with services involving young people, including the youth sector, needs to be improved to ensure that education/prevention/advocacy programmes better meet the
needs of young people and to ensure the next generation of young people remain smoke free. The collection of data via the commissioned Health Related Behaviour Questionnaire will provide a valuable baseline of the smoking rates among young people in the city. Messages relating to the social norm of not smoking must be emphasised to young people and workers engaged with them.

Reducing smoking and pregnancy rates remains a priority. The implementation of an action plan on this issue by The Newcastle upon Tyne Hospitals NHS Foundation Trust will help to improve further the already established programmes to address the high numbers continuing to smoke in pregnancy.

The further development of the stop smoking programme with the BME community should help to provide a culturally acceptable programme of activity. All nine mosques and the Hindu temple and Sikh Gurdwara are to be involved in the next stage of the programme piloted last year. Compliance with and enforcement of regulations on labelling and packaging of niche tobacco products including chewed tobacco and shisha waterpipes need to be improved to protect BME communities and others from the health risks associated with using these products. Regulation and stop smoking work must acknowledge these different products, and adapt to the specific needs of different ethnic groups.

Communicating information about the dangers of secondhand smoke exposure continues to be important. The ‘Take 7 Steps Out’ campaign highlighting the need for smokers who are not ready to quit to go right outside their home if they wish to smoke, has had a positive impact. Its messages need to be reinforced by frontline staff working with parents/carers. More of these staff need to access and put into practice the ‘protecting children from secondhand smoke’ training course offered by Newcastle Hospitals Community Health, so that there is a reduction in children suffering from the effects of parental smoking requiring treatment by health services.

Action to tackle illicit tobacco in local communities remains a priority as it is undermining activity to reduce prevalence, particularly in disadvantaged communities, where smoking rates are higher. Consistent reinforcement of messages is important to increase intelligence on local sources of illicit tobacco and this criminal activity. This approach requires strong partnership working between relevant statutory agencies, as well as public support for action to reduce anti social behaviour. This will be addressed through the North of England Tackling Illicit Tobacco Plan.

In summary, developmental areas are as follows:

1. Smoke Free Newcastle should continue its multi component evidence based eight strand approach to tobacco control.
2. NHS Stop Smoking Services should continue to develop and target services appropriately.
3. Commissioners need to continue to prioritise tobacco control and support its implementation through service contracts.
4. Engagement with services involving young people needs to be improved.
5. The Newcastle upon Tyne Hospitals NHS Foundation Trust will implement its action plan to address the high numbers continuing to smoke in pregnancy.
6. Further development of the stop smoking programme with the BME community.
7. Communicating information about the dangers of secondhand smoke exposure.
8. Action to tackle illicit tobacco in local communities.
Reaching Out
Understanding the health attitudes of harder to reach groups in the North West
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The North West is a region of contrasts. Travelling from the north you will find the rural beauty of Cumbria, the mill towns of Lancashire and the conurbations of Greater Manchester and Merseyside. In all these areas, the region’s hospitals and healthcare services manage an enormous range of issues. The post-industrial legacy of the region, however, means that amongst areas of prosperity there are still pockets of deprivation and inequality, where there is a higher likelihood of ill health and subsequently shorter life expectancies.

Against this background, NHS North West, Our Life and Pfizer have come together as a partnership to look at a sector of the population that does not routinely use the healthcare system in the North West, is economically deprived, and has existing health risk factors. For the purposes of this report, the research group is termed ‘harder to reach’.

As equal partners in this project, we recognise the significant health challenges that face the population of the North West and we aim to suggest potential ways of bringing that population and the healthcare system closer together. We also share a determination to address those challenges by working in a spirit of collaboration. Our partnership, bringing together the public sector, health campaigners and the pharmaceutical industry, is an excellent example of how different organisations can join together and work across sectors to address issues and solve problems.

If we are to be successful in truly addressing health inequalities it is crucial that we gain an understanding of the attitudes and motivation of harder to reach population groups. This aim was central in commissioning our collaborative research and has informed all our work on the project.

By working together and reaching out to a group of citizens who do not traditionally have a relationship with health services in the region, NHS North West, Our Life and Pfizer hope to identify ways to improve and ultimately transform the health and wellbeing of an important part of the North West population.

We commend this research to colleagues and partners across the region.

Alison Giles, Chief Executive, Our Life
Richard Blackburn, Head of Primary Care, Country lead, Pfizer UK
Mike Farrar, CBE, Chief Executive, NHS Northwest

The North West Project > page three
In order to better understand the challenges facing the North West region and its healthcare services, and in recognition of the aims of the Marmot review, three health stakeholders in the North West – NHS North West, Our Life and Pfizer – have come together to provide this research. Over a four week period, Adelphi Research interviewed 258 volunteers within Cumbria, Lancashire, Merseyside, Greater Manchester and Cheshire.

The results of this study demonstrate the clear views of some of those living in the North West about who is responsible for their health and when they choose to access the NHS. Around two thirds (64%) of those questioned believe it is their responsibility alone to take care of their health. They do not see the NHS as a primary means for supporting them with lifestyle issues such as smoking, drinking or obesity and their priority lies with their families over their personal health.

All those chosen to be surveyed had not visited a doctor within the last one to three years, were economically deprived and were at risk of lifestyle-induced, long-term illness. There were 187 smokers who took part in the survey along with 67 people who had been classified as obese. For the purposes of this report, the surveyed group is termed ‘harder to reach’.

This research clearly highlights a number of recommendations that, if implemented, may support the transformation of the health and wellbeing of individuals and communities across the North West:

01> Refining the content and delivery of communications and messaging about healthy lifestyles and preventive services – Effectively targeting PCT communications to encourage disengaged individuals to take responsibility for their own health and to raise awareness of available lifestyle support services.

02> Increasing motivation of disengaged individuals through financial incentives.

03> Re-shaping services to better meet the needs of disengaged individuals and communities – Using insight to commission and deliver services appropriate to the target users in terms of place, time and style.

04> A skilled workforce – Regional workforce programmes need to ensure that the public sector workforce is fully aware of the attitudes and preferences of harder to reach population groups and are sufficiently skilled in responding to them.

This research is timely and supportive for NHS organisations, and highlights that individuals do not recognise the need to improve their own health and lifestyles or see the health system as a source of health and lifestyle support and intervention. In response, the NHS must formulate better ways of reaching out and engaging with this audience. Managing the issues highlighted by this research will require a range of stakeholders using very specific communications channels to reach these communities and ensure appropriate provision of preventive services. Inactivity on behalf of the NHS will result in patients being condemned to ongoing poor health, matching the worst statistics anywhere in the UK.
Introduction

The full effect of the diversity that exists within the NHS North West region is apparent to anyone driving through the M6 corridor. From the rural beauty of Cumbria to the conurbations of Greater Manchester and Merseyside, our region’s hospitals and PCTs manage an enormous range of health issues. The historic legacy of the region, however, means there are still some areas of deprivation where there is a higher likelihood of ill health and subsequently shorter life expectancies.

The region has the highest death rates in the UK from heart disease and stroke and the highest rates of long-term mental health problems and hospitalisation from violent injuries\(^1\). NHS North West and other stakeholders, including Our Life, have been working to address these unacceptable inequalities and a comprehensive strategic plan is in place to improve health and life expectancy, especially within those communities most affected by poor outcomes.

A review of health inequalities by Sir Michael Marmot aims to identify the health challenges facing England and determine the evidence most relevant to underpinning future policy and action. Part of the Marmot review is to understand how this evidence could be translated into practice in specific demographics.

This current study aims to develop a deeper understanding of those individuals who are less likely to engage with the healthcare system in the North West and to suggest interventions that can address the determinants of health inequalities.

In order to better understand these attitudes, three health stakeholders in the North West – NHS North West, Our Life and Pfizer – have come together to provide this research. Over a four week period, Adelphi Research interviewed 258 volunteers within Cumbria, Lancashire, Merseyside, Greater Manchester and Cheshire\(^1\).

All those surveyed had not visited a doctor within the last one to three years, were perceived to be socially deprived and were at risk of lifestyle-induced, long-term illness. There were 187 smokers who took part in the survey along with 67 people who had been classified as obese\(^1\).
Objectives and methodology
Each interviewee fitted into each of the following three criteria:

01> Non-routine user of primary care
   - 18-34 yr olds not seen a GP in the last three years
   - 35-54 yr olds not seen a GP in the last two years
   - 55+ yr olds not seen a GP in the last year

02> Economically deprived
   - Respondents must be in receipt of benefits
   - Household income of less than £11,000 per year, excluding benefits

03> At risk
   - Having a health risk factor such as smoking, drinking, obesity, chronic condition, family risk factor

Working in conjunction with Adelphi Research UK, the research was developed in two distinct phases – a qualitative development stage and a quantitative stage.

Stage One: Qualitative development stage
A pilot day, consisting of five 45-minute in-depth interviews with candidates from the target demographic, was designed to canvass individual views on their perception of health issues relating to them and their families.

The questionnaire was subsequently tested and refined before it was rolled out in the quantitative stage.

Stage Two: Quantitative – trends and analysis
For the second stage of research, recruiting from the same demographic, 258 people from Cumbria, Lancashire, Merseyside, Greater Manchester and Cheshire were interviewed for 30 minutes each.

The resulting data were analysed to reveal key trends and relationships within the target demographic to gain an insight into their attitudes and perceptions of healthcare.

This research was designed to provide an insight into the attitudes around the health and lifestyles of this under-served sector of the population in the North West. The results from this study aim to inform the strategy for how best to encourage this group to improve their own health and to identify how the NHS could provide preventive services, with specific emphasis on key areas of smoking and obesity.
The North West at a glance

- Cumbria
- Lancashire
- Greater Manchester
- Merseyside
- Cheshire

210,500 Staff Employed by NHS

64 NHS Organisations

7 Million Population

24 Primary Care Trusts

39 NHS Hospital Trusts
A snapshot of healthcare in the North West

NHS North West is the second largest of England’s 10 Strategic Health Authorities (SHA). There are 64 NHS organisations including 24 Primary Care Trusts and 39 NHS Hospital Trusts in this region with 210,500 staff currently in NHS employment.

The North West has the country’s highest rates of deaths from heart disease or stroke, a high percentage of long-term mental health problems and an increasing number of hospital admissions for alcohol and drug-related conditions. It also has a high level of hospital admissions for depression, anxiety disorders and schizophrenia, as well as an increase in violent injury incidences serious enough to require a hospital stay.

‘Struggling Families’ are low-income families, living on traditional low-rise estates.

‘Blue-Collar Roots’ are communities in which most employment is in traditional blue-collar occupations.
The North West has a population of some seven million – higher than the national Strategic Health Authority (SHA) average population of over five million\(^1\) – and includes areas of great ethnic diversity.

The area suffers from significant health problems and severe social inequality – more than 50% of the North West population is considered to be deprived, and this region is the second most deprived SHA in the country\(^2\). This deprivation closely follows the density of the population, with more urban areas such as Liverpool and Manchester experiencing higher levels of social inequality\(^3\). The more deprived the area and the lower the annual income levels, the higher the health needs\(^5\). This supports the theory that the more deprived a population, the more likely it is to have current or future health issues.

The majority of the individuals studied in this report would be classified as socially deprived according to ACORN\(^3\) (a geodemographic classification system of residential neighbourhoods which classifies the UK into five categories, 17 groups and 56 types)\(^2\).

Using the ACORN classification system to analyse respondents, better methods to reach these demographic types can be identified. Models already exist for reaching out to the ACORN types identified in this report – these will provide valuable insights when developing future communication strategies.

77% of the survey respondents were grouped under the following: Struggling Families, Blue-Collar Roots and Burdened Singles\(^6\).

‘Struggling Families’ are low-income families, living on traditional low-rise estates. This group has generally low incomes, a relatively high level of unemployment and high incidences of long-term sick leave. Additionally there is low educational attainment amongst this group\(^6\).

‘Blue-Collar Roots’ are communities in which most employment is in traditional blue-collar occupations. This group also has low levels of educational qualifications; incomes range from moderate to low and unemployment is higher than the national average, as is occurrence of long-term illnesses\(^6\).

‘Burdened Singles’ are urban groups, characterised by single adults. These include single pensioners, young singles and lone parents. Members of this group again have low incomes, higher than average unemployment and a high incidence of long-term illnesses\(^6\).

There are frequently cited disadvantages highlighted in each of the ACORN classified types described, including low income, high levels of unemployment and low educational attainment\(^8\). These disadvantages, combined with other lifestyle choices and low presentation to the NHS, could be determining factors in the higher than average occurrence of long-term illnesses in those surveyed.

This highlights the need for a better understanding of this group in order for the NHS and other stakeholders to develop effective strategies to communicate about services on offer, with the audience studied in this research.
Perceptions of the NHS and responsibility for healthcare

The data suggest that the majority of the respondents questioned are registered with a GP (89%), but that they do not regularly visit their local surgery or medical centre. One of the key objectives of this research is to understand why these individuals do not use the preventive services provided by the NHS.

The doctor remains an influential figure for respondents. The research suggests that patients neither mistrust nor are afraid of visiting their doctor – 63% say they would trust their GP or family doctor to deal with conditions such as weight loss, smoking or alcohol use. And 70% would not be embarrassed to discuss their problem with their GP. In addition, 43% of those questioned said that professional sources are the ones they most trust, with only 17% valuing opinions of family and friends first.

However, when it comes to lifestyle issues such as obesity or smoking, this group does not see the NHS as a primary source of help. Instead, 64% believe that it is their responsibility to look after their own health if they do get ill.

Of the 16% of those questioned who did visit their GP within the last year, the majority of appointments were mainly for benefit purposes (allowing the individual to claim benefits based on ongoing illness certification from their GP) or for their children, rather than being prompted by their personal health needs. In addition, 77% of those questioned believe that they have to be ill in order to see their GP.

So, while respondents understand the role of the NHS in dealing with specific health problems and issues, like diagnosing illnesses and dispensing medicines, there is a lack of awareness of the role that the NHS can play in helping to tackle various lifestyle health issues at an early stage.
Understanding social foundations and perceptions of health
Parts of the North West region have a high proportion of social deprivation, with 50% of the population said to be deprived\(^3\). In order to acquire a deeper understanding of this group’s attitudes to health, the research also probed favoured social activities, what is important to them and the information sources they currently value.

Across almost all areas investigated, respondents thought they were significantly healthier than they were. Of those questioned, 26% were clinically obese (with a BMI of over 30) yet only 7% of those recognised they are overweight\(^3\). Additionally, as few as 6% thought they were binge drinkers, whereas the reality is 40%\(^3\).

There is also a level of misunderstanding as to what constitutes a healthy diet – 72% of respondents eat an unbalanced diet yet only 59% think they do\(^3\). In addition, for over half of those questioned (52%), health awareness was only triggered at point of diagnosis\(^3\). This low health-awareness and the extent of potential problems could be just one reason for not using preventive health services.

**Family values**
Family comes first for those surveyed. When asked what was important to them, the value of family was significantly ranked above health in order of importance\(^3\).

**Access to information**
This study indicates a largely sedentary lifestyle, with 81% of those questioned saying that watching TV is their most common social activity\(^3\). In contrast, just 33% go to the park regularly and only 7% play a sport or use the gym\(^2\).

While only 36% use the internet\(^2\) and 37% read national newspapers\(^1\), the majority of respondents (55%) read local newspapers\(^3\).
Key barriers to health and maintaining a healthy lifestyle
To better understand the poor health of those surveyed, it is important to understand what they believe are their key barriers to maintaining a healthy lifestyle. Lack of money (54%), laziness (52%), and genetics (20%) were most frequently cited as the top three barriers to having a healthy lifestyle. The research reveals that 40% of respondents who smoke heavily do not worry about their health at the present time, and 46% of clinically obese patients are not currently trying to lose weight. However, 40% of respondents would like to live longer than they actually expect to live.

Health is recognised by this group as a key driver to living longer. Of those questioned, 17% realise that they need to be healthier and 21% know they need to eat more healthily in order to live to the age they aspire to. However, 84% of those questioned say that they do not really worry about their health at the moment, but 64% state that they are likely to worry about the impact their health will have on their life in the future.

In addition to a reluctance to visit their GP, those questioned also cited barriers to being healthy in general. We have already demonstrated the misconceptions that exist between what is perceived as healthy and what actually is healthy among those questioned. Although they understand and see the link between their ‘health’ and ‘living a healthy lifestyle’, perceptions of what this entails vary enormously.
Routes to improved healthcare
Taking responsibility

As mentioned earlier in this report, the majority of respondents (64%) recognise it is their responsibility to take care of their own health\(^3\), but would not approach the NHS for help or guidance – instead, 54% turn to family to look after them when they are ill\(^3\). In comparison, only 9% would visit their GP or family doctor and only 1% would go to their local hospital\(^3\).

There is a clear understanding of the need to improve lifestyles in order to enjoy a better quality of life and gain a longer life expectancy. There is recognition of wanting to improve their lifestyles for the sake of their future – over two-thirds (64%) admit they worry about the impact of their lifestyle on their future health and how it could affect them in the future\(^3\).

Community and environment

When comparing personal health against the perceived health of the community, 56% of smokers believe their health is about the same as others in the local area\(^3\), while 57% of those with a BMI of more than 30 also see themselves being as healthy as others in their community\(^3\).

It would appear that community and lifestyle references play a significant role in shaping self-perception. Those questioned make observations relating to their own health based on the people and lifestyles around them.

Methods to reach the target audience

While 40% of those questioned did not recognise any previous health campaigns\(^3\), there were a number of Government campaigns that did resonate; including the F.A.S.T stroke campaign, which 28% of those questioned recognised spontaneously and the ‘It’s 30 for a reason’ speeding campaign, which was recognised by 17% of the survey sample\(^3\).

We have already revealed that the most common social activity for those questioned was watching the television – with 81% stating that this was their top social activity undertaken in leisure time\(^3\). The research revealed that 80% of those questioned believed that television would be the best way to make individuals aware of services that are available to them locally and 33% say that materials through the door would be the best method\(^3\).

The research also reveals that the majority of respondents (55%) read local newspapers\(^3\) and 37% read national newspapers\(^3\), highlighting an alternative potential route for intervention.

Opportunities for intervention

When asked, 46% of those questioned said they were not aware of any solutions that could help improve their health and lifestyles. However, when all respondents were prompted with some potential solutions, many were enthusiastic about using them.

Introducing financial incentives as a means towards a healthier lifestyle was very well received. For example, offering individuals vouchers to redeem against certain healthy foods such as fruit and vegetables was the most popular idea for intervention – eight in ten (81%) confirmed they would be likely to use this service\(^3\). Additionally, free or subsidised services such as weight-loss, fitness and swimming classes were also a popular option. This option was particularly favoured by those with a BMI of more than 30, of whom, 50% said they would be very likely to take advantage of this service\(^3\).
Discussion and recommendations
The real challenge is to identify effective methods to encourage and motivate disengaged individuals to improve their health and to raise awareness of the support that is available. This could be their GP, local pharmacist or other community health services. The task ahead is to develop communications and services appropriate to the target users.

This report provides a timely and geographically relevant precursor to the publication of the Cabinet Office Social Exclusion Task Force’s work with the Department of Health examining primary healthcare for socially excluded groups. Their study is looking at how well the primary healthcare needs of the socially excluded are being met and will identify recommendations and tools for improvements.

As well as contributing new analysis about specific groups, their project will consider how to improve access to, and quality of, primary healthcare for the most vulnerable in our society. It also aims to provide greater clarity about the contribution that primary healthcare services can make to social inclusion, and expose innovative ways of delivering NHS-funded care to those at risk. The report is due to be published in early 2010.

Children and family-related messages

Given that 15% of the population in the North West are classified by ACORN as ‘Struggling Families’, who engage with their GPs primarily for benefit reasons, this group is likely to have a high exposure to child health services.

This provides an opportunity to engage with these individuals using children and family-related messages which may have a stronger impact.

The Family Nurse Partnership Programme is a targeted intervention programme aimed at the most vulnerable pregnant teenagers. It is being piloted nationally and there are eight pilot sites in the North West.

The intervention works with the mother to explore her aspirations and future hopes, and her readiness to adopt a healthy lifestyle. It encourages the teenage pregnant woman to consider the importance of being engaged in training or employment – an important element in prevention of ill health in families. Support is offered to those ready to make lifestyle changes. Whilst the overall emphasis is on ensuring maximum health of the child, the programme looks to encourage the mother to become the parent she would like her child to have.
Discussion and recommendations

Direct to consumer campaigns
Given that the surveyed group is largely home-based, due to high levels of part-time employment, unemployment and long-term sickness, communications delivered direct to their home may be a good route to reach this audience. Respondents identified television and local newspapers as good routes to engaging individuals. This study found low educational attainment amongst this group and so information should be succinct and easy to understand.

Skilled for Health (SfH) is a national programme focused on engaging low-skilled people in learning in order to improve their health and skills for life. By embedding Skills for Life learning into health improvement topics it can address both the low literacy and health inequalities prevalent within traditionally disadvantaged communities. The North West piloted the SfH programme through community settings. National evaluation, across all settings, shows clear evidence of the success of the programme. A second phase of the programme is being rolled out in more community sites in the region, as well as linking SfH to NHS North West’s self-care programme and to the Offender Health Programme.

Other communication mechanisms

01> PCTs should take action to identify those individuals who are not registered with a GP and seek ways of encouraging full registration.

02> PCTs should describe the prevention services on offer in each area tailored to individuals at different stages of their lives.

The NHS in the North West should consider developing a core guide for this purpose that is given out with every new GP registration, every new medical card issued, at the first appointment as an expectant parent, and generally available from PCTs and other local NHS websites.

03> Health professionals should use every patient contact as an opportunity to ask about lifestyle, directing them to appropriate prevention services if necessary.

Increasing motivation
Lifestyle change in response to financial incentives is another key route to reach some of the disengaged audiences. As mentioned previously in this report, ‘Burdened Singles’ have very low incomes and are less likely to interact regularly with healthcare services unless they have a serious problem. This means that services may need to be provided in a social or community-based setting, using a clear quantitative financial reinforcement. The Points4Life initiative, highlighted as a case study in this report, is adopting this type of approach.

Commissioning and delivering appropriate services
As this research has shown, many people in the North West do not avail themselves of health and wellbeing services because they do not recognise the NHS as a source of support. The findings of this report highlight that people’s aspirations for better health for themselves, their family and community may not be high. The most effective solutions will involve individuals and communities themselves in service development and in some cases delivery.
Commissioners, with public health colleagues, need to ensure they are collecting data on the population segments identified in this study, and are using the data effectively to inform the Joint Strategic Needs Assessment and the provision of appropriate services. As understanding grows of what it takes to be well, it is important that services build on the assets of local communities.

Commissioners should adopt a more collaborative approach to designing health improvement programmes, working with the end-users and the media as well as public health and communications colleagues. This co-production with the end-user will inspire the belief and drive for behaviour change to happen. The very act of involvement creates a value statement which is important at all levels.

As the findings of the report and the case-studies testify, there is no one solution but the focus should always be on the service user. To this end, commissioners need to prioritise the development of joined-up and holistic services, with more social involvement by primary care. With this comes a need to take an integrated approach, and to move away from individual organisations delivering similar or overlapping services with the commensurate risk that some population groups or types of services are not catered for at all.

A skilled workforce

Regional workforce programmes need to ensure that the public sector workforce is fully aware of the needs of harder to reach population groups and be sufficiently skilled in responding to them. The findings of this report provide valuable insights into some of the barriers and motivations that may be at play, and some of the potential solutions that a skilled workforce might employ in supporting healthier lifestyles.

The findings of this report highlight that people’s aspirations for better health for themselves, their family and community may not be high
Case Studies

11
Steps have already been taken to improve the lifestyles of those living in the North West

CASE STUDY ONE
Using financial incentives – Points4Life in Manchester

Problem
Many people, especially among the most economically disadvantaged, do not understand what constitutes a healthy diet or an appropriate level of physical exercise. And anyway, it is hard to resist temptation when faced with frequent choices between immediate gratification and more distant health benefits.

Background
Points4Life, developed by NHS Manchester and Manchester City Council, is the world’s first citywide wellness incentive programme, rewarding people for making healthy and active choices. Points4Life brings together a range of partner organisations to help people measure their diet and activity levels, and create incentives to change behaviour.

Solution
Points4Life will launch in Manchester in the summer of 2010. Members earn Points4Life when they buy healthy food through partner retailers and by participating in physical activity with a range of partner organisations. The rewards depend on the number of Points4Life earned, with a range of rewards such as leisure and entertainment experiences, gadgets and money-off vouchers, as well as chances to win money-can’t-buy prizes. Members who reach their Points4Life goals – representing achievable steps towards a healthier lifestyle – qualify for bigger rewards.

CASE STUDY TWO
Improving health and wellbeing in Lancashire

Problem
Lack of physical activity in Blackburn with Darwen.

Background
The Re:fresh scheme was developed as a result of the Active People Survey, published in December 2006, which revealed that Blackburn with Darwen has:
- The lowest adult participation rates in the North West for any physical activity
- The 3rd lowest adult participation rates in the country
- 92% of the population do not do enough physical activity
- 58% of the population does no physical activity at all.

Through the Re:fresh scheme local communities are encouraged to increase activity levels with the incentive of free leisure facilities, health advice, dietary advice and more.

Solution
A £6 million programme of activities and support has been implemented across Blackburn which has resulted in a 71% increase in uptake of beeZ cards (Blackburn with Darwen Borough Council’s leisure discount card).

CASE STUDY THREE
Taking heart disease prevention into the heart of the community in Merseyside

Problem
Knowsley is one of the most deprived boroughs in the county and has very significant health inequalities to address, with rates of heart disease and stroke far higher than the national average.

Background
The latest health statistics (2008) show that although significant improvements have been made in recent years, the rates of heart disease and stroke remain much higher in Knowsley than the national average. It is estimated that more than 13,000 residents in Knowsley alone are at risk of heart disease. In 2008, ‘Knowsley at Heart’ was launched – a huge cardiovascular programme targeting high-risk groups with free health checks carried out in a community setting.

Solution
From October 2008 to the end of March 2009, over 1,300 Knowsley residents received a free general health check.

A £6 million programme of activities and support has been implemented across the borough which has resulted in a 71% increase in uptake of beeZ cards (Blackburn with Darwen Borough Council’s leisure discount card). There has also been a 62% increase in attendance at leisure facilities in the borough resulting in many more people now leading healthier lifestyles.
Case studies

CASE STUDY FOUR
Reducing obesity in Greater Manchester

Problem
In Wigan borough, 57% of the population is overweight or obese. Wigan is now recognised as the most overweight borough in the North West.

Background
The Lose Weight, Feel Great programme was developed to help people of all weight ranges (overweight, obese and morbidly obese) access the help and support they need to lose weight. Public access to the care pathway is via a local free-phone number manned by NHS Direct staff where patients can be directed and enrolled into the most appropriate service or intervention.

Solution
The extensive social marketing programme for Lose Weight, Feel Great was rolled out in the first part of 2009 and inspired 2,500 adults to change their behaviour towards weight management either with an improved diet and/or an exercise routine specifically tailored to their needs.

CASE STUDY FIVE
Helping those in Cheshire live longer healthier lives

Problem
There is a need for a fundamentally different approach to tackling the source of sickness and ill health in Cheshire. People need to be given more opportunities to take responsibility for their own health.

Background
The YourHealthCoach service is part of the Staying Healthy for Longer project and is designed to provide extra support to patients with long-term conditions, above what would normally be provided by their GP.

Solution
The YourHealthCoach programme is a free telephone-based, nurse-led service that offers health advice and information. People can call a health coach to discuss their personal health concerns, or a health coach may call an individual to introduce them to the service, following a referral from their GP. On a monthly basis, health coaches will focus on different health campaigns and contact those individuals who have been identified as potentially requiring support (e.g. smokers or the overweight).

Half of the GP practices in Cheshire are participating in the YourHealthCoach initiative and the feedback from patients has been extremely positive.

CASE STUDY SIX
Reducing alcohol harm in Cheshire and Merseyside – a social marketing pilot in partnership with the pub industry

Problem
Most areas in Cheshire and Merseyside are well below the England average for alcohol harm but there are still high levels of people drinking to hazardous and harmful levels putting great pressure on health care services.

Background
In autumn 2008 the Cheshire and Mersey Public Health Network (ChaMPs) alcohol leads group commissioned the North West Public Health Observatory to undertake research to segment hazardous and harmful drinkers of alcohol in Cheshire and Merseyside. The aim of the research was to identify how a sub-regional response to preventing alcohol harm could be developed and targeted; identify areas for further research; and identify how drinking behaviour could be positively influenced and changed.

Following this report, ChaMPs Social Marketing team commissioned in-depth qualitative research to inform their alcohol segmentation pilot with a key Mosaic segment of male drinkers in Cheshire and Merseyside, ‘Ties of Community’. There are high numbers of this group across Cheshire and Merseyside and they are predominantly in manual semi-skilled occupations and regularly drinking to hazardous or harmful levels. They do not access health services generally and may have underlying health problems as a result of excessive drinking.

The qualitative research showed that this group are not contemplating a change in their drinking habits at present.
and awareness needed to be raised to communicate the benefits to them of drinking less and encourage them to set their own behavioural goals to reduce their drinking levels.

**Solution**

The decision was taken to work with the pub industry to take the social marketing intervention to the pub itself rather than asking the men to access traditional NHS services. After extensive talks with the drinks industry, Robinsons brewery agreed to work in partnership with ChaMPs and trial a social marketing intervention in one of their pubs in November 2009 in the Central and Eastern Cheshire area. The main aim was to help men become more health aware and realise the effect that alcohol may be having on their physical and emotional wellbeing. ChaMPs Public Health Network in partnership with Central and Eastern Cheshire PCT made free, confidential health checks available in the pub to males aged between 35 and 55, which incorporated advice on reducing alcohol consumption, along with other interventions and promotions. The health checks have proved popular in the trial pub and many pub drinkers had not visited their GP in years.

The University of Chester is currently writing their evaluation report on the trial to see how it has worked and the programme will be available in June 2010.

**CASE STUDY SEVEN**

*Health trainers in Greater Manchester*

**Problem**

Health inequalities persist in our most deprived areas as well as specific population groups. We all know that making health-related lifestyle change can be thwarted by circumstances unique to each individual. These include bereavement, illness, debt, social isolation, violence, poor education, housing, self esteem and so on.

Health and social care professionals are often compromised by their perceived authority in their interactions with people around lifestyle-choices. Interlinked are issues of self efficacy, wellbeing, and perceived general health, which are key to being able to identify goals and achieve them.

**Background**

Information campaigns around lifestyle choices have not resulted in reducing health inequalities. Research reviews show that people who are least likely to make and maintain a lifestyle change need extra support from someone who thinks like them – a peer to peer approach.

Health Trainers are recruited from local communities and engage in community settings as well as building relations with key professionals and community leaders. This is a national initiative with four main outcomes:

- Reaching the hard to reach
- Making sustained behavioural change
- More timely and appropriate use of services
- Building the public health workforce.

The Health Trainer role is unique in bringing both community engagement and behaviour change competencies into one qualification and applied in practice. With a network of support across the country, more than 80% of PCTs in the North West have set up a Health Trainer service.

**Solution**

Tameside and Glossop, in Greater Manchester, established a Health Trainer service for people who want to make a lifestyle change.

This team has worked with people in geographically deprived areas, in community venues, the acute trust’s occupational health unit, post-stage 4 cardiac rehab, probation approved premises, schools, SureStart and multi agency one-stop shops. The team has also worked with people who have low-level mental health concerns, people at risk of coronary heart disease, and anyone else over age of 16.

Reaching the hard to reach is at the heart of their work. For example, on one day in January 2010 in Glossop, Health Trainers knocked on 126 doors, spoke to 50 people and generated nine clients who wanted to make a lifestyle change but need support to do so.

At present, the largest proportion of referrals are coming from General Practice (33%) and the next highest is self referral – testimony to the credibility and reputation of the service within the community. Within the last nine months 71% of clients have achieved a goal they set within their Personal Health Plan.
References


03> Understanding Attitudes to Health in the North West. Presentation prepared for Pfizer and NHS North West. Adelphi Research UK. Project No. 6640. 16th July 2009


06> North West Research: Acorn Category of Responders


11> The Vision one year on> Healthier Horizons. NHS North West. Date TBD
Our Life, Pfizer and NHS North West would like to take this opportunity to thank the respondents of this study, Adelphi Research UK and Red Health.
This project is a collaboration between Our Life, NHS North West and Pfizer.
### Minutes

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<thead>
<tr>
<th>Item No</th>
<th>Item</th>
<th>Action</th>
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<tr>
<td>1.</td>
<td>Present:</td>
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<tr>
<td></td>
<td>• Meng Khaw, Director of Public Health for Newcastle (Chair)</td>
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<tr>
<td></td>
<td>• Rachel Forth, Voluntary Sector Representative, Cancer Research</td>
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<td>• Jeannie Fraser, Sexual Health Group</td>
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<td>• David Stobbs, Eat Well Group</td>
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<td></td>
<td>• Judith MacMorran, Smoke Free Newcastle</td>
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<td></td>
<td>In attendance:</td>
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<td></td>
<td>• Liz Robinson, Strategic Partnership Coordinator</td>
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<td></td>
<td>• Naomi Warne, PA to Director of Public Health (minute taker)</td>
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<td></td>
<td>• Vivienne Air, Head of Regeneration and Environmental Protection</td>
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<td>• Nicola Woodward, Head of Planning</td>
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<td></td>
<td>• Karen Inglis, Project Manager, Adult Services Directorate</td>
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### Apologies:
- Tony Durcan, NCC
- Chris Drinkwater, Healthworks Newcastle
- Helen Lamont, Newcastle Hospitals NHS Trust
- Frances Blackburn, Newcastle Hospitals NHS Trust
- Su Cumming, Active Newcastle, NCC
- Dr Jean Adams, FUSE/University of Newcastle
- Helen Golightly, Environment and Regeneration

### 2. Smoke Free Newcastle Annual Report

2.1 MK introduced JMcM who gave a brief overview and the context of the annual report being presented. She stated a bigger report is available on the Fresh website.

2.2 JMcM gave background to item number 5. Next Steps of her report and explained Blakelaw was the locality selected for the specific targeted intervention. JMcM explained although prevalence wasn’t the highest in this area, Blakelaw misses out on a lot of services in other areas.

2.3 JMcM informed the board that their JSNA is almost completed and could bring copies and table at the next HLB meeting.

**Action:** JMCM to bring copies of completed JSNA for board members.

2.4 MK thanked JMCM for her very detailed and well written report.

### 3. Cowgate Residents Survey

3.1 MK introduced Karen Inglis from Adult and Culture Services, Newcastle City Council who gave an update to the tabled paper of a recent resident’s survey taken in the Cowgate area of Newcastle. Karen informed the board that this paper highlighted the results of a second survey where 400 households participated which enabled measurement of progress from 2010 to 2011. A number of these people had asked for support on lifestyle issues.

3.2 Karen informed the board that the results showed that people were not accessing some services. Karen suggested it would be possible to use these people to act as champions in their neighbourhood.

3.3 Wide discussions took place around questions asking how it could be possible to harness these people who have come forward and link them into services and use them to spread knowledge. JMcM suggested using the mosaic profiles for the area relating to smoking.
3.4 MK asked Karen what she would like from the HLB and Karen suggested as next steps to share data and have specific discussions with service leads to see how to engage and harness the 75 residents on taking things forward.

**Action:** Karen Inglis to circulate the Cowgate Residents Survey to Board and make contact with members for advice and assistance.

### 4. Role of regulation and planning in improving health

#### 4.1 MK introduced Vivienne Air from Environment and Regeneration who gave a presentation on the role of regulation and planning with a themed approach around alcohol and health issues.

#### 4.2 Vivienne informed the board that they still operate in regulation health work with statutory duties. Vivienne went on to present slides covering all aspects from private sector housing, air levels, food safety and licensing issues relating around alcohol.

#### 4.3 Nicola Woodward from Environment and Regeneration gave the second part of the presentation which covered spatial planning.

#### 4.4 Nicola informed the board of the cities Local Development Framework. Within this they are working with Gateshead on a Joint Core Strategy as Health and Wellbeing policies. Nicola went on to explain that there is a Health and Wellbeing policy in there and they are presently looking at reducing health inequalities. Nicola explained that they are doing as much as they can within constraints of planning policy but working in collaboration will impact on health and lifestyle choices.

#### 4.5 Vivienne Air informed the board that they have been written into the land permit for next years Evolution Festival which will manage cigarette sales and healthy foods.

#### 4.6 Nicola Woodward informed the board of a recent Health Plan Workshop and the actions resulting from this event; to pull cases of past planning with health improvement properties and perhaps linking in with a bylaw approach. A brief discussion took place regarding recognising the potential of food safety and combined learning’s and actions from this board.

**Action:** Next steps have a local workshop perhaps with Neil Bradshaw.

### 5. What’s new?

#### 5.1 JMcM requested that Health Related Behaviour questionnaire to go onto a future agenda and will give a presentation in the October meeting.

#### 5.2 MK informed the board that the Healthy Lives, Healthy People: Update and Way Forward paper is now out reporting on the structures and functions, however, the outcomes will not be published until later this
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<tr>
<td>5.3</td>
<td>LR reported the Health Summit Tuesday 19 July and the Alcohol event in November.</td>
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<tr>
<td><strong>6.</strong></td>
<td><strong>Minutes of meeting held 13 January 2011</strong></td>
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<tr>
<td>6.1</td>
<td>Minutes from the previous meeting were agreed.</td>
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<td><strong>LINk reports</strong></td>
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<td>LR has received responses from DS and JMcM  LR to respond from board to Craig Deurden.</td>
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<td>LR meeting DR from Family Intervention Service</td>
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<td><strong>7.</strong></td>
<td><strong>AOB</strong></td>
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<td>7.1</td>
<td>August board meeting will go ahead as enough members should be present.</td>
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<tr>
<td><strong>7.</strong></td>
<td><strong>Date and time of next meeting:</strong></td>
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<td>25 August 2011, 1pm – 3pm</td>
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