Deputy Chief Executive's Office
Dean Taylor

Members of the Health and Wellbeing Board:

Dr S Aitken, J Bremner, P Brown, CJ Bull, J Davidson, C Keetch, PM Morgan (Chairman), J Newton, Dr A Watts and M Woodford

Your Ref: N/A
Our Ref: Tuesday 18 October 2011
Please ask for: Tim Brown, Democratic Services
Direct Line:
Fax: 01432 260239
E-mail:
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14 October 2011

Dear Councillor,

Health and Wellbeing Board - Supplementary Reports

Please find attached supplementary reports that were not available prior to the publication of the agenda for the forthcoming meeting (Tuesday 18 October 2011, at 2.00 pm). Please bring these papers to the meeting.

7. INTEGRATED NEEDS ASSESSMENT - ALCOHOL NEEDS ASSESSMENT

To consider the integrated needs assessment for alcohol.

Ward:

8. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2011

To receive a presentation on the Director of Public Health Annual Report 2011.

Ward:

9. COMMUNICATIONS PLAN

To receive a presentation on a Communications Plan.

Ward:

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**18 OCTOBER 2011**
TITLE OF REPORT:	**ALCOHOL INTEGRATED NEEDS ASSESSMENT – EXECUTIVE SUMMARY**
REPORT BY:	**Dr Sarah Aitken & Dr Alison Merry**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

For the Health and Wellbeing Board to note the alcohol integrated needs assessment including the methodology that has been developed for this and to approve the recommendations.

Recommendation(s)

THAT:

(a) the methodology developed for this alcohol INA is adopted as the Health and Wellbeing Board's standard Integrated Needs Assessment (INA) methodology;

(b) this INA is used to inform the development of an alcohol harm reduction strategy in the context of a commissioning cycle;

(c) a coordinated range of actions are undertaken to address alcohol-related harm to health using the ladder of interventions as a conceptual framework;

(d) data collection and surveillance on alcohol-related harm to health continues to be developed and refined ("step 1 of the ladder");

(e) social marketing campaigns are developed to reduce alcohol-related harm to health in young people ("step 2 of the ladder");

(f) IBA (identification and brief advice) services should be expanded across health and non-health settings increasing the number of at risk people who are supported and allowing specialist services to focus on specialist care ("middle of the ladder");

(g) clear commissioning intentions for integrated alcohol services are

Further information on the subject of this report is available from
Dr Sarah Aitken or Dr Alison Merry (01432) 344344

developed using the NTA's stepped model which covers tier 1 to tier 4 services ("middle of the ladder");

(h) work continues to build on existing partnership initiatives to reduce alcohol-related harm to health through influencing default choices, incentives, disincentives and enforcement ("top of the ladder");

Key Points Summary

- The INA methodology uses quantitative and qualitative data, including wide stakeholder input to bring together information on "what is the size of the problem", "what are the current services" and "what works" and to make recommendations for future action.
- INA contributes to the JSNA process, informs strategy development and forms the first step in the commissioning cycle
- Key findings of alcohol INA – in Herefordshire:
    - 23% of men and 11% of women drink over recommended limits
    - Alcohol-attributable hospital admissions are a major cause of hospital admission in and have increased by over 30% since 2007/08.
    - The alcohol-specific hospital admission rate for under 18 year olds is significantly higher than the England average.
    - There is an upwards trend in alcohol-specific hospital admissions with a 19% increase (men) and 29% increase (women) since 2007/08.
    - There is a strong social gradient in alcohol-attributable hospital admissions
    - People from the most deprived neighbourhoods are **twice as likely** to be admitted with an alcohol-attributable condition as people from the least deprived neighbourhoods.
    - Young people from the most deprived neighbourhoods are **twelve times more likely** to be admitted to hospital with an alcohol-attributable condition than those from the least deprived neighbourhoods.
    - Alcohol-specific hospital admission rates for young people are higher in Herefordshire than in other areas with similar population characteristics.
- The National Treatment Agency recommends a four-tiered "stepped model" for integrated alcohol harm services. Compared to this, there are gaps within local service provision.
    - Increased provision of Identification and Brief Advice (IBA) is needed in a range of health and non-healthcare settings
    - Specialist services currently focus on non-specialist care and there is insufficient specialist capacity within county
- Recommendations are included in the report and have been outlined above.

Alternative Options

1 n/a

Reasons for Recommendations

2 Based on assessment of need and evidence of what works

Introduction and Background

3 The Health and Wellbeing Board has agreed to look at alcohol-related harm to health and alcohol harm reduction services with the first step being to undertake an alcohol integrated needs assessment. This paper provides an executive summary of the alcohol needs assessment and provides a standard methodology for future integrated needs assessments on other topic areas. The INA is intended to inform the development of an alcohol harm reduction strategy in the context of a commissioning cycle.

Key Considerations

4 As set out in the alcohol INA

Community Impact

5 To be determined

Financial Implications

6 To be determined

Legal Implications

7 To be determined

Risk Management

8 To be determined

Consultees

9 A range of stakeholders were consulted in the course of developing the INA using a questionnaire, structured interviews and a stakeholder workshop

Appendices

10 n/a

Background Papers

- None identified

Alcohol Integrated Needs Assessment

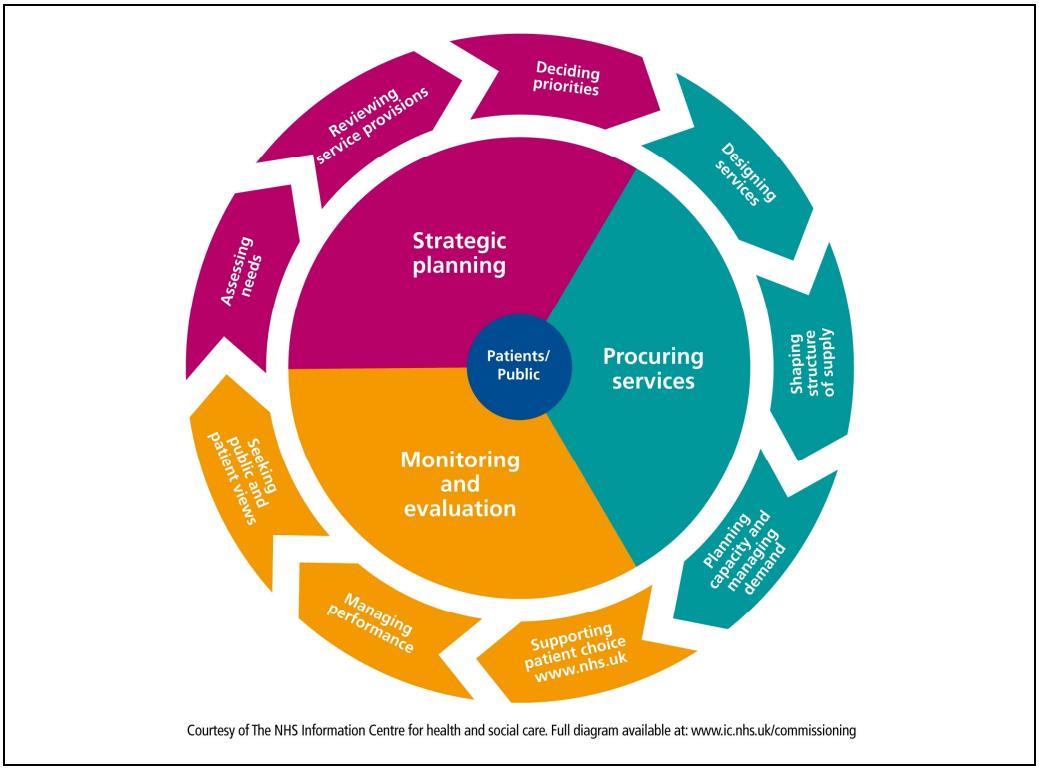
Executive Summary Report for the Herefordshire Health and Wellbeing Board October 2011

1. Introduction

This report provides an executive summary of the Alcohol Integrated Needs Assessment (INA) which has been undertaken by Public Health on behalf of the Health and Wellbeing Board. The full alcohol INA is available separately.

The intention of the alcohol INA is that it will form the alcohol section of the Joint Strategic Needs Assessment which will, in turn, inform the development of strategic plans for alcohol harm reduction as part of the overall Health and Wellbeing Strategy. In effect, the alcohol INA provides the first step of a new commissioning cycle for alcohol harm reduction in Herefordshire (figure 1).

Figure 1 The commissioning cycle



Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

2. Background

The Health and Wellbeing Board has agreed to look at alcohol-related harm to health and alcohol harm reduction services as a practical "working example" in order to a) start the process of addressing alcohol-related harm to health and b) develop a methodology and ways of working which would be applicable to other population health and wellbeing issues.

Alcohol misuse is responsible for a range of acute and chronic health problems in addition to social problems such as crime and disorder, domestic violence and anti-social behaviour. Alcohol is thought to be associated with 25-33% of known cases child abuse.

Guidelines for sensible drinking and definitions of hazardous, harmful and binge drinking are shown in table 1. Alcohol-misuse can also be categorised according to the level of dependence: mild, moderate, severe dependence.

Table 1 Definitions of hazardous, harmful and binge drinking

	Men	**Women**
Sensible Drinking Limits (Dept of Health guidelines)	Men should not regularly drink more than 3-4 units of alcohol per day	Women should not regularly drink more than 2-3 units of alcohol per day Pregnant women or those trying to conceive should avoid alcohol
Hazardous Drinking	Between 22 and 50 units of alcohol per week	Between 15 to 35 units of alcohol per week
Harmful Drinking	More than 50 units of alcohol per week	More than 35 units of alcohol per week
Binge Drinking Is the consumption of at least twice the daily recommended amount of alcohol in a single drinking session	8 or more units in a single session	6 or more units in a single session

3. Health needs assessment and integrated needs assessment

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve population health and reduce inequalities. Typically, the health needs assessment process focuses on healthcare issues, however, the methodology that has been developed for this *integrated* needs assessment widens the scope to ensure that the wider influences on health are also considered – for example by allowing for the inclusion of data and input from partner organisations and

stakeholders such as police, and community and voluntary sector organisations. In relation to this alcohol INA, stakeholder views have been sought using a variety of methods including a questionnaire, semi-structured interviews and an interactive stakeholder event.

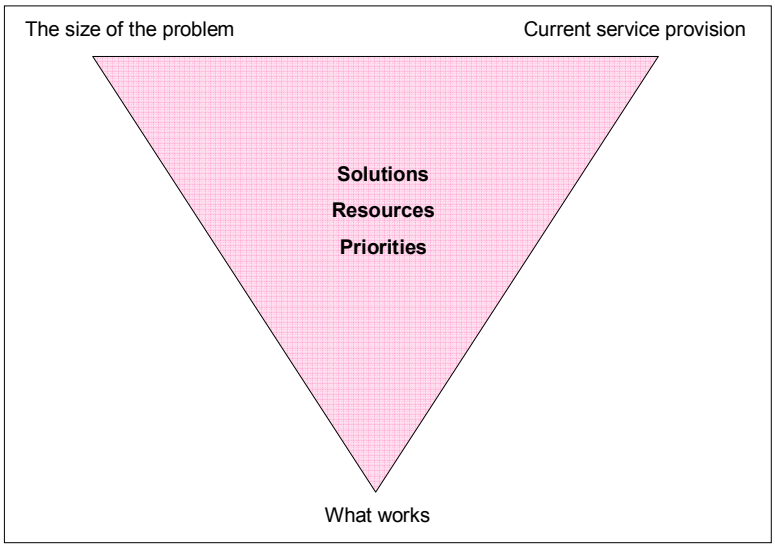
4. INA - the standard methodology

The INA methodology explicitly recognizes the need to address the wider determinants of health and wellbeing and uses both quantitative[A] and qualitative[B] evidence to look at the following three areas (figure 2):

- The nature and size of the problem (in this case alcohol-related harm to health);
- Current service provision;
- The evidence of what works.

The findings are then used to develop recommendations for future action which might include the introduction of evidence-based services or changes to or the withdrawal of ineffective ones.

Figure 2 The "three-legged stool" integrated needs assessment model



[A] Quantitative data – describes numerical data that can be quantified
[B] Qualitative data – tends to be more descriptive, subjective information which does not lend itself to being quantified but is still valid. A combination of both quantitative and qualitative information together is often valuable in understanding the nature and size of an issue.

The size of the problem

Ascertaining the size of the problem involves using a range of quantitative and qualitative data to systematically look at "who", "what", "where" and "when" for example:

- **who** is affected in terms of age, sex, ethnicity, disease or other condition?
- **where** are affected people to be found in the county?
- **what** are the current, past and future trends?

This step also involves comparison with other areas using benchmarking.

Importantly, it also involves stakeholders and partner organizations from beyond the healthcare arena in order that the full range of relevant data sources and wider determinants affecting health and wellbeing are taken into consideration.

Quantitative data sources include a wide range of data sets covering demographics, social, behavioural, economic and environmental determinants of health, data on service access and utilization, and evidence of effectiveness – with analysis and interpretation used to turn this into intelligence.

Qualitative data comes primarily from seeking stakeholder views. This involves wide consultation with service users and their advocates, third sector organizations and providers, public and private sector partners and national players. Wide stakeholder involvement is important not only for gathering data, but also as it encourages wide ownership and supports the ability to implement recommendations.

Stakeholder involvement in alcohol INA:

- Questionnaire survey of 34 key stakeholders (38% response rate)
- Semi-structured 1 hour interviews with key stakeholders
- Participatory stakeholder workshop "Alcohol misuse: we need to CHAT" hosted by Churches in Herefordshire Action Team (CHAT) on 9th September 2011. This was attended by a wide range of representatives from the public sector, private sector and voluntary sector including a local MP, police, nightclub/licensed trade, faith/church, housing, PCT and council.

Current service provision

This step reviews current service provision and looks at service provision in terms of the following six domains of quality: effectiveness, efficiency, access, responsiveness, social acceptability and equity.

Consideration is also given to whether there are any gaps in service provision and, if so, what and where they are. Interagency dimensions to service provision are also examined including whether there are any gaps or barriers between agencies in relation to service provision.

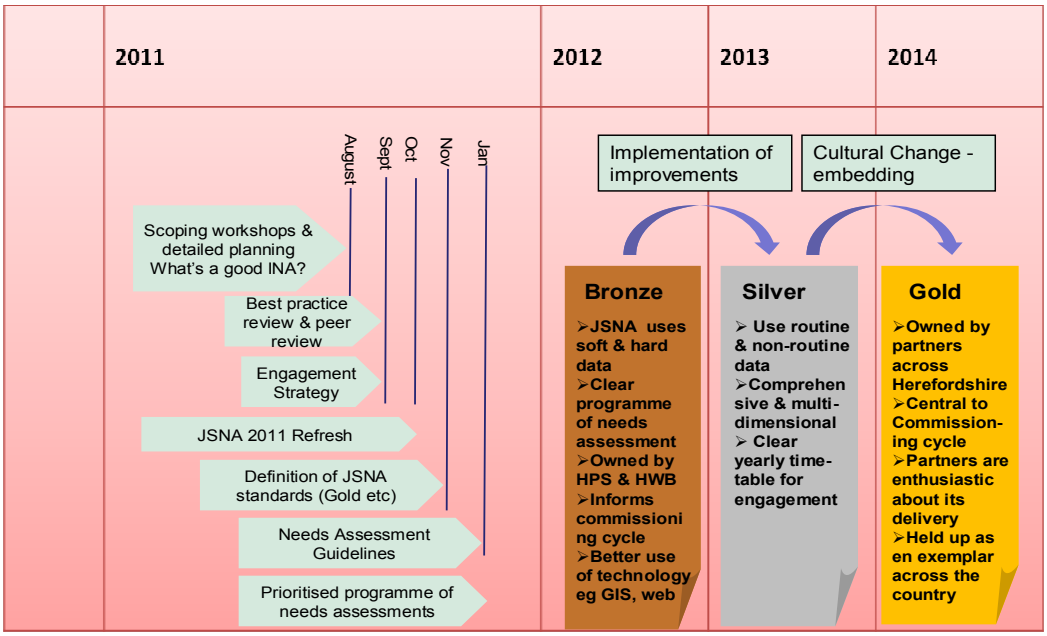
What works

This step in the process involves reviewing the evidence base for interventions/models of care to determine what works, what the evidence for this is

and how strong and reliable this evidence is. This involves a systematic approach to finding evidence and assessing its quality through critical appraisal of published literature and evaluation of national and/or local best practice.

The methodology developed for the alcohol INA provides a basis for a standard methodology from which future INAs can be developed in other topic areas. In addition to supporting the commissioning of services and driving the commissioning cycle, this will contribute to the overall development by 2014 of a comprehensive "gold standard" JSNA which will be central to the commissioning cycle and owned by partners across Herefordshire (figure 3).

Figure 3 Route-map to a "gold standard" JSNA



Recommendations – the final step of the INA

Having considered the issues, current services and the evidence of what works, the final step in the INA process is to make recommendations (such as interventions or suggested models of service provision) and where possible, to identify the resources required for implementation and to recommend priority areas for action, which is particularly important when resources are scarce. The methodology used for the alcohol INA is applicable across both medical and non-medical models of care.

The alcohol INA has built upon standard, accepted healthcare needs assessment methodology by going beyond healthcare data to include other relevant data – for example in relation to crime and disorder, licensing and trading standards.

5. Alcohol INA – summary of findings

5.1 The size of the problem

This section looks at what we know about patterns of drinking in Herefordshire.

5.1.1 Prevalence of hazardous, harmful and binge drinking

Hazardous and harmful drinking

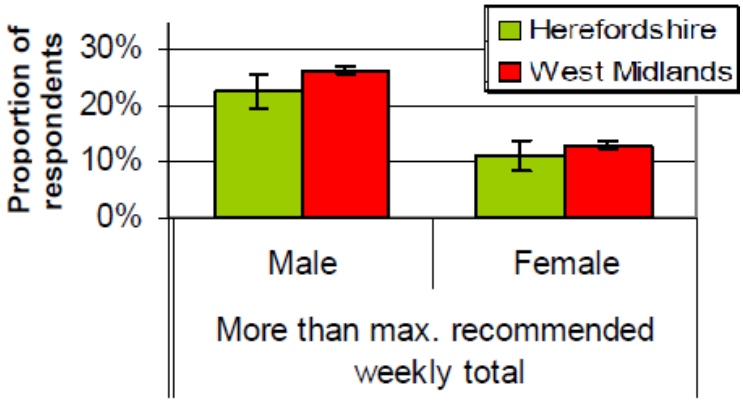
In Herefordshire:

- 18.8% of over 16 year olds drink at a hazardous level; 4.1% drink harmfully and 17.8% binge drink. This is similar to regional and national levels.
- 23% of men and 11% of women drink over the recommended limit (figure 5).

Nationally, the highest levels of hazardous drinking are found in:

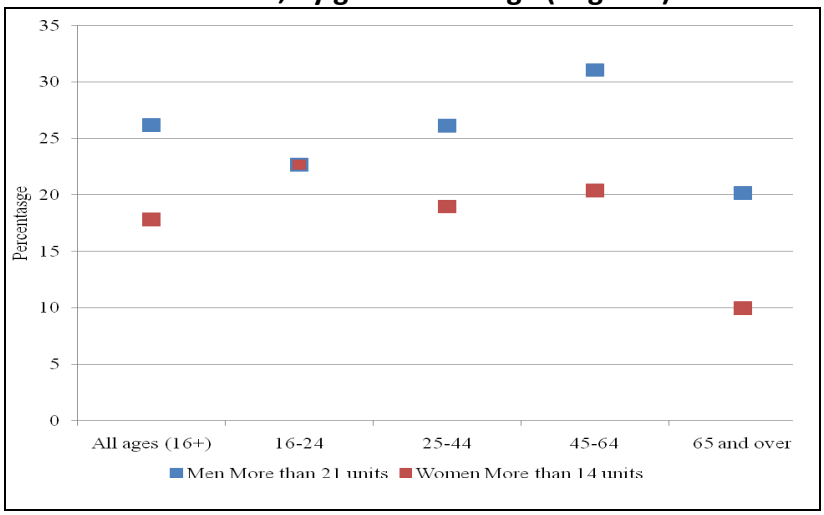
- men aged 45-64
- women aged 16-24 (figure 6).

Figure 5 The proportion of respondents drinking over recommended levels in Herefordshire and West Midlands by sex



Source: Herefordshire Regional Lifestyle Survey (2005)

Figure 6 Hazardous drinking: alcohol consumption (units per week) among adults, by gender and age (England)

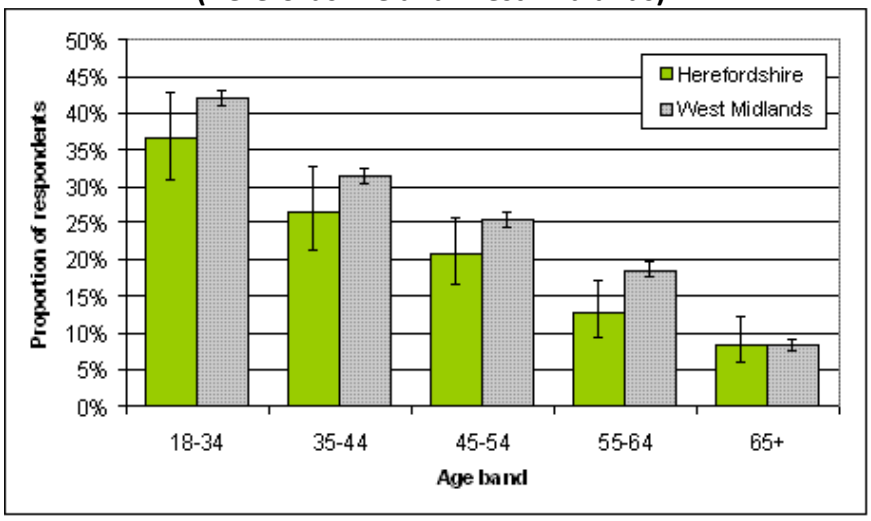


Source: Information centre 2011 statistics on alcohol in England, General Lifestyle Survey 2009. The Office for National Statistics (ONS)

Binge drinking

- Levels of binge drinking are highest in the 18-34 and 35-44 age groups (figure 7). Around twice as many men binge drink compared to women (table 5).
- The highest estimated prevalence of binge drinking is found in Hereford city.
- By the age of 17 only 2% of teenagers are non-drinkers.

Figure 7 Proportion of respondents who binge drink by age group (Herefordshire and West Midlands)



Source: Regional Lifestyle Survey (2005)

Table 5 Binge Drinking in Herefordshire

	Males	Females	Total
Herefordshire	33%	15%	23%
West Midlands Region	36%	19%	28%

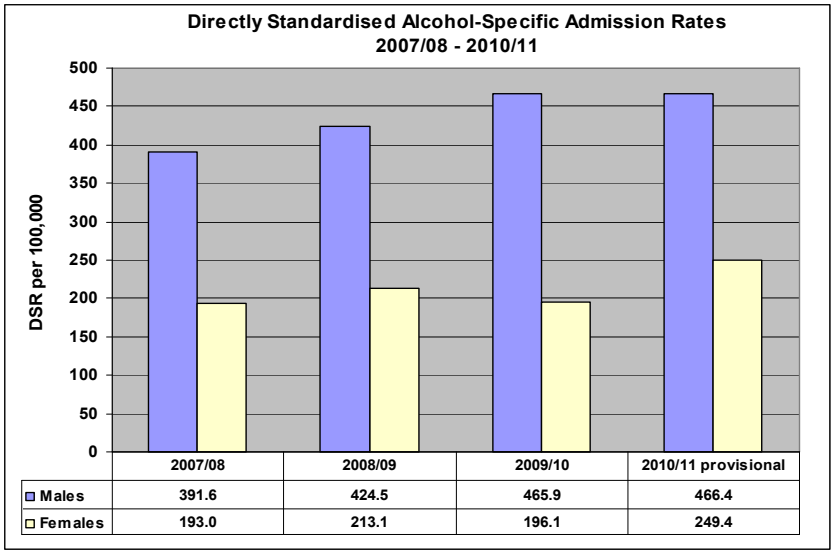
Source: Regional Lifestyle Survey 2005, WMRO & WMPHO

5.1.2 Alcohol-related harm to health

- ***Alcohol-attributable mortality*** is lower in Herefordshire than in the West Midlands but increased by 53% in women and 15% in men between 2004-08.
- ***Alcohol-attributable hospital admissions*** are a major cause of hospital admission in Herefordshire (over 3,500 admissions in 2010/11) and have increased by over 30% since 2007/08.
- ***The alcohol-specific hospital admission*** rate for under 18 year olds is significantly higher than the England average (80.7/100,000 population compared to 64.6/100,000 population).
- ***Alcohol-specific hospital admissions*** in Herefordshire show an upwards trend (figure 8): male admissions have increased by 19% between 2007/08 to 2010/11; female admissions have increased by 29% in the same period. The majority (86%) of alcohol-specific admissions are emergency admissions.

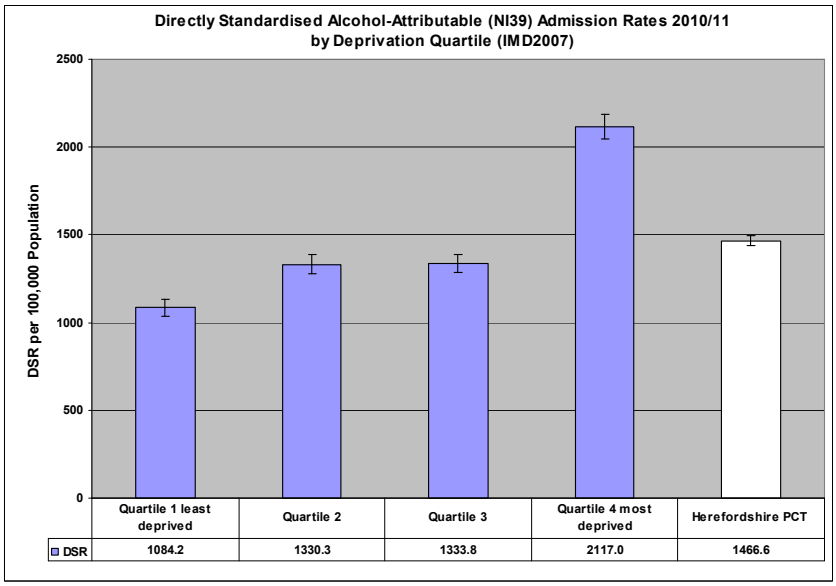
- ***There is a strong social gradient in alcohol-attributable hospital admissions*** within Herefordshire:
  - People living in the most deprived neighbourhoods are twice as likely to be admitted with an alcohol-attributable condition as those who live in the least deprived neighbourhoods (figure 9);
  - **Young people from the most deprived neighbourhoods are twelve times** more likely to be admitted to hospital with an alcohol-attributable condition than those from the least deprived neighbourhoods (figure 10).
  - Alcohol-specific hospital admission rates for young people are higher in Herefordshire than in other areas with similar population characteristics.

Figure 8 Trends in alcohol-specific admissions of Herefordshire residents



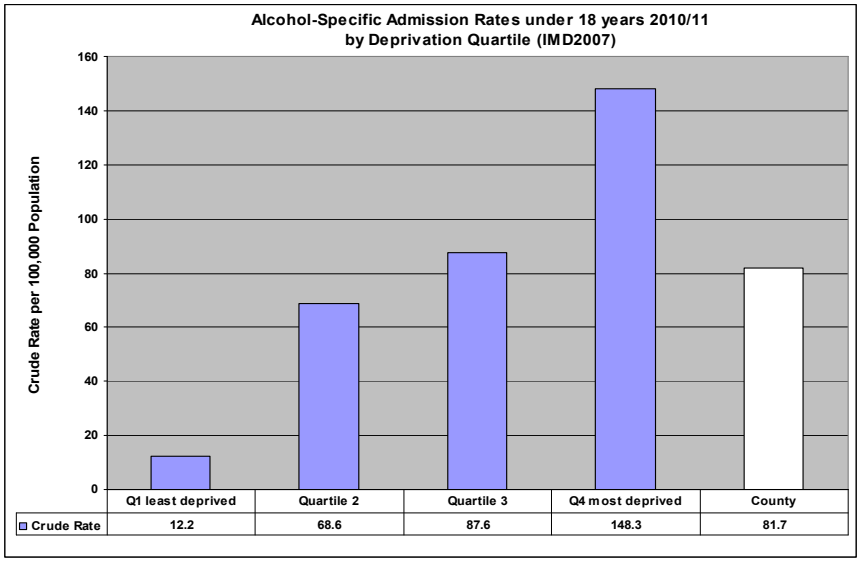
Data Source: Hospital Episode Statistics (HES), Analysis: Public Health Dept, NHSH

Figure 9 Alcohol-attributable admissions of Herefordshire residents, by deprivation quartile



Data Source: Hospital Episode Statistics (HES), Analysis: Public Health Dept, NHSH

Figure 10 Alcohol-specific admissions of Herefordshire residents under 18 years, by deprivation quartile



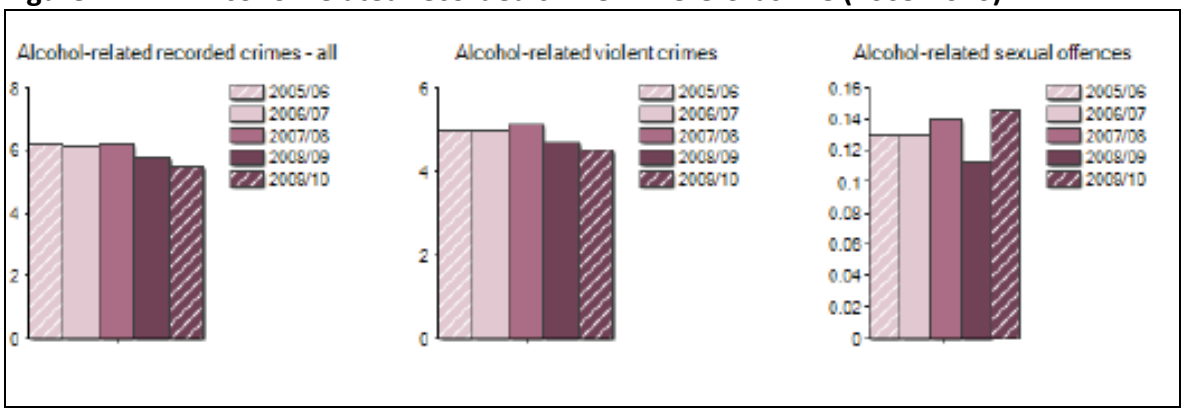
5.1.3 The wider picture

- Data from A&E shows that between October 2010–March 2011 (the 1st 6 months' data from the new A&E database) out of 211 alcohol-related attendances: 74% of had an alcohol-related assault; 17% had an alcohol-related injury; 66% were male; 47% were 16-24 years old.
- Herefordshire's alcohol-related recorded crime rate is lower than in the West Midlands (5.5/1,000 population compared to 8.1/1,000). There has been a gradual overall fall in alcohol-related crime over recent years – although not in alcohol-related sexual offences (figure 11).
- There are approximately 1,000 licensed premises in Herefordshire. Alcohol-related assaults generally occur near to licensed premises (figure 12).
- In relation to under-age drinking and binge drinking in young people:
    - Under-age drinkers in the 12-14 year old age group typically obtain alcohol at home; 15-17 year olds are more likely to be bought alcohol by an older friend (proxy sales).
    - "Pre-loading" – drinking before a night out - is common.

Compared to the rest of the West Midlands and England (figure 13) Herefordshire has:

- significantly higher levels of alcohol-specific hospital admissions in under 18 year olds
- significantly higher levels of mortality from alcohol-related land transport accidents than the regional and national average (Herefordshire: 4/100,000 population; England: 1.7/100,000 population).
- a relatively high proportion of employees who work in bars (3.1% of all employees) compared to England (2.4%).

Figure 11 Alcohol-related recorded crime in Herefordshire (2005-2010)



Source: North West Public Health Observatory - LAPE Report 2010

Figure 12 Prevalence of incidence of alcohol related assault or accident against location of licensed premises

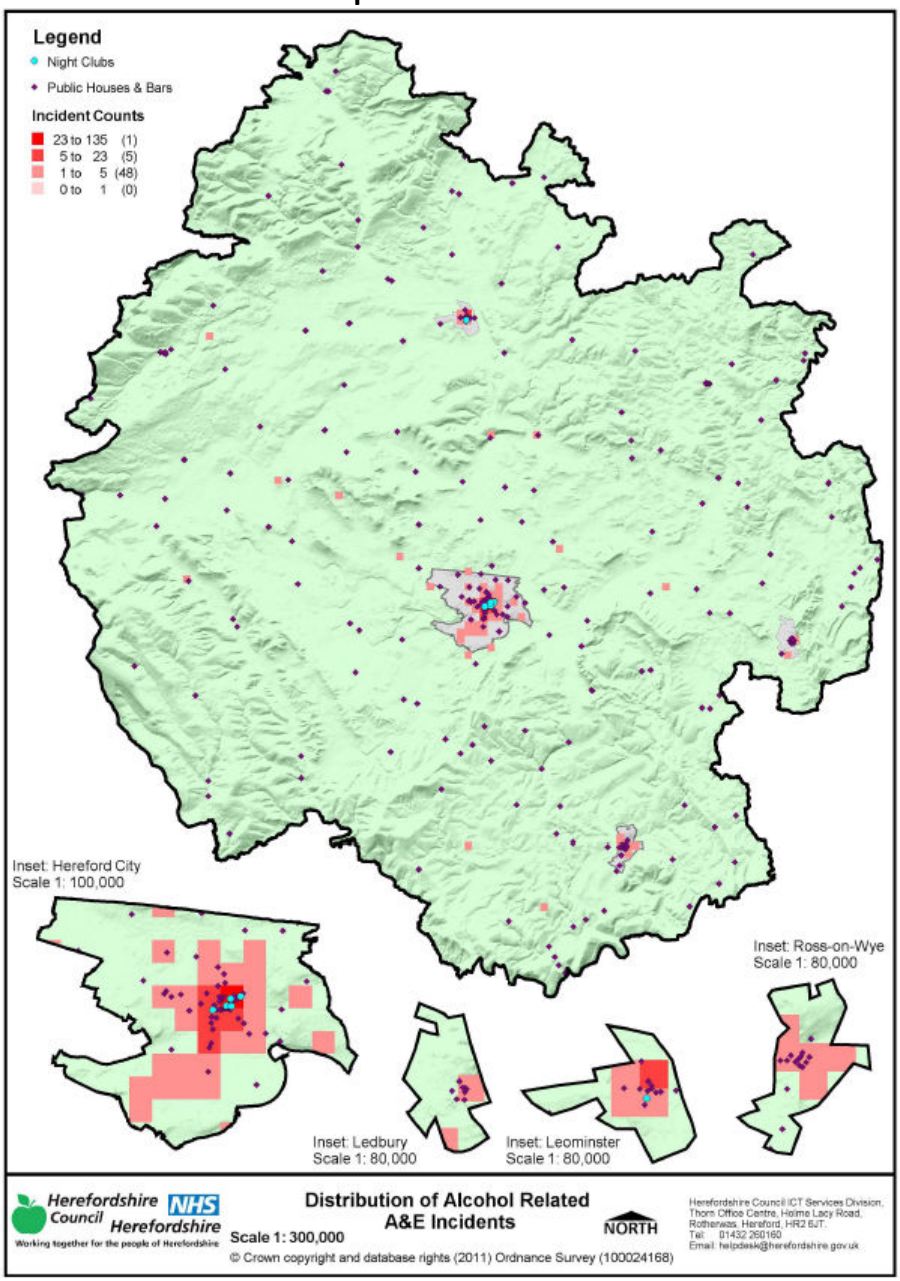
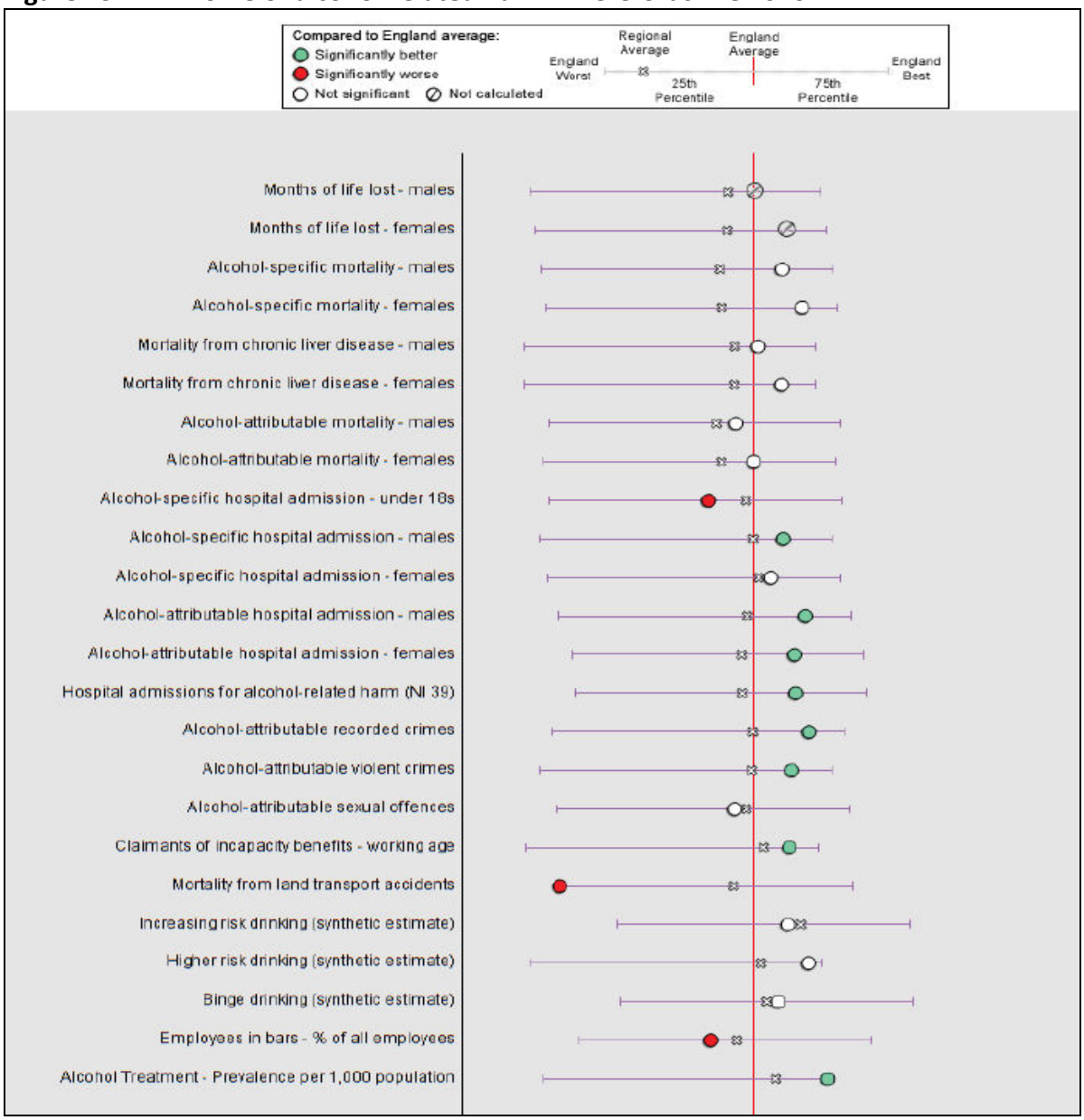


Figure 13 Profile of alcohol-related harm – Herefordshire 2010



Source: North West Public Health Observatory - LAPE Report 2010

5.2 Current service provision

Alcohol harm reduction services can be categorised into four tiers which range from tier 1 (the least intrusive) to tier 4 (the most intrusive). These can be summarised as:

- Tier 1 identification of those at risk and the provision of simple brief advice
- Tier 2 extended brief interventions
- Tier 3 less intensive specialist treatment
- Tier 4 intensive specialist treatment

These are aligned to levels of risk/harm from alcohol misuse as discussed in more depth in section 5.3 and provide for the development of an integrated, care-pathway approach.

Currently, the main dedicated alcohol-harm reduction services in Herefordshire consist of the Community Alcohol Service and the Alcohol Liaison Nurse Service.

The Community Alcohol Service

The Community Alcohol Service (CAS) is the main alcohol harm reduction service in Herefordshire:

- CAS has 3.5 WTE staff covering Hereford, Bromyard, Ledbury, Ross-on-Wye and Leominster;
- 2 sessions/week psychiatrist support for community withdrawal (Hereford only);
- 584 referrals to CAS in 2010/11 - the majority of CAS referrals are from GPs;
- The majority of CAS activity consists of Identification and Brief Advice (IBA) (ie tier 1 and 2)
- CAS only provides limited tier 3 and 4 services because of its focus on IBA (although it is intended as a specialist tier 3 and 4 service);
- Specialist capacity and activity (tier 3 and 4) is low:
    - clients requiring specialist support are placed on a waiting list;
    - a high proportion (estimated at 75%) are lost to follow up;
    - a high proportion (estimated at 50%) are referred for residential withdrawal due to lack of community provision;
    - 1 community supervised withdrawal/month on average;
    - 3 residential supervised withdrawals/year on average.

Although CAS is designed to provide a tier 3 and 4 service with community based care, planned treatments, counselling individual and family, community supervised withdrawal and assessment for residential rehabilitation, it is evident that this service primarily provides a tier 1 and 2 service due to the lack of provision at this level elsewhere in the county.

Alcohol Liaison Nurse Service

An Alcohol Liaison Nurse (ALN) based in Hereford County Hospital provides screening and brief advice to patients in A&E, admissions and on the wards.

- The majority of patients receive tier 1, simple brief advice;
- Activity is relatively low and a relatively high proportion of those referred to the ALN, do not attend for further support;
    - 102 patients were referred and 66 screened in 2008/09
    - 78 patients were referred and 57 screened in 2009/10
    - 164 patients were referred and 66 screened in 2010/11
- There is lack of provision for those requiring onward referral for specialist treatment with a high proportion of onward referrals being lost to follow up.

Identification and brief advice

Over recent months considerable progress has been made in relation to the introduction of structured brief intervention for alcohol in primary and secondary care and in locality settings:

- Identification and Brief Advice (IBA - brief intervention for alcohol) is in the 2011/12 CQUIN;
- Roll-out of a training programme for IBA which supports CQUIN delivery and is providing training for primary and secondary care staff;
- An alcohol-related assault and injury database installed in A&E is informing joint work eg between Public Health, Wye Valley NHS Trust, Licensing/Trading Standards, Police, Ambulance. This is supporting work to reduce alcohol-related A&E attendances (see below);
- A Directly Enhanced Service (DES) is in place for GPs to provide IBA, although this is limited to new patients;
- IBA is currently also provided by CAS.

Summary of stakeholder views

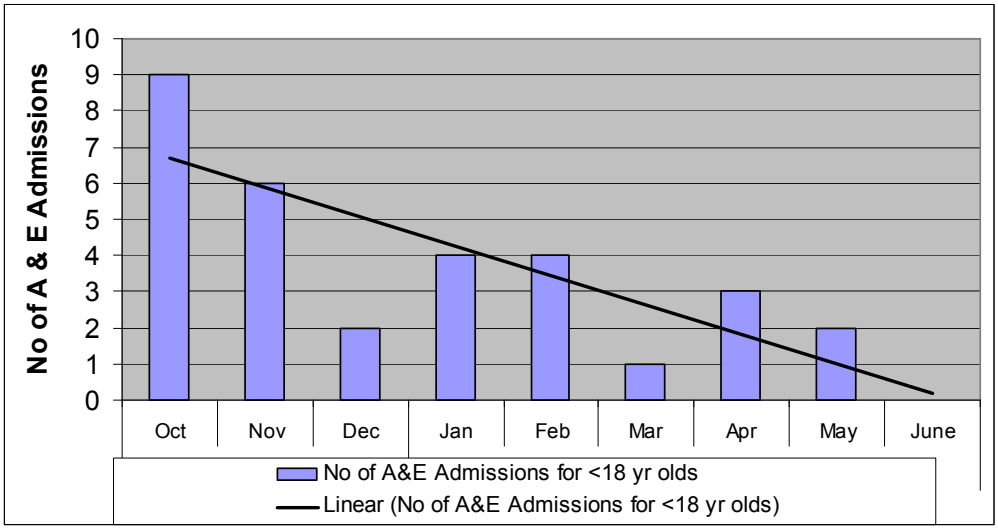
Key findings from stakeholder engagement include:

- Increased identification and support for hazardous and harmful drinkers is needed to include:
  - Expansion of IBA in primary and secondary care
  - Extension of IBA to generic/non-health settings
- The Community Alcohol Service should focus on providing specialist treatment and not IBA
- Binge drinking amongst teenagers and the relationship of this with crime is a significant issue in Herefordshire.

Licensing and enforcement

Since November 2010, Herefordshire Trading Standards' Licensing team working with the police, public health and other partners has undertaken a covert operation to "crackdown" on under-age sales, informed by the identification of "hotspot" using the A&E database. Figure 14 shows that there has been a dramatic fall in alcohol-related A&E admissions in under 18s since this operation began.

Figure 14 Alcohol-related A&E admissions in under 18 year olds in Herefordshire (Oct 2010–June 2011)



National recommendations for alcohol services - the stepped care service model

A stepped care service model has been advocated for alcohol harm reduction services.[1] This involves offering interventions which are appropriate to the individual's level of alcohol-related risk/harm with a spectrum of four levels of intervention being available (figure 15). Moving from left to right along this spectrum, clients are offered the least intrusive and least expensive intervention that is likely to be effective irrespective of the level of misuse. The next intensive treatment is only offered if the first line intervention fails and so on from left to right along the triangle shown in figure 15.[1] Existing services in Herefordshire and local gaps within the stepped care model are discussed in summarised in table 6.

Figure 15 Spectrum of responses to alcohol-related problems[1]

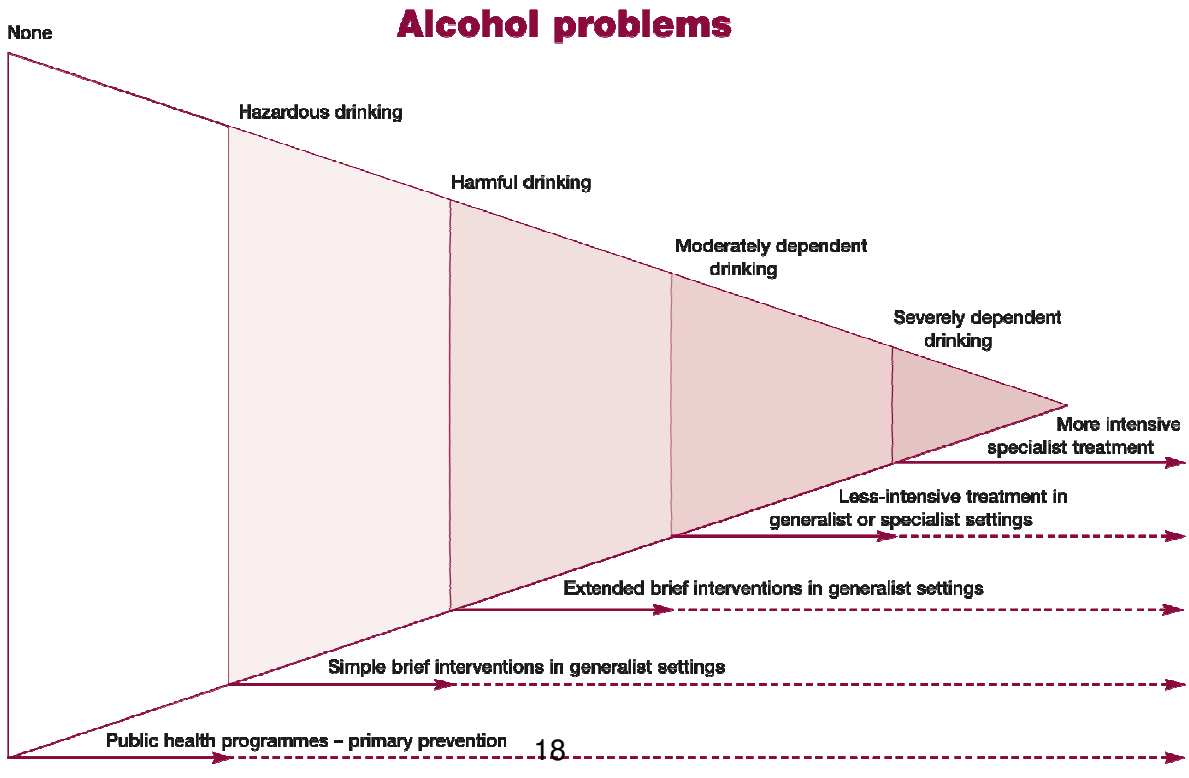


Table 6 Summary of existing alcohol harm reduction services in Herefordshire and gaps in existing provision by tier

	Existing service	Gaps
Tier 1	Recent increase in primary and secondary care-based IBA linked to training, and CQUIN	Provision of IBA in generic (non-healthcare) and settings where alcohol is not the main focus
Tier 2	Some provision from CAS & ALN	Scope to develop a wider network of providers
Tier 3	Very limited service from CAS	Gap in community-based support including detoxification Specialist services unable to focus on specialist work due to lack of provision at tier 1 and 2
Tier 4	No specialised service in county	Residential detoxification and rehabilitation within county
Integration between tiers	Specialist services providing non-specialist activity	Lack of integration, between services working at different levels Care pathways not clear

5.3 What works

A range of interventions are available which aim to reduce alcohol-related harm to health and to minimise its impact on health and wider society. Some interventions are more effective if offered in a specific setting targeting a specific group of people. The evidence-base for each requires rigorous evaluation before being put into practice.

A critical literature review has been undertaken to determine the cost and clinical effectiveness of these interventions - the section below gives a brief summary.

1. **Educational programmes**
   - Current evidence suggests that universal multi-component programmes (ie combined school, family or community interventions) designed to impact on range of health and lifestyles behaviours among young people are effective in preventing alcohol misuse in school-aged children up to 18 years of age.[2]

- Universal family-based prevention programmes (eg psychosocial and educational interventions) can be effective in this age group.[3]
- Certain generic psychosocial and developmental prevention programs including "Life Skills Training Program", the "Unplugged Program" and the "Good Behaviour Game" can also be effective in young people.[4]
- However, there is evidence to suggest that classroom-based programmes taught by adult health educators and uniformed police officers have no medium or long-term effects on alcohol use.[5]

2. Alcohol pricing

- Making alcohol less affordable is the most effective way of reducing alcohol harm. The evidence suggests that the most cost-effective policy intervention is to reduce demand for alcohol through minimum pricing; a 50p minimum price would result in an estimated 12.4% fewer hospital admissions each year.[6]

3. Licensing restrictions

- There is evidence to suggest that licensing restrictions (eg reducing the density of alcohol outlets and reducing licensing hours, reduced access to retail outlets and a comprehensive ban on advertising) would reduce alcohol-related harm.[7]
- Cost-effectiveness analyses show that a cumulative 10 year harm reduction for public sector of between £0.4b and £5.1b could be achieved by a 10% decrease in the number of both off-trade and on-trade outlets; a cumulative 10 year savings for the public sector, ranging from a loss of £0.36b to a gain of £5.2b could be achieved by 10% reduction in trading hours; and a cumulative 10 year savings for the public sector could be as much as £33.5b with a total advertising ban and associated price control.[8]

4. Alcohol misuse treatment interventions

The National Treatment Agency proposes a stepped care model as outlined in section 5.2.[1] A critical review of the evidence on the clinical and cost effectiveness of various interventions within the stepped model suggests that:

- **Brief interventions are effective** in reducing alcohol consumption among hazardous and harmful drinkers to low-risk levels.
- **Brief interventions are one of the most cost-effective of all health service interventions** and lead to health gain. In the average PCT (population 350,000), for every £91,611 invested there would be a saving of £393,927 in return on investment (£4.30 for every £1).[9] Brief intervention can be offered in variety of settings such as GP practices, community pharmacies and A&E departments.
- Less intensive treatments including "A basic treatment scheme", "Brief conjoint marital therapy", "Condensed cognitive behavioural therapy",

"Motivational interviewing" and "Motivational enhancement therapy" are also effective in reducing alcohol problems in moderately dependent drinkers and can sometime benefit harmful drinkers without dependence.

- Alcohol-focussed specialist treatment (psychosocial treatments) including "Social behaviour and network therapy", "Behavioural self-control training" and "Coping and social skills training" are effective in achieving moderate drinking in dependant drinkers.
- Both "Social behaviour and network therapy" and "Motivational enhancement therapy" can yield £5 net saving to the public sector for every £1 invested in these interventions.[10]
- A range of pharmacotherapies involving detoxification and relapse prevention are effective in minimising alcohol harm in dependant drinkers.

6. Alcohol INA – summary of recommendations

The recommendations from the alcohol INA are summarised here. They are presented within the framework of the "ladder of interventions" which contains eight categories or "steps" which range from the least intrusive ("do nothing") to the most intrusive ("eliminate choice").

Step one – do nothing or simply monitor the current situation

- Coordinated data collection and monitoring of alcohol-related risk and harm in Herefordshire across the lifecourse and including:
    - existing routinely available data supplemented by non-routinely available data from eg schools, 3rd sector, NHS treatment services
    - continued collection of data on alcohol-related A&E attendances through the A&E database
    - continued long-term funding for A&E database
- Further refinement of the A&E alcohol database
- Carry out further analysis to better understand the link between domestic violence and alcohol in Herefordshire.

Step two – provide information

Run social marketing campaigns as part of an overall multi-component strategic approach:

- for 11-16 year olds and families on wider lifestyle risk factors including alcohol, addressing social norms and supporting the development of social interaction skills
- for 15-24 year olds and families focusing on social norms and binge drinking:
    - building on existing good practice including the Bottletop programme and the willingness of the Further Education Colleges to address alcohol-related harm
    - to encourage sensible drinking at home

- to discourage parental support of "pre-loading"
- to reach out particularly to young people from deprived communities (to address the 12-fold gap in alcohol-specific admissions in u18s).

Step three – enable choice and support people to change their behaviour

- Develop clear commissioning intentions for alcohol services from tier 1 to tier 4 and ensure a choice of services is available from tier 1 to tier 4 as part of an integrated care pathway including:
  - identification and support for people who are at risk of alcohol-related harm to their health because of hazardous or harmful drinking using IBA provided in a wide range of health and non-health settings across the county
  - release of specialist capacity within CAS to concentrate on the provision of specialist services rather than tier 1 or 2 services, thereby increasing capacity and choice of specialist care
- Healthy Lifestyle Trainer Service to undertake targeted work with post-16 providers to support 16-17 year olds at highest risk with healthy lifestyle choices.

Step four - guide choice through changing the default choice

- Free fresh drinking water should be available in pubs and clubs to provide an alternative to alcohol. This is currently a licensing requirement and there is scope to explore the role of the licensing team in enforcing this.
- Explore opportunities to encourage pubs, clubs, restaurants to set small measures as the default serving (eg when serving wine or spirits).

Step five - guide choice through incentives

- Support and evaluate initiatives that incentivise licensed premises to prevent under-age drinking. For example, initiatives which incentivise door and/or bar staff to report fake/fraudulent ID and proxy sales.
- Work with Hereford Against Night-time Disorder (HAND) and Ledbury Against Night-time Disorder (LAND) to encourage the development of incentives for licensed premises – linking with existing inspection work.

Step six - guide choice through disincentives

- Local use of fixed penalty fines in relation to under-age sales.
- Strengthen joint planning of enforcement activity/penalty notices with Police.
- Continue to use Expedited License Reviews for licensed premises in breach of Licensing Objectives (as described in the Licensing Act 2003).

Step seven - restrict choice

- Explore working with local/national retailers to encourage sensible in-store placement of alcohol in order to discourage hazardous, harmful and binge drinking. The Public Health Responsibility Deal provides a possible mechanism for this.

- Intelligence-led local enforcement, including spot checks, for under-age sales at off-licence and on-licence premises – moving towards regular, frequent and comprehensive inspections.
- Undertake surveillance of licensed premises in relation to sales to intoxicated customers and where appropriate request that the Police undertake a licensing review.
- Promote a sensible drinking culture in Herefordshire through the use of Cumulative Impact Zone powers including review of existing requirements regarding density of outlets and proximity of outlets to key settings (eg schools, fast food outlets).

Step eight - eliminate choice

- Increase use of Section 27 Dispersal Orders as part of a regular programme.
- Subject to anticipated changes to the Licensing Act (2003), to explore opportunities to restrict opening times by bringing the "terminal hour" (closing time) forwards to 2am (this is currently 3.30am in 2 clubs and 2.30-3am in others). This would reduce the time available for people to drink at licensed premises and would increase the time for people to sober up before the following morning (thereby reducing the risk of them being involved in accidents on the road or at work the following morning).

REFERENCES:

[1] National Treatment Agency for Substance Misuse (2006) Review of effectiveness of the treatment for alcohol problems, National Treatment Agency for Substance Misuse

2 Universal multi-component prevention programmes for alcohol misuse in young people; *The Cochrane Library*2011, Issue 9

[3] Universal family-based prevention programmes for alcohol misuse in young people; *The Cochrane Library*2011, Issue 9

[4] Universal school-based prevention programmes for alcohol misuse in young people; *The Cochrane Library*2011, Issue 5

[5] Jones L, James M, Jefferson T, et.al. (revised 2007) A review of the effectiveness and cost-effectiveness of interventions delivered in primary and secondary schools to prevent and/or reduce alcohol use by young people under 18 years old. NICE (http://www.nice.org.uk/nicemedia/live/11666/36327/36327.pdf)

[6] University of Sheffield (2008) Independent review of the effects of alcohol pricing and promotion, Part B. Modelling the potential impact of pricing and promotion policies for alcohol in England. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_091364.pdf

[7] Alcohol-use disorders: preventing harmful drinking. NICE (2010) Public Health Guidance 24 http://www.nice.org.uk/nicemedia/live/13001/48984/48984.pdf

[8] University of Sheffield (2009b) Modelling to assess the effectiveness and cost effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield alcohol policy model version 2.0. http://www.ias.org.uk/resources/ukreports/uni-sheffield/univ-sheffield-am.pdf

[9] Alcohol-prevention programmes, cost-effectiveness review; Liverpool Public Health Observatory (2010)

[10] UKATT (2005). Cost effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). *BMJ* 2005;331:544.

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**18 OCTOBER 2011**
TITLE OF REPORT:	**DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2011**
REPORT BY:	**INTERIM DIRECTOR OF PUBLIC HEALTH**

CLASSIFICATION: Open –

Wards Affected

County-wide

Purpose

1. To inform the Board of key population health issues in Herefordshire and of the recommended strategies and actions to address these as set out in the Annual Report of the Director of Public Health – 2011

2. To seek support from the Board that the recommended approach and actions highlighted in the report will inform service development and commissioning aimed at improving health and wellbeing of the population of Herefordshire

Recommendation(s)

THAT: The Board consider and comment on the Director of Public Health Annual Report 2011 executive summary.

Key Points Summary

- This is the third Annual Report of the Director of Public Health since the appointment of a Joint Director of Public Health for the county;

- This year, the key messages are:

    - There is a social gradient in health in Herefordshire and reducing that social gradient is important for the sustainability of both the economy and health and social care services in the county.;

    - The ladder of intervention framework provides a vehicle for integrating lifestyle and enforcement action into a single integrated strategy for improving population health and wellbeing.

    - The social gradient in health starts in the womb and accumulates through life. A life course approach is necessary to reduce the social gradient in health.

Further information on the subject of this report is available from
Dr Sarah Aitken, Interim Director of Public Health on (01432) 260668

- A child's readiness for school at age 5 is strongly predictive of their future health and wellbeing, and the development of 5 year olds in Herefordshire is significantly below average for England.

- Circulatory disease is the single largest cause of long term ill-health and disability in Herefordshire. The NHS Health Checks programme has the potential to reduce the social gradient in circulatory disease in Herefordshire.

- The cost of falls-related admissions for older people in Herefordshire is substantial and could be reduced through strength and balance training, assessment of hazards in the home, assessment of vision and medication review.

Alternative Options

1 There are no Alternative Options as the Director of Public Health Annual Report is a statutory requirement.

Reasons for Recommendations

2 The report is required to provide an overview of health and wellbeing in the county and is the view of the Director of Public Health. The Board is asked to support the recommended approach and actions to improve health and wellbeing in Herefordshire.

Introduction and Background

3 There has been significant progress in implementing the recommendations from the previous reports and the longer term strategic actions from those reports are now embedded in current strategic and operational plans.

- The report complements the Joint Strategic Needs Assessment and recommends areas of focus over the next 3 years to reduce the social gradient in health and reduce health inequalities;

- The Executive Summary of the report is attached and will be made widely available.

- The full report will be available online via the Herefordshire Public Services websites, with a limited number printed for distribution on request.

- The 2011 Public Health Annual Report was launched at the public meeting of the shadow Health and Wellbeing Board on 18th October 2011

Key Considerations

4 These are as follows:

- Implications for the health and well-being of HPS staff as members of the local population and as key providers of the lifestyle management interventions recommended in the report.

- Implications for changing traditional work practices, adding more people to the lifestyle management workforce and for staff training across HPS to accommodate the proposals in the report.

- Supports the NHS Herefordshire QIPP agenda (quality, innovation, productivity and

prevention).

- Supports the implementation of the Public Health system reforms proposed in the white paper 'Healthy Lives, Healthy People'.

Community Impact

5 The report highlights a range of health inequalities in the county and makes recommendations in relation to reducing inequalities.

Financial Implications

6 Following consultation with relevant stakeholders and through the annual planning and prioritisation processes, if agreed, the cost of implementation of recommended actions would be included in annual operating budgets of relevant partner organisations in the county. There are potential long term financial and workforce implications around the strategic shift to the prevention of ill health.

Legal Implications

7 None

Risk Management

8 If not addressed, issues raised in the report will have an impact on the achievement of health and wellbeing targets to reduce inequalities in health.

The main risks revolve around the implementation of service transformation and challenge to traditional practices.

Consultees

9 HPS Leadership Team (6th September 2011)

Leader's Briefing (15th September 2011)

PCT Public Board (28th September 2011)

Health and Wellbeing Board (18th October 2011)

Cabinet (20th October 2011)

Appendices

10 Director of Public Health Annual Report 2011 – Executive Summary attached as Appendix 1

Background Papers

None identified.

Executive Summary

Public Health Annual Report 2011

Healthy Lives, Healthy People in Herefordshire

Herefordshire Council

NHS Herefordshire

Working in partnership for the people of Herefordshire

Introduction: The social gradient in preventable lifestyle-related disease and premature death

Key Points

- Overall, people from deprived socio-economic groups not only have shorter lives, but also spend more of their later years living with a chronic disease or disability compared to more affluent people.

- On average the difference in life expectancy between people who live in the most deprived parts of England compared to those living in the least deprived areas is *seven* years (the difference in years between the lowest and highest parts of the upper curve in Figure A).

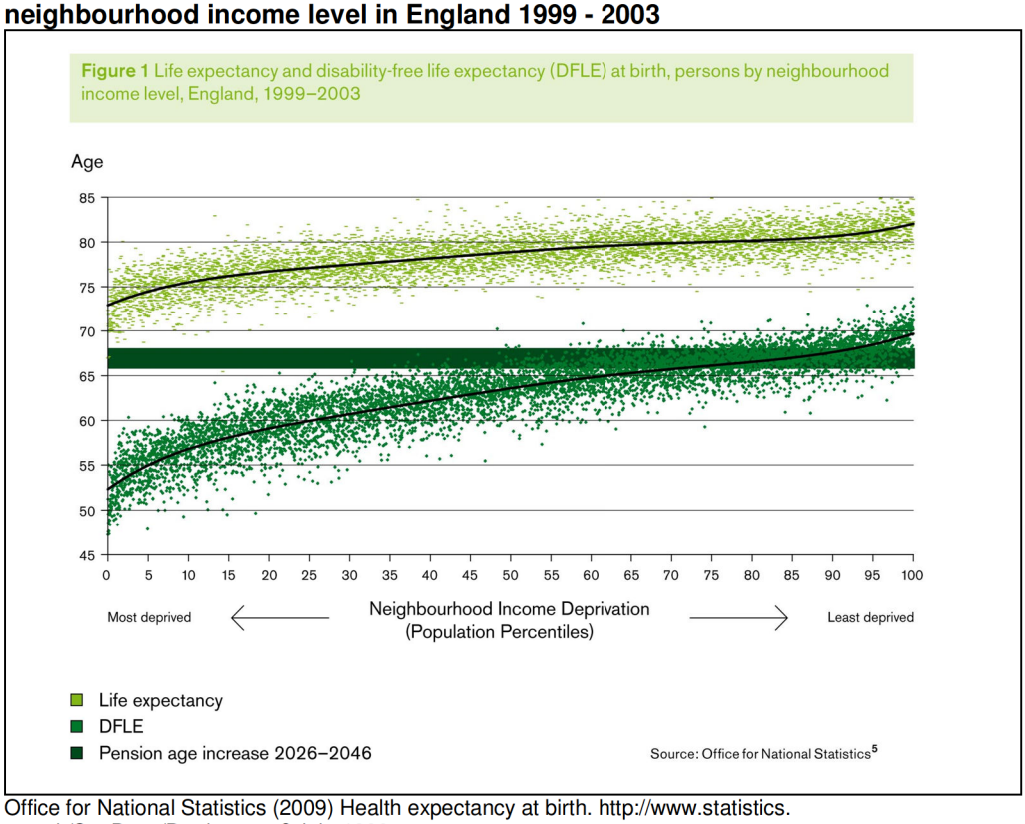
- On average the difference in disability-free life expectancy between people who live in the most deprived parts of England compared to those living in the least deprived areas is *seventeen* years (the difference in years between the lowest and highest parts of the lower curve in Figure A).

- As a result of this social gradient in health, only around a quarter of adults in England presently reach the proposed retirement age of 68 without having developed a chronic health condition or disability (the intersection of the green line and the lower curve in Figure A).

- The same social gradient in health exists in Herefordshire (Figure B) but is disguised by average health in Herefordshire being better than average for England

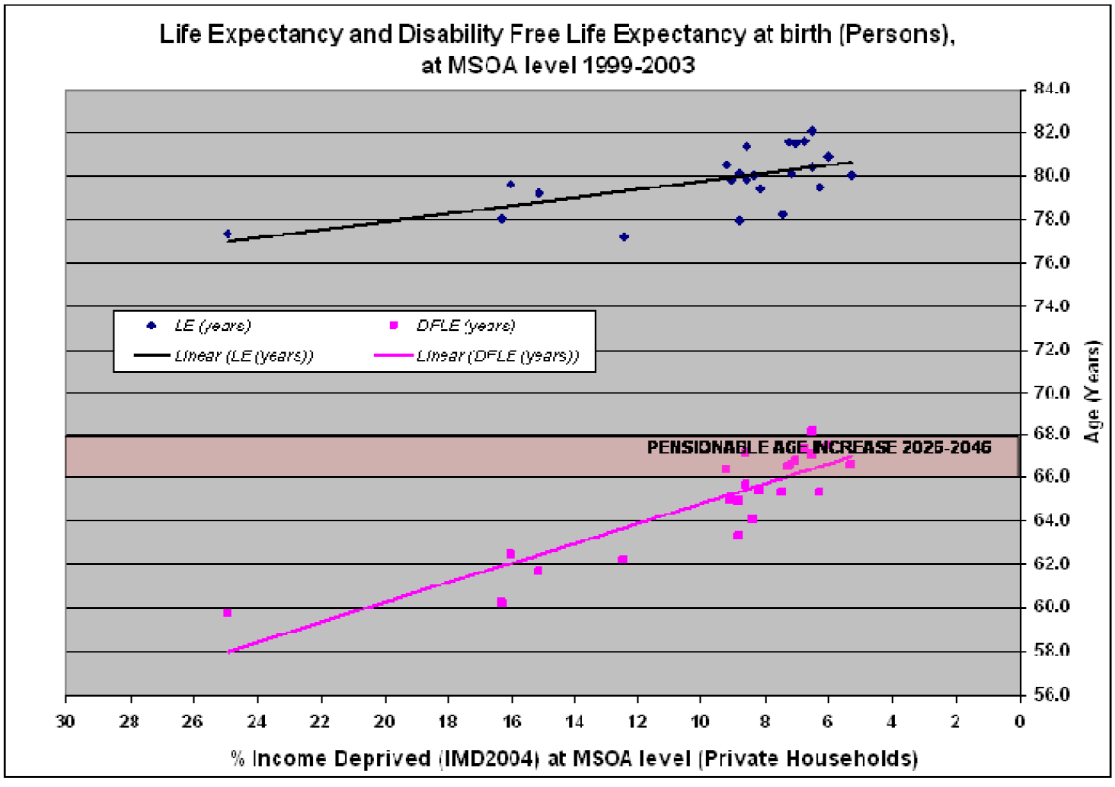
- The social gradient in health starts in the womb and accumulates through life meaning it is necessary to take a life course approach to reducing the social gradient in health, with the most effective interventions being those in the first years of life.

Figure A: Life expectancy and disability-free life expectancy at birth, persons by neighbourhood income level in England 1999 - 2003



Office for National Statistics (2009) Health expectancy at birth. http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=1296

Figure B: Life expectancy and disability-free life expectancy at birth, persons by MSOA level in Herefordshire 1999 - 2003



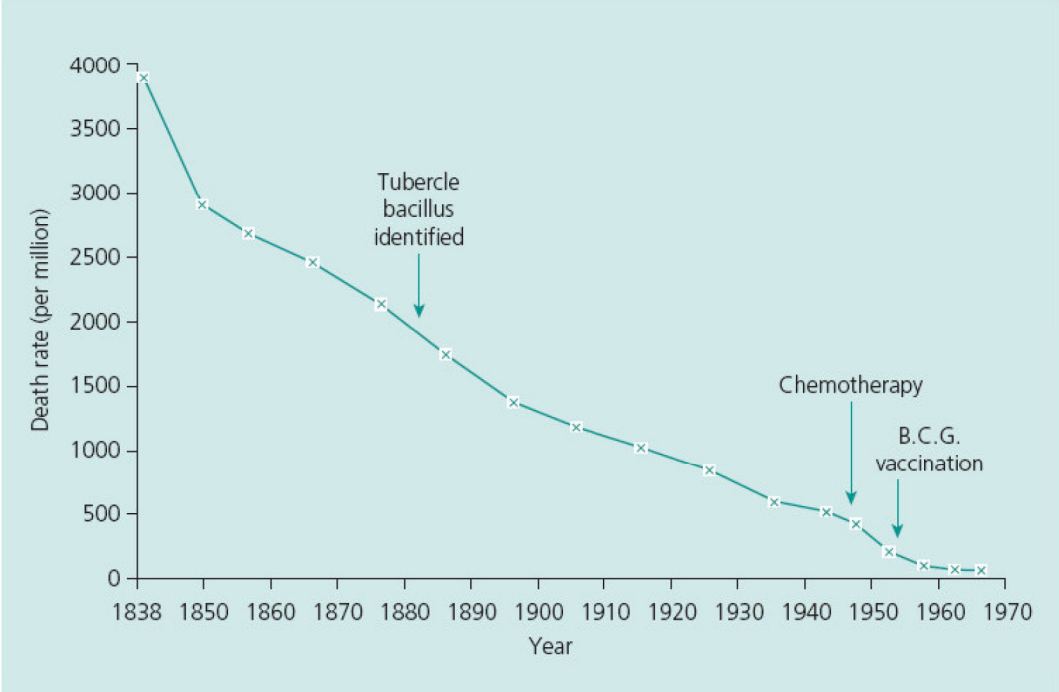
Office for National Statistics (2009) Health expectancy at birth. http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=12964

Chapter 1: Learning from the history of public health in Herefordshire: the importance of environmental and social change

Key Points

- A review of the history of improving population health and wellbeing in Herefordshire reminds us that environmental and social changes in living conditions and the introduction of public health legislation rather than innovations in health care led to a dramatic reduction in the death rate from infectious disease in the nineteenth and early twentieth centuries.
- A good example is the 90% decline in the death rate from tuberculosis before the introduction of chemotherapy and vaccination, as shown in Figure EX1.1. The TB sanatorium in Herefordshire closed in 1952 a year before the introduction of the BCG vaccination in UK secondary schools.

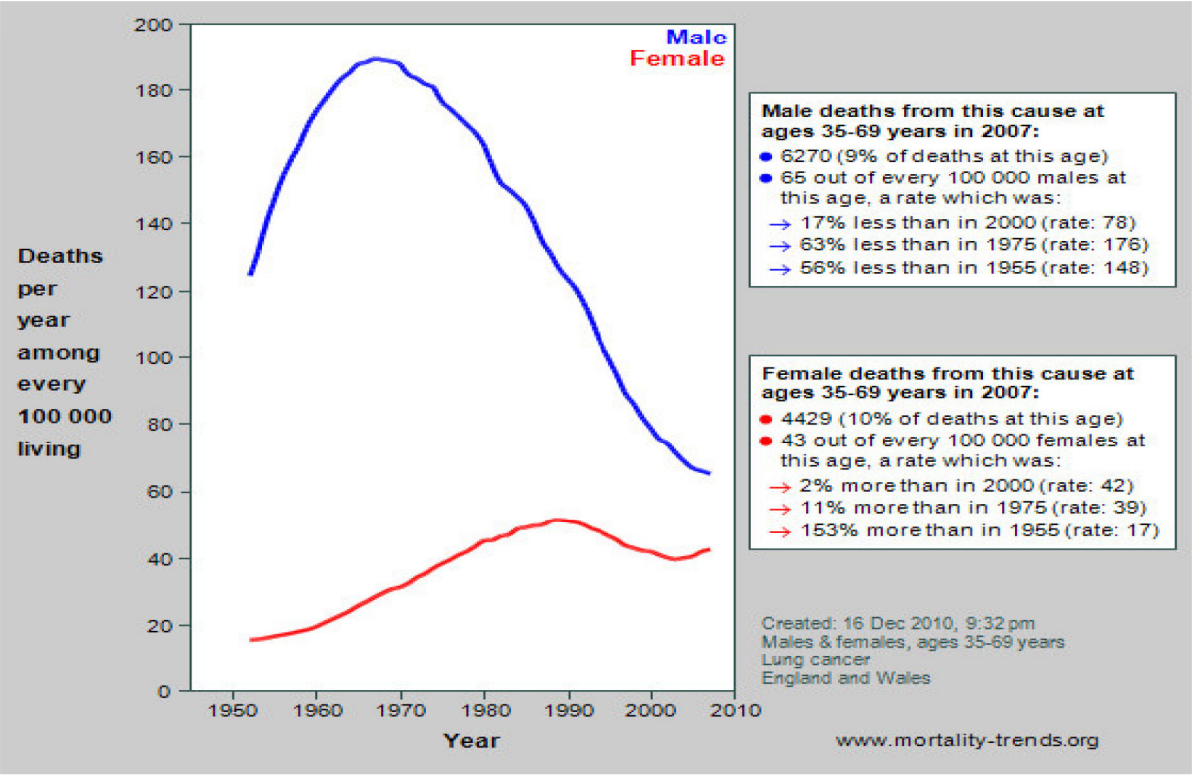
Figure EX1.1: Respiratory tuberculosis death rates in England & Wales 1838-1970



McKeown, T (1976) *The Modern Rise of Population*, Hodder, London

- Lifestyle related diseases have replaced infectious diseases as the main cause of premature deaths in England and Wales, as demonstrated by the rise in the premature death rate from lung cancer during the twentieth century (Figure EX1.2)
- The increase in the lung cancer death rate was first attributed to the increase in smoking rates among men by Sir Richard Doll in 1950, but it was not until 1970 that fewer men smoking started to result in lung cancer death rates falling. Conversely lung cancer death rates in women continued to rise as more women started smoking in response to increasing social freedom for women (Figure EX1.2) demonstrating the importance of the social determinants of health even when a behaviour is known to be harmful.

EX1.2 Mortality trends for lung cancer: 35-69 years of age, England and Wales



www.mortality-trends.org, using data from WHO and the UN Population Division

Milestones in the History of Improving Health and Wellbeing in Herefordshire

- Pre-19th century: philanthropy and folklore. The rise of the almshouses after the reformation; the first voluntary hospital; local folk remedies, and John Kyrle, the Man of Ross.
- 19th century: the dawn of public health legislation. Public Health legislation in a national and local context; sanitation improvements in the towns of Herefordshire, Reverend John Venn, benefactor to the people of Hereford.
- Early 20th century: the need for healthy recruits for the army. The development of the system of Medical Officers of Health and evidence from local records; children's health and medical inspections with examples of the effects of good food in rural areas; army recruitment, and pandemic influenza.
- 1920-1947: a better organised public health system. Further improvements in sanitation in Herefordshire market towns; the Herefordshire TB sanatorium opened, despite large reductions in TB cases due to public health improvements; Philanthropy through the Bulmer family to support housing improvements.
- 1947: the advent of the National Health Service. Reporting on post-war housing requirements; sanitation for rural areas; the rise of deaths from lung cancer in Herefordshire and the impacts of smoking; transfer of public health to the National Health Service.
- Late 20th Century: the age of expanding health inequalities. A report on health inequalities every decade from the 1970s onwards; Legionnaire's disease in Hereford
- 21st century: proposed transfer of public health back to local authorities

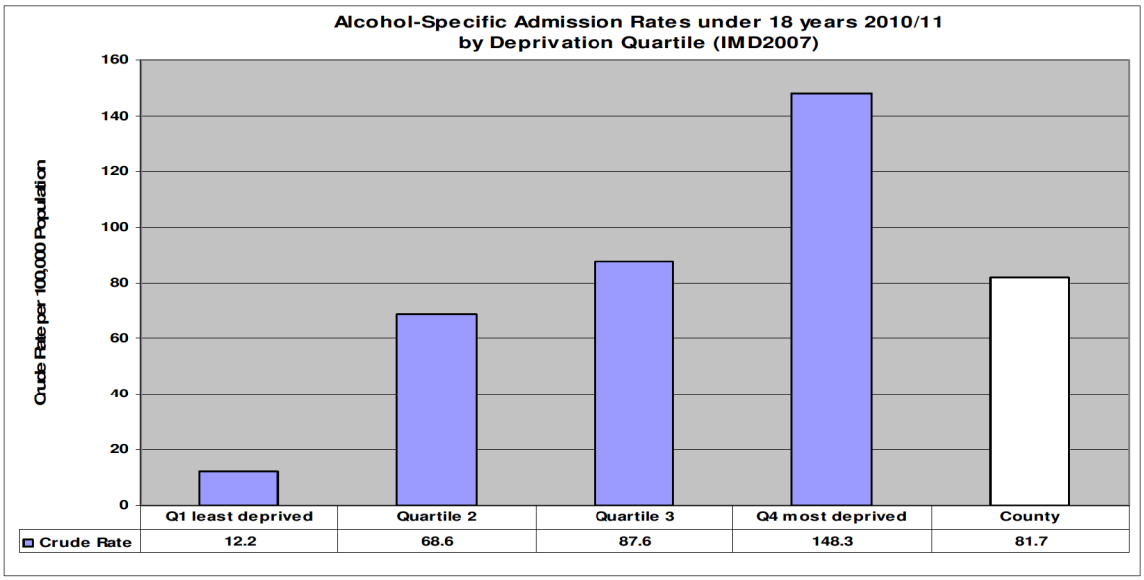
Chapter 2: The ladder of interventions: an integrated approach to improving people's health and wellbeing through alcohol harm reduction in Herefordshire

Key points

- This chapter focuses on employing the ladder of interventions to develop an integrated approach to alcohol harm reduction in Herefordshire.

- In Herefordshire, there has been a 10% increase in alcohol-related hospital admissions every year since 2007-08 with a significant increase in people aged 20-24 years
- It is estimated that the annual cost of alcohol related hospital admissions for Herefordshire residents is in the order of £5.5 million.
- A young person living in the most deprived quartile in Herefordshire is twelve times more likely to be admitted with an alcohol-specific condition than the one living in the least deprived quartile (Fig EX2.1)

Figure EX2.1 Alcohol-specific Hospital Admissions (<18 years) by Deprivation Quartile 2010-11



Data Source: Hospital Episode Statistics (HES), Analysis: Public Health Dept, Herefordshire PCT

- The strong social gradient in alcohol specific admissions evident in Figure EX2.1 suggests a social gradient in young people's attitude to harmful drinking.
- The "Bottletop" project has been an innovative local example of designing a campaign message that is relevant to young people
- Provision of Identification and Brief Advice (IBA) programme is very limited in Herefordshire
- Covert underage test purchases for both off-sales and on-sales of alcohol in Herefordshire, and prosecution of proprietors found guilty of selling illegally has been effective in reducing under age sales of alcohol.
- There is evidence that limiting the number of licensed outlets and licensed opening hours is effective in reducing the cost to society of harmful alcohol consumption.

- Alcohol consumption is directly related to the price. It is estimated that a minimum price for alcohol of 50p per unit would result in 98,000 fewer hospital admission per year in England. A minimum price of 21p per unit of beer and 28p per unit of spirits has been proposed by the coalition government in England.

Recommendations

Monitor the current situation

- Further develop the A&E data base for alcohol-related attendances

Provide information

- Support schools in Herefordshire to provide evidence based drug and alcohol education as an integral part of the school curriculum
- Expand the Bottletop project to promote sensible drinking using social marketing to target young people living in areas of multiple deprivation
- Locally enhance national campaigns to 'Know Your Limits' and to increase awareness of the units of alcohol in standard measures of alcoholic drinks

Enable choice and support people to change their behaviour

- Develop a commissioning strategy for alcohol harm reduction services to provide county wide Identification and Brief Advice services and a pathway to Tier 3 and Tier 4 specialist services

Guide choice through changing the default choice

- Ensure provision of readily available fresh water at all times in the night clubs, to give customers a free alternative to alcohol

Guide choice through incentives

- The effectiveness of any local scheme to provide incentives to reduce harmful alcohol consumption should be robustly evaluated

Guide choice through disincentives

- Consider licensing restrictions on premises selling alcohol at less than 50p per unit

Restrict choice

- Consider restricting opening hours of licensed premises and reducing the density of licensed outlets in Hereford city and the market towns.

Eliminate choice

- Strengthen the use of enforcement measures such as Dispersal Orders, Designated Public Place Orders and multiagency operations to stop underage sales to eliminate opportunities for young people to drink alcohol hazardously.

Chapter Three: The Foundation Years: the social gradient is established before children start school

Key Points

- The government has adopted the term Foundation Years to mean the phase of life from pregnancy to age five and its importance in underpinning later achievement and health
- Social gradient in health starts in the womb and accumulates through life.
- By the time today's 5 year olds reach retirement age they will be expected to work to age 68 years but many will not be healthy enough to do so without urgent action to reduce the social gradient in health
- The cost effectiveness of interventions to reduce the social gradient is highest in the foundation years and reduces as the child becomes older with interventions costing more and having less effect
- Action to reduce child poverty has close synergy with action to improve population health because reducing the social gradient in readiness for school at age 5 is the effective way to achieve both goals.
- Parenting is the biggest determinant of a child's readiness for school at age five, with the social gradient being strongly evident by age three.
- The average 'readiness for school' of 5 year olds in Herefordshire is significantly worse than average for England. (Fig EX3.1)

EXS3.1 London Health Observatory Marmot Indicators for Local Authorities in England

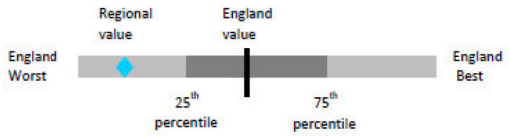
Fair Society, Healthy Lives

London Health Observatory

Marmot Indicators for Local Authorities in England

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives. Results for each indicator for this local authority are shown below. On the chart, the value for this local authority is shown as a circle, against the range of results for England, shown as a bar.

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



Herefordshire, County of

	Indicator	Local Authority Value	Regional Value	England Value	England Worst	Range	England Best
	Health outcomes						
	Males						
1	Male life expectancy at birth (years)	79.1	77.5	78.3	73.7		84.4
2	Inequality in male life expectancy (years)	3.5	8.7	8.8	16.6		2.7
3	Inequality in male disability-free life expectancy (years)	6.1	11.3	10.9	20.0		1.8
	Females						
4	Female life expectancy at birth (years)	83.3	81.9	82.3	79.1		89.0
5	Inequality in female life expectancy (years)	2.5	5.8	5.9	11.5		1.8
6	Inequality in female disability-free life expectancy (years)	5.0	9.2	9.2	17.1		1.3
	Social determinants						
7	Children achieving a good level of development at age 5 (%)	45.4	56.4	55.7	41.9		69.3
8	Young people not in employment, education or training (NEET) (%)	6.7	7.2	7.0	13.8		2.6
9	People in households in receipt of means-tested benefits (%)	11.6	17.9	15.5	41.1		5.1
10	Inequality in people in receipt of means-tested benefits (% points)	16.8	37.9	30.6	61.3		2.9

http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

EXS3.2 An overview of the Healthy Child Programme

Universal	Progressive	Higher Risk
Health and development reviews	Promoting child development including language	Referral for specialist input
Screening and physical examinations	Additional support and monitoring for infants with health or developmental problems	Contribution to care package led by specialist service
Immunisations		
Promotion of health and wellbeing, e.g.: - smoking - diet and physical activity - breast feeding - healthy weaning - keeping safe - prevention of sudden infant death (SIDS) - dental health	Promotion and extra support with breastfeeding. Support with behaviour change (smoking, diet, keeping safe, SIDS, dental health).	
Promotion of warm, sensitive, authorative parenting	Parenting support programmes including assessment and promotion of parent-baby interaction	High-intensity-based intervention
Involvement of fathers		
Mental health needs assessed	Emotional and psychological problems addressed	
Preparation and support with transition to parenthood and family relationships	Topic based groups and learning opportunities	Intensive structured home visiting programmes by skilled practitioners
Signposting to information and services	Help with accessing other services and sources of information and advice Common Assessment Framework completed	Action to safeguard the child

Recommendations

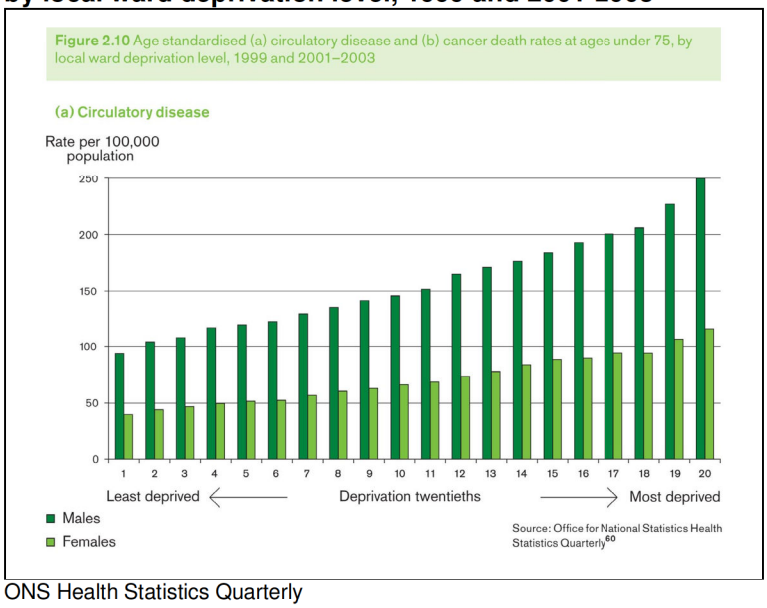
- A high priority should be given to improving the 'readiness for school' of 5 year olds in Herefordshire, with an emphasis on reducing the social gradient
- A commissioning strategy should be developed to increase support to all parents of children in the foundation years, with proportionately more support offered to parents of children with poor language development and/or behaviour problems and/or poor parent-child interaction.
- A commissioning strategy should be developed to achieve full implementation of the Healthy Child Programme, with an emphasis on reducing the social gradient in health through county-wide implementation of the progression from 'universal' services to 'universal plus' and 'universal partnership plus', (Fig EX3.2)
- The expansion of the Health Visiting workforce provides an opportunity to identify children with below average language development and/or poor behaviour and to provide or organise additional support to the child and parents to improve their readiness for school.
- The new offer of 15 hours per week free early education to 2 year olds from disadvantaged backgrounds provides an opportunity to reduce the social gradient in readiness for school.
- A decision as to whether or not to commission a Family Nurse Partnership Programme in Herefordshire should be taken once the results of the current trial are reported in 2013.
- At school entry age, all children should be assessed for their readiness for school and if necessary provided with additional support to bring them up to the average for England, with intensive support provided for those children significantly below the English average.
- The governance for action to reduce the social gradient in health in the Foundation Years should be encompassed by the governance arrangements for the Herefordshire Child Poverty Strategy.

Chapter Four: Adults of working age: the social gradient in preventable lifestyle-related disease and premature death

Key Points

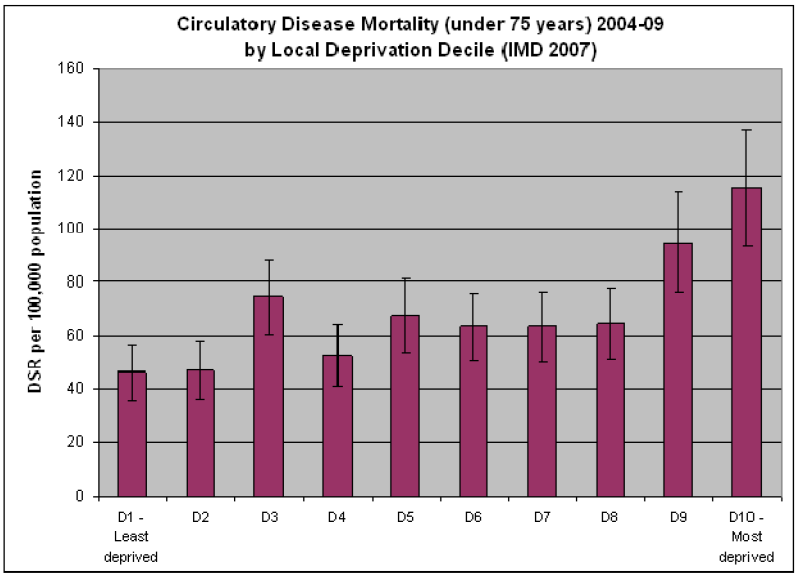
- Circulatory disease makes a major contribution to the burden of avoidable chronic disease and premature death. It is the single largest cause of long-term ill health and disability in Herefordshire and the second leading cause of premature death.
- A social gradient in circulatory disease is seen both at a national level (figure EX 4.1) and within Herefordshire (figure EX 4.2).

Figure EX 4.1[1] Age standardised circulatory disease and cancer death rates at ages under 75 by local ward deprivation level, 1999 and 2001-2003



ONS Health Statistics Quarterly

Figure EX 4.2 Circulatory disease mortality



[1] Marmot Review

Source: Dr Foster

- Nationally, health inequalities have been estimated to cost £31-33 billion per year in lost productivity, £20-32 billion per year in lost taxes and higher welfare payments and over £5.5 billion per year in the provision of additional NHS health care.
- Chronic disease impacts on people's ability to work and to be economically active. Unless efforts are made to improve the social gradient in the health of adults, many people will not be fit enough to work until the proposed new retirement age of 68 years with wide economic impact.
- Lifestyle behavioural factors such as smoking, diet, physical inactivity and alcohol consumption make a major contribution to the development of circulatory disease.
- These factors are all potentially modifiable through behaviour change interventions aimed at supporting people to quit smoking, to become more physically active, to eat healthily and to drink alcohol within recommended limits.
- The NHS Health Checks programme invites people aged 40-74, who haven't already been diagnosed with a chronic disease, to have an assessment of their risk of developing circulatory disease. This programme has the potential to make a major contribution to improving population health and to reducing future health and social care costs associated with the management of long-term conditions.

Recommendations

- Greater priority should be given to identifying people at high risk of circulatory and other chronic disease due to their unhealthy lifestyle behaviours and supporting them to change their behaviour to reduce their risk.
- The NHS Health Checks programme should be fully implemented in Herefordshire as soon as possible, ensuring that a range of services are available to support people found to be at high risk of circulatory disease to change their lifestyles.
- A high priority should be given to ensuring that healthy lifestyle services reduce the social gradient in health and are accessible to those at highest risk, particularly those from deprived communities where levels of unhealthy lifestyle behaviours are higher.
- High priority must continue be given to ensuring that smokers are identified and supported to quit smoking through the continued expansion of structured brief intervention by frontline NHS staff, the continued expansion of the network of providers of smoking cessation support, and the development of new smoking cessation support services delivered in workplaces employing unskilled and semi-skilled workers.
- New healthy lifestyle services should be developed within an integrated 'ladder of intervention' approach to reducing the social gradient in adult health with increasing physical activity levels and reducing harmful alcohol consumption being the priorities for new service development.
- Brief intervention training should become more generic so that frontline NHS staff are able to provide brief intervention in relation to a range of lifestyle risk factors

Chapter Five: Older people's health and wellbeing: focus on falls prevention

Key Points

- Older people are the main users of health and social care services. At a national level over 65 year olds make up 16% of the population but account for 43% (£16.47bn) of total NHS spend and 58% of the total social services budget (£6.38bn).
- Falls in older people are a major public health issue and can have a serious impact on older people's health and wellbeing.
- Falls are the commonest cause of accident-related hospital admission and the third most common cause of accidental death in Herefordshire. Over recent years there has been an increasing overall trend in the number of hospital admissions due to falls in the county.
- In Herefordshire there were around 760 falls-related hospital admissions in older people in 2010/11 and there are typically around 200 hip fractures per year. This figure can be expected to increase as the local population ages.
- Over half of all serious falls occur at home and slips, trips and stumbles (32%), steps and stairs (11%) and falls from beds and chairs (7%) are the top three contributory factors. Over 60% of the falls that lead to hospital admission in Herefordshire occur in people over the age of 65.
- The serious consequences of falls include physical injury such as fractures of the hip, lost confidence, increased social isolation and reduced independence. Fear of falling in itself can severely limit an older person's daily activities and thereby have a dramatically detrimental effect on their physical and mental wellbeing.
- Estimates of the average cost of each hip fracture range from £11,700 to the NHS and over £3,800 over 2 years for social care to over £28,000 for combined health and social care costs.
- In 2010/11 the costs associated with hospital admissions for falls-related injuries in older people in Herefordshire stood at over £2.48m – this does not include any social care costs.
- Falls prevention measures can reduce the incidence of falls by up to 30%, but "falls prevention services" typically focus only on people who have already had a fall (secondary prevention).
- There are cost-effective and evidence-based interventions which can be used to reduce the incidence of falls. The interventions which are known to be effective are simple and inexpensive and have the potential to save many thousands of pounds in health and social care costs. These include a combination of strength and balance training, assessment of hazards in the home, assessment of vision and medication review.
- Falls are not an inevitable part of growing older and, as discussed in Chapter 4, many of the lifestyle-related chronic diseases affecting people in their later life are preventable.
- Taking part in social activities and maintaining an active lifestyle throughout adulthood and into older age is good for the physical health and mental wellbeing of older people. Staying fit and healthy into older age is an achievable goal.

Photo: Bandemonium performing outside Hereford Cathedral

Recommendations

- A new Herefordshire falls prevention strategy should be developed with an emphasis on the primary prevention of falls in older people.
- A review of the existing falls prevention services in Herefordshire should be undertaken. Services which are ineffective or not based on sound evidence of effectiveness should be discontinued so that the funding can be invested in effective interventions.
- A local system needs to be developed for identifying those older people in the community who may be at risk of a first fall and ensuring that they receive appropriate sources of support.
- Front-line staff who are routinely in contact with older people (such as sheltered housing and care home staff, GP practice staff, environmental health and trading standards staff, community transport and library staff) have an important role in identifying people who are at risk of falling and should receive training in referring or signposting them to sources of help.
- A range of exercise programmes for older people which are designed to build strength and improve balance should be available across the county. This should include programmes in different settings (eg care homes, sheltered housing, community settings), of different types (eg chair-based exercises, “over 60s” exercise classes in the community, tailored home-based programmes) and in different geographical locations across the county.
- Despite the financial pressures on public services an affordable and trusted home improvement service should be available to vulnerable older people as a measure to prevent the much higher health and social care costs of falls-related hospital admissions.
- The Health and Wellbeing Board should develop and agree an integrated falls prevention strategy that incorporates strength and balance training, assessment of hazards in the home, assessment of vision and medication review.

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To prevent waste and save costs, only a small number of copies of the full report are being printed. The full Public Health Annual Report 2011 can be downloaded from www.herefordshire.nhs.uk/156.aspx. If you require a paper copy of the full report, please contact Louise Harper, email louise.harper@herefordpct.nhs.uk. The executive summary is also available as either a paper copy or a download from the same website.

The Joint Strategic Needs Assessment (JSNA) can be downloaded from http://www.herefordshire.gov.uk/factsandfigures/jsna.aspx

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**18 OCTOBER 2011**
TITLE OF REPORT:	**PUBLIC SECTOR COMMUNICATION STRATEGY**
REPORT BY:	**DEPUTY CHIEF EXECUTIVE**

CLASSIFICATION: Open

Purpose

To inform the Health and Wellbeing board about the local communications strategy, which supports the locally and nationally driven changes to public services, what activities have been achieved to date and how the Health and Wellbeing Board agenda fits into the overall strategic communication considerations.

Recommendation(s)

THAT: the Health and Wellbeing Board

(a) Note the updated communications strategy and joint key messages.

(b) Agree next steps to bring common communication messages and activities together

(c) Identify any initial key messages about the work of the Board itself or more generally about health and well being

Key Points Summary

- There are a number of key communications and engagement activities, which are being developed to support stakeholders and organisations through the transitional period of public sector change within Herefordshire

- The Health and Wellbeing board is key in implementing many of those changes, as well as having oversight of health and social care within Herefordshire. It is therefore important that the communication and engagement priorities of the board are developed and implemented in close coordination to those of other public sector organisations.

- A longer discussion is planned for a future meeting about our health and well being engagement strategy; this report sets the scene for shared communications and updates the Board on the joint communications strategy already agreed by the PCT Board and Clinical Commissioning Group

Further information on the subject of this report is available from
Richard Beavan-Pearson (01432 261721/ 07792880246)

Alternative Options

1 There are no alternative options, given that the Board has identified communications and engagement as a one of its key issues in the Development Framework.

Reasons for Recommendations

2 The joint communications strategy is designed to relate to all relevant areas of public sector reform within Herefordshire. As these reforms are all interdependent, a joint plan will be the most effective way of joining up the key communications messages.

Introduction and Background

3 A joint communications strategy was developed earlier this year to help support the partners who form the new health and social care landscape.

4 The scope of the strategy aims to support a seamless public-sector wide health and social care transition commissioning to the identification of key stakeholders who have a role or interest in the changes.

5 The strategy is designed to ensure that, regardless of who is commissioning or providing health and social care, messages are consistent and timely. This is particularly important in times of change which can be unsettling for both patients, the wider public, our partners and stakeholders.

6 The Health and Wellbeing Board is integral to this communications strategy due to it's leading role in relation to health and wellbeing across the county - particularly because of it's breadth of membership and determination to engage people in the development of its work and priorities. Crucially, however, is the requirement to engage residents, communities and all stakeholders across the county in taking responsibility for health and well being, through personal actions, informed lifestyle choices and building capacity at a local level.

Key Considerations

7 In order to develop the requirements of the Health and Wellbeing Board development framework and to link those expectations with the communications strategy, it will be necessary to ensure that the Board Engagement Plan is fully incorporated where appropriate and that the results of those activities influence the ongoing iterations of the plan.

8 Supporting the implementation of the strategy is a group of key stakeholders who regularly review the implementation of the action plan. Through this process a 90 day plan is being developed to support the more detailed activities which are relevant to the health and social care changes within Herefordshire. Key activities will range from information about the changes, informed by the key messages detailed in the plan to campaigns which are designed to support the required changes. Examples of these communications activities include:

a) A&E campaign launched.

A wide-ranging information campaign was launched in September to promote the alternatives to A&E and try and tackle the rising numbers using the service inappropriately. Numbers have risen from (approx) 43,000 in 2005 to 48,000 in 2008/09. Each A&E visit costs around £93, which is a significant cost in challenging economic times.

The campaign aims to raise awareness of what A&E should be used for and alternatives to it. It has seen bus advertising and a radio campaign launched already with GP practices and pharmacists also playing key roles in getting information out to local people using those services. Posters will appear in all NHS H, council and WVNHST properties including key venues such as libraries and children's centres. Shortly, billboards around the town and at the local football club will also be brought into the campaign in time for the festive season.

b) Flu vaccination

The annual flu vaccination plan is being rolled out. However, following evaluation it was found that previous campaigns have not reached pregnant women and so this year the campaign is being run through midwives. A wider information campaign, using national promotional materials will target groups such as older people and staff.

c) Summary Care Records

Summary care records are an electronic summary of information created for every individual patient. They can be shared via NHS staff and are particularly helpful for people with long-term conditions or in emergencies. They list only medications and conditions and are fully data protected. They will be rolled out in Herefordshire in the near future.

9 The Health and Wellbeing Board development framework details a number of issues which will need to be implemented in order that a Health and Wellbeing Engagement Plan can be developed. Many of these issues are similar, or shared with those required to develop engagement and communications activities required to support changes elsewhere within the public sector locally. Indeed, the Health and Wellbeing Board development framework states that these are:

- *Informing residents about the change and seeking their views about how this should happen locally*… using the 9 locality areas to tailor messages to the distinctive needs of each, bringing together local GPs, Elected Members, local delivery teams, parish councils and voluntary sector groups
- *Seeking to persuade residents to change their behaviour to promote better health for themselves and their families, to use the health and social care system responsibly and to take personal responsibility*… this is a role for all agencies (via the Herefordshire Partnership) in the context of health and well being, where a few simple messages need to be communicated repeatedly
- *Ensuring public involvement in the new system and appropriate local accountability*… this will be a key aim for the Consortium and the Board, working with HealthWatch and the wider VCS across the County

10 Therefore, once the Health and Wellbeing board priorities and workplans are developed, the key areas where HPS communications and engagement teams can support the work being carried out – for example, in support of the engagement activities, through social marketing, media and information campaigns can be identified and agreed.

11 This will then enable those activities and messages to be coordinated through the ongoing management of the joint strategy action plan, 90 day plan, and other key activities.

12 The Board may wish to identify any initial key messages about the work of the Board itself or more generally about health and well being

Community Impact

13 There are significant implications for the community. An effective communications strategy will help to engage residents, communities and all stakeholders across the county in taking responsibility for health and well being, through personal actions, informed lifestyle choices and building capacity at a local level.

Financial Implications

14 None identified at present.

Legal Implications

15 None

Risk Management

16 A lack of integration between communication and engagement activities which support the health and social care changes which are underway within Herefordshire may lead to unnecessary duplication of those activities and associated messages.

Consultees

17 The PCT Board and Herefordshire Health-Care Commissioners have agreed the strategy

Appendices

18 Joint Communications Strategy

Background Papers

19 Health and Well Being Board Development Framework.

The new health and social care landscape – A communications strategy for the public sector changes in Herefordshire

1.0 Overview/Introduction

1.1 This strategy is intended to ensure a seamless transition from NHS Herefordshire to GP led commissioning (Herefordshire Health-Care Commissioners) by providing clear and consistent communication to all identified stakeholders during this time. It is important for the public, colleagues and staff across both the commissioning and provider organisations to understand the changes and, in the case of staff, the impact upon them individually.

1.2 In order to ensure that this strategy can work to best effect, it is recommended that it is owned equally by Herefordshire Council, NHS Herefordshire and Herefordshire Commissioning Consortium. It will be informed through the strategic objectives set out by the HPS Transition Board and Herefordshire Health-Care Commissioners (HHCC) and the Herefordshire Public Services Leadership Team.

1.3 It should also link with the work streams emerging from the new Health and Wellbeing Board (HWBB). It is anticipated that the HWBB will be the vehicle through which local health and wellbeing outcomes will be addressed and improved, as a result of its multi-agency membership. The work emerging from the HWBB will provide significant opportunities to impress upon stakeholders the need for people to take personal responsibility for lifestyles (of which health is one aspect of) and to improve the way we use feedback from stakeholders and the public. There are also opportunities to develop an ongoing dialogue between health and social care commissioners and their stakeholders through innovative engagement work, which can inform future social marketing campaigns, as well as the development of services.

1.4 As the local health and social care landscape is developing rapidly, this strategy is designed to run in 90 day cycles so that it can provide flexibility and evolve to meet changing requirements and milestones during the transition.

1.5 Key documents informing the strategy going forward should include the HPS Joint Corporate Plan, the Health and Wellbeing strategy, the HPS Transition plan, the Joint Strategic Needs Assessment, the PCT Annual Plan, the QIPP; West Mercia, Wales and Gloucestershire Cluster plans, NHS Listening exercise results and the HPS Public Engagement Strategy and Plan.

1.6 There are three main strands to the strategy: stakeholder communication, internal communication and public and staff engagement.

2.0 Objectives

2.1 This strategy has a number of key objectives, which are intended to inform stakeholders from the partner organisations, the community, regionally and nationally about the changes happening to public services within Herefordshire and which are nationally recognised as innovative. These are:

- To support, inform and supplement 'business as usual' communications for Herefordshire Council, NHS Herefordshire and Herefordshire Healthcare Commissioning Consortium.

- To reaffirm the message that communications and responsibility of ensuring a smooth transition to the new NHS commissioning arrangements is a responsibility shared across the public sector. Everyone within Herefordshire Public Services and beyond has a personal responsibility to advocate for and participate constructively in the changes.

- To facilitate a seamless transition from NHS Herefordshire to HHCC

- To ensure that consistent messages are produced on behalf of all organisations throughout the transition period indicating clearly that good services, based on local need and quality patient care are at the heart of what we do

- To raise the profile of health and well being with Herefordshire residents, community groups, parish councils, local businesses and increase engagement in, and ownership of, it

- To begin, with our colleagues across the Herefordshire Partnership, to embed a broader culture of personal responsibility, which is wider than health than the health agenda

- To create a culture where people take responsibility for their own health

- To establish the HWBB as the central mechanism locally for delivering health and wellbeing outcomes by partners from across the public sector

- To establish an effective stakeholder engagement programme to inform the work streams identified by the HWBB and maximise opportunities for local people, staff and targeted stakeholders to get involved

- To develop a programme of internal communication to keep staff abreast of developments and changes during the transition period and to support the HR process

- To respond to and address issues identified through the NHS Listening exercise/national pause, ensuring that the Herefordshire's integrated approach to health and social care is seen as robust and influencing/reflecting national policy

- To support the development of HealthWatch and enable it to promote its work as a local 'health watchdog'

- To respond to requirements arising through the clusters in West Mercia, Wales and Gloucestershire.

3.0 Risks and Issues

3.1 There are a variety of risks and issues which can impact both the direction and speed of travel of the changes and these are set out below.

RISK	IMPACT	LIKELIHOOD	RATING	MANAGEMENT
Substantial changes to reform bill	• Any changes could impact how the set up is rolled out in Herefordshire • More/continued responsibilities for PCTs/clusters • Longer transition timelines • Potential need to adapt rethink Herefordshire models	2	3	Risk analysis looking at all potential outcomes. Communications plans applied and delivered under the umbrella of this strategy, guided by new strategic objectives of HPS Transition Board and HHCC board.
Continued uncertainty about the future for staff	• Uncertainty can lead to disengagement and low productivity • NHSH and HHCC lose out because staff move on to other jobs, taking their knowledge with them • May impact JCP objective to retain high quality workforce	4	3	Development of internal communications plan to keep staff informed of what is happening. Utilise Team Talk briefing system

RISK	IMPACT	LIKELIHOOD	RATING	MANAGEMENT
Less third sector funding and this impacts provision of services and support, and their ability to support service redesign	• Impact on local services • Inability to deliver against some health targets • Disengagement of third sector at a time we want to deliver a message of 'everyone having healthcare responsibility'	3	4	Risk analysis required to inform future planning and development
Savings required through QIPP impact frontline services	• £11m savings required – could impact services. Risk not being able to win and retain public/customer support for new health and social care landscape	3	4	Foster a culture of proper use of services. Communications plans should be in place to support process
Lack of customer/ stakeholder understanding about who is responsible for services	• Not knowing who to call or contact for help or advice – impact on reputation of ALL organisations	3	4	Single point of contact, branding exercise and direct communication with residents so that they know who to contact
Perceived lack of accountability in how services are commissioned	• As highlighted through the NHS Listening Exercise	4	4	Apply any mitigation as directed by Government and communicate wish to be open and accountable locally

RISK	IMPACT	LIKELIHOOD	RATING	MANAGEMENT
Challenge to make everyone take responsibility for their own health and wellbeing	• Unless communicated positively and effectively, could be seen as council/GPs taking money out of local services in climate where people expect everything to be available to them "we pay for it and expect you to do it for us"	3	3	Stakeholder and public engagement projects to help understand barriers to good health and create sense of responsibility Communicating the choice and control/personalisation agenda to help people stay independent and living in their own homes
Projected health and social care funding gap of £29m by 2014	• Greater demand upon services, unable to meet local need	2	5	Need for current services to be streamlined so that money can be reinvested to meet the growth in demand
That NHS reforms continue to be politically charged and become so at a local level	• Negative messages about health and social care services being shared through media, locally	2	3	Need to create climate of ownership – elected members can play a vital role in delivering and receiving information that can be used to develop effective services

4.0 Opportunities

a) Establishment of new HWBB, Herefordshire early implementer: Opportunity to work with stakeholders to inform HWBB themes and to begin move to increase people's responsibilities for their own health and overall lifestyles.

b) New role for public health within local authority rather than NHSH, role for HC to be championing health and personal responsibility for lifestyles.

c) Establishment of HealthWatch

d) End of the NHS Listening Exercise: It would be useful if we were in a position to hit the ground running, demonstrating how Herefordshire has/is responding to the points raised under the four consultation themes.

e) Herefordshire is already leading the way nationally through its work on integrated health and social care services.

f) Any milestones emerging from the HPS Transition Board.

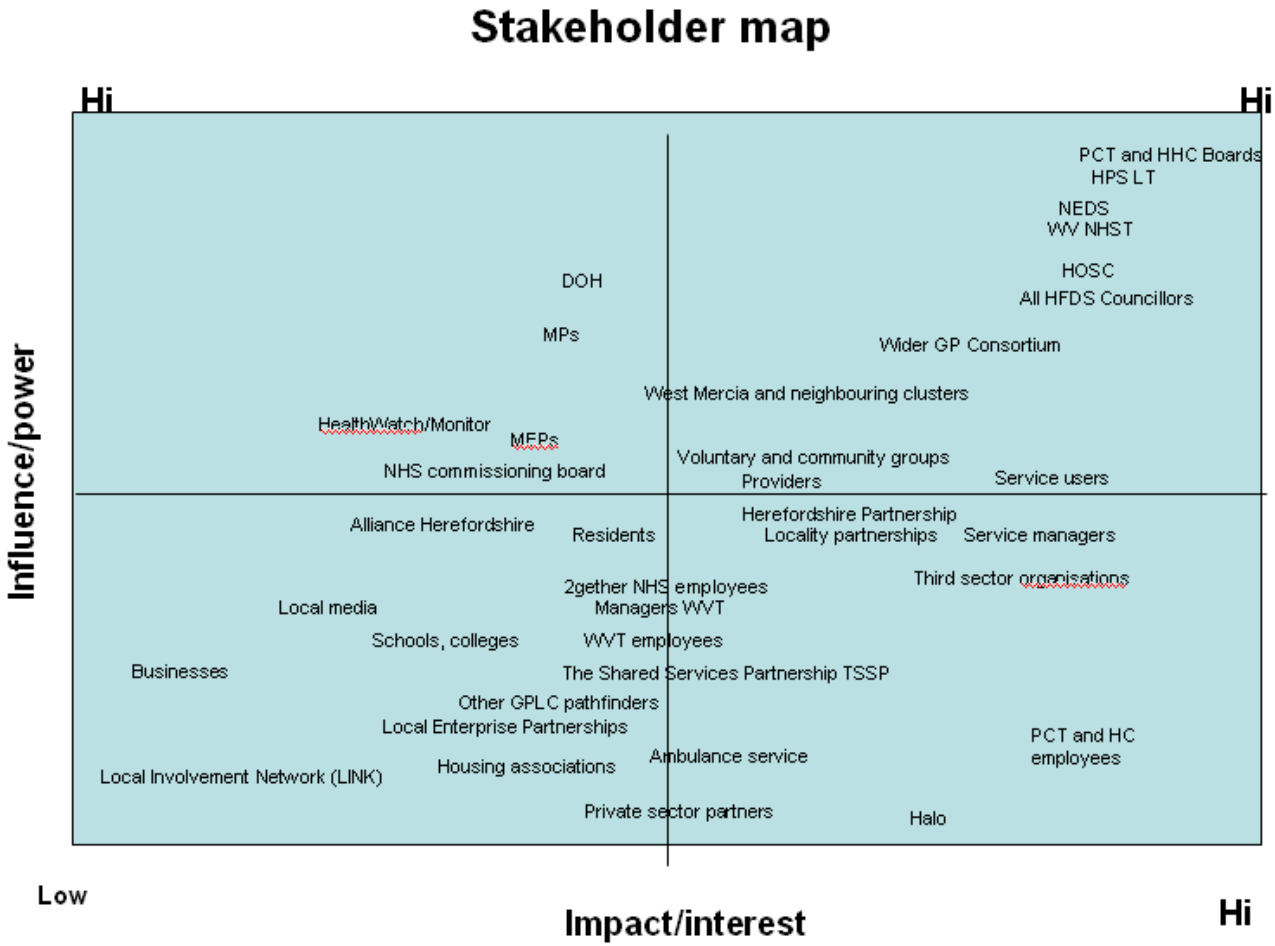
g) The establishment of nine locality areas will allow the develop of precise messages, tailored to the individual needs of each area and delivered through local GPs, elected members, local delivery teams, parish councils and voluntary sector groups.

h) A new approach to health and wellbeing, encouraging residents to change their behaviour and take personal responsibility for their own and their family's health. This could be supported through a social marketing campaign, backed by the wider Herefordshire partnership, rather than one organisation.

i) Ability to demonstrate Herefordshire's determination to be locally accountable and transparent from the outset of this new way of working

5.0 Stakeholders

The matrix below identifies the stakeholders impacted by these changes



6.0 Target Audiences

6.1 A number of audiences have been identified as the initial communications and engagement targets of this strategy and have been grouped together to allow development of appropriate messages and communications.

6.2 As we move through the life of the strategy, they can be updated and refocused as required.

- Residents, customers, patients and service users in Herefordshire
- Our employees and colleagues across NHS Herefordshire, Wye Valley NHS Trust, 2Gether and the council
- Employees within our numerous contractor and provider organisations, and trade union representatives
- Elected county, town and parish councillors, scrutiny members and appointed non-executive directors, and MPs and MEPs
- Young people – through schools and colleges, after school and special interest clubs and groups
- Third sector providers and partners
- Businesses, trade associations and the private sector

7.0 Key messages

7.1 Key messages will be used in all our communication to ensure consistency and support the transition, clearly demonstrating commitment to continuity within those services during and after the transition, backed by the council, primary care trust and HHCC. General messages should join up across the HHCC strategy, Joint Corporate Plan and the PCT Annual Plan (see 7.1 below). More work should be done to develop these messages, with input and agreement from the Boards to ensure that communications work is owned and steered by their vision alongside tangible targets.

7.2 Added to this, in some cases, key messages will need to be developed to target specific audiences, depending on what it is we wish to ask them, or tell them about the transition period. In some instances, stakeholder and public engagement will also inform key messages to be used in social marketing campaigns around health and social care.

General messages

- That we are committed to continuing to create sustainable health and social care services of the highest quality in Herefordshire and that the partnership of public services within the county will continue to work together to achieve this aim.

- We want to create effective health care services for Herefordshire, influenced and designed by local people and healthcare experts, which meet the needs of our patients.

- Everybody has/we all have a responsibility for their/our own health and wellbeing.

- Herefordshire is leading the national health and social care agenda, thanks to its robust approach to providing health and social care, closer to where people live

- Patients, service users and carers are at the heart of what we do and they will have a greater voice and more choice in how services are managed and delivered for them by local organisations in their local area

7.2 Key message to staff and colleagues

- ***That we are committed to continuing to create sustainable health and social care services of the highest quality in Herefordshire and that the partnership of public services (which includes HC, NHSH, WVNHST and HHCC) within the county will continue to work together to achieve this aim.***

And more specifically:

- Herefordshire is at the forefront of NHS/ public sector reforms and pathfinders for clinical commissioning consortium and HWBB

- Ensuring a smooth and sustainable transition from PCT to GP-led commissioning is our most important commitment to our customers and patients

- Your experience and knowledge is invaluable during this time of transition

- These new ways of working are an opportunity to make our health and social care services leaders in the field

- We all have a responsibility for our own health and wellbeing and should be advocates for this in the wider community

7.3 Key messages to other stakeholder groups

As the strategy develops, key messages may be developed and tailored to the needs of stakeholder groups identified as key communications targets, depending upon the behaviour you wish to change or influence or whether messages are to inform people about the transition, with no action needed.

8.0 Key corporate strategic communications activities

8.1 This strategy should be led by milestones emerging from the Joint Corporate Plan, the establishment of the HWBB, the HHCC work plan so that all communications work can be aligned to what is actually happening at key stages.

Board members will be responsible for highlighting these key milestones to the communications team.

8.2 There should be a monthly health story, highlighting a success in healthcare, in order for a repeated drip feed of success, demonstration of continuity of services and ongoing commitment to creating high quality and sustainable health and care services.

9.0 Strategic Communications action plan

Denotes completed

What	Audience	Action	Additional notes	Timelines	Responsible
PCT/WVT APM	Public and identified stakeholders	Opportunity to communicate key themes and priorities across all organisations		July 26	PCT Board to deliver messages Complete
Stakeholder workshops	As identified through stakeholder map		Beginning of the conversation with key stakeholders	July 2011	Dean Taylor
Develop timed action plan to support public health staff during transfer to council	• Is national guidance available? • Timeframes for transfer • Develop robust communications to support HR	Communications channels could include face-to-face, Team Talk, manager briefings, CEO road shows, First Press, intranet, change champions		Ongoing	Communications team with HR
Agree target engagement groups for health change	Relevant engagement groups as identified through work themes		To be signed up to by HWBB, HHCC, HPSLT	Autumn	Public engagement team
Develop key messages	Each stakeholder group see 6.0	Identify primary and secondary messages,	To be signed up to by HWBB, HHCC,	Autumn	Developed by Boards supported by

		from each strategy	HPSLT		communications team
A/E Campaign	Herefordshire Citizens	Use range of communications channels to reduce A/E attendances/ admissions	Example of joined up working	Autumn-Winter	GPCC
Strong health story for media/ Digital channels	All Herefordshire residents and businesses	Identify forthcoming good health stories which identify commitment to continuity and best practice		Once work plans agreed	Project/care leaders to highlight to communications team
Develop stakeholder engagement programme	Businesses Third Sector Parish Councils Older People	Develop an engagement programme based on HWBB work stream, JPC work streams and HHCC work streams	This work has started but is dependent upon the relevant forums providing clear areas of work and priorities	Autumn	Public Experience team
Agree a shared health vision	All local people	HHCC, PCT and HC to agree a shared vision and it to be communicated as part of the strategy	Could this be informed by the workshops?	August Complete (see HWBB Dev Framework)	HPS LT/ GPCC/HWBB
Strong health story for media/digital channels	All Herefordshire residents and businesses	Identify forthcoming good health stories which identify commitment to continuity and best practice		Autumn	Project/care leaders to highlight to communications team

What	**Audience**	**Action**	**Additional notes**	**Timelines**	**Responsible**
Stakeholder workshops - localities	Local communities in nine locality areas	• Clarify purpose and scope of these events • Build upon Reaching the Hearts • Separate stakeholder maps to be drawn up	Facilitated by Public Experience team	October	Dean Taylor/ C Staite/ Public Experience Team
Drip feed messages and change to all staff	• Agree key priority messages • Put together action plan • Communicate through channels as outlined above	Should be a more general campaign based around changes in organisation and messages arising through HWBB		August/Sept 2011	Led by Boards with communications support
HealthWatch early implementer	Wider community and stakeholders	Need to communicate the establishment of the HW, its intentions and role in	Dependent upon receiving implementer status	August - complete	RBP/communications team

		the health and social care landscape going forward			
HealthWatch Early Implementer	Local Community Public Sector leaders	Ongoing communication regarding the development and implementation of the HealthWatch early implementer		October 2011-June 2012	Communications Team/ RBP