WARRINGTON
Borough Council

To: **Members of the Warrington Health and Wellbeing Board**

Professor Steven Broomhead
Chief Executive

Town Hall
Sankey Street
Warrington
WA1 1UH

11 July 2018

Meeting of the Warrington Health and Wellbeing Board, Thursday, 19 July 2018 at 1.30pm in the Council Chamber, Town Hall, Sankey Street, Warrington, WA1 1UH

Agenda prepared by Bryan Magan, Head of Democratic and Member Services
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Note – In line with The Openness of Local Government Bodies Regulations 2014 this meeting may be recorded. A guide to recording meetings has been produced by the Council and can be found at https://www.warrington.gov.uk/info/201104/council_committees_and_meetings/1003/access_to_council_meetings

A G E N D A - Part 1

Items during the consideration of which the meeting is expected to be open to members of the public (including the press) subject to any statutory right of exclusion.

A. STANDARD GOVERNANCE ITEMS AND MATTERS

1. To Receive any Apologies for Absence

2. Code of Conduct - Declarations of Interest
Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012

Members are reminded of their responsibility to declare any disclosable pecuniary or non-pecuniary interest which they have in any item of business on the agenda no later than when the item is reached.

3. Minutes

To confirm the minutes of the meeting of the Board held on 31 May 2018 as a correct record.

4. Updates from Reference Groups

B. PROMOTING INTEGRATION

5. Health and Social Care Integration/Transformation – Updates - Simon Kenton

C. DEVELOPMENT AND DELIVERY OF HEALTH AND WELLBEING STRATEGY

6. Cheshire and Merseyside Prevention Framework - Report from Dr Muna Abdel Aziz

7. Refreshing the Health and Wellbeing Strategy - Report and presentation from Dr Muna Abdel Aziz

D. OVERSIGHT OF IMPORTANT STRATEGIES AND REPORTS

8. Making Every Contact Count - Report from Dr Muna Abdel Aziz

9. Update on position with PHE regarding smoking/vaping - Report from Dr Muna Abdel Aziz

E. INFORMATION AND CONTEXT

10. Issues of Strategic Importance - round the table updates from key partners on current or imminent 'heat in the system' issues.

- Update on new Hospital (Mel Pickup)

F. CONCLUDING BUSINESS

11. Work Programme

To keep under review the Board's Work Programme

12. Future Meetings

Town Hall, Warrington at 1.30pm on Thursday 13 September 2018

Part 2 – Nil

Membership:

Chairman: Professor Steven Broomhead

Warrington Borough Council
Leader of WBC
Executive Lead Member, Statutory Health and Adult Social Care
Executive Lead Member, Public Health and Wellbeing
Executive Lead Member, Children's Services
Executive Board Member - Culture and Partnerships
Opposition Spokesperson
Steve Peddie, Interim Executive Director, Families and Wellbeing (as Director of Adult Social Care and Director of Children's Services)
Dr Muna Abdel Aziz, Director of Public Health

Warrington Clinical Commissioning Group
Dr Andrew Davies, Chief Clinical Officer of Warrington Clinical Commissioning Group
Dr Dan Bunstone, Clinical Chair, Warrington Clinical Commissioning Group
David Cooper, Chief Finance Officer, Warrington Clinical Commissioning Group
Carl Marsh, Chief Commissioner, Warrington Clinical Commissioning Group

Joint Appointments
Simon Kenton, Accountable Care Partnership Lead Officer, Warrington Borough Council / Warrington Clinical Commissioning Group

Other Representatives
Helen Speed, Chair, Healthwatch Warrington
Steve Cullen, Third Sector Network Hub
Simon Barber, Chief Executive, 5 Boroughs Partnership NHS Trust
Colin Scales, Chief Executive, Bridgewater Community Healthcare NHS Trust
Mel Pickup, Chief Executive, Warrington and Halton Hospitals NHS Trust
Nigel Gloudon, Head of Finance, NHS England, Merseyside, Cheshire, Warrington and Wirral, Area Team
Richard Strachan, Independent Chair Warrington Safeguarding Children Board
Michael Sheppard, Chief Executive Officer, Warrington Community Living - Third Sector Provider Representative
David McGuinn, Director, Premier Care Ltd - Private Care Sector
Gill Healey, Group Head of Social Investment, Torus – Housing
Tim Long, Headteacher, Bridgewater Community High School - Education
Mike Larking – Cheshire Fire and Rescue
David Keane, Police and Crime Commissioner

Standing Invitees (Not Members of the Board)
Cllr Rebecca Knowles, Chair of Health Overview and Scrutiny Committee

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MINUTES
WARRINGTON HEALTH AND WELLBEING BOARD
31 May 2018

Present:-

Professor Steven Broomhead (Chairman), Councillors I Marks, M McLaughlin, and P Wright and Dr M Abdel Aziz, S Barber, D Cooper, S Cullen, Dr A Davies, G Healey, S Kenton, Lois Murray, S Peddie, M Pickup, M Sheppard, C Williams (for C Scales)

Also in Attendance:- Bryan Magan, and J Taylor

HWB1 Apologies

Apologies for absence were received from Councillors J Carter, R Knowles, T O'Neill and D Price and from Dr D Bunstone, C Scales, N Glouden, D KeaneM Larkin, T Long, D McGuin, L Thompson, R Strachan and H Speed

HWB2 Declarations of Interest

There were no declarations of interest submitted at this meeting.

HWB3 Membership and Terms of Reference

Resolved – Received and noted subject to

- The clerk contacting D Keane about his plans for attendance in the future
- Adding C Marsh from the CCG to the membership (proposed by Dr A Davies)

HWB4 Minutes

Resolved – That the minutes of the meeting of the Board held on 29 March 2018 be received as a correct record and be signed by the Chairman.

M Pickup updated the Board in relation to Minute number HWB71 site for Warrington new hospital

The Chairman asked that the paper in relation to admissions and charges from hospital HWB71 Hospital Admissions, Flow and Discharge refers be brought to the next meeting of the Board

HWB5 Updates from Reference Groups and Other Matters

- Budget deficits in NHS – 70 anniversary of NHS plans - Mel Pickup provided an update on this matter in relation to the local Warrington position

- Dr M Abdel Aziz reported on the position Public Health England in relation to vaping and smoking cessation and agreed to bring a more detailed paper to a future meeting of the Board

Resolved – To note the above updates.

HWB6 Health and Social Care Integration/Transformation Update

Simon Kenton, Programme Director, Warrington Together provided a comprehensive update in relation to the Warrington Together Programme.

Resolved – To note the progress of the work being driven by the Warrington Together Programme.

HWB7 Shared Care Record

The Board considered a verbal report of Dr Andrew Davies supported by a briefing paper tabled at the meeting.

The next steps included –

- Present the final business case at Warrington Together Board on 18 June to ensure that the deliverables meet their needs and benefits are agreed by partners;
- Present the final business case at all organisational boards or committees in June for a decision and commitment of resources;
- Alongside the final business case will be back to back contracts flowing down the NHS responsibilities for delivery

Resolved – To note the update report

HWB8 Health and Wellbeing Performance Overview

The Board considered a report from Simon Kenton Assistant Director Integrated Commissioning which provided a full year summary report 2017-18 of the performance position for the Health and Wellbeing Strategy.

Resolved – That the report be received and noted and Board Members consider any action or further information required based on reviewing the current performance position. Note it was agreed that the report be developed into a public facing document.

HWB9 Warrington Integrated Pandemic Influenza Health, Social Care and Education Plan

The Board considered a report from Dr Muna Abdel Aziz, Director of Public Health and Lois Murray, Specialty Registrar in Public Health on behalf of partners in the

Warrington Health Protection Forum which detailed the final draft of the Warrington Integrated Plan outlining arrangements for coordination of services and communication in the event of a pandemic influenza outbreak.

It was noted that Warrington was the first local authority in C&M to develop this plan and that these local arrangements reflect best practice guidance and arrangements in the NHS and social care. In addition, schools in Warrington had taken on board the key messages and put in place arrangements for business continuity recognising that schools response would have an effect on parents/carers and hence staffing of essential services

Resolved – The Health and Wellbeing Board approved the integrated plan for implementation to prepare for flu pandemic and noted that individual organisations were putting in place their organisational plans for business continuity which fit with regional arrangements. It was noted that the plan would be tested by the Health Protection Forum and reported to the Health and Wellbeing Board in early 2019.

HWB10 Public Health Annual Report 2018 Protecting Health in Warrington

The Board considered a report from Dr Muna Abdel Aziz, Director of Public Health which presented the Public Health Annual Report 2018. Views of Board Members could be submitted up to and including Monday 4 June 2018.

Resolved – The Health and Wellbeing Board received and noted the report.

HWB11 Issues of Strategic Importance

Board Members raised a number of items including:-

- The Chair reported that the Local Authority had achieved a further £17m of savings (real cash) and reported significantly low £120k overspend. This was achieved by the Council's innovative approach to property investment and was achieved despite the increasing demands on Adult and Children's care budgets.
- Steve Peddie updated members on the award of the Health Watch
- Dr A Davies reported on achieving a full green accounts rating with no special notes to address and a small benefit recorded.
- Steve Peddie reported on the Green Paper on Social Care expected in the summer time.

Resolved – To note the issues of strategic importance raised.

HWB12 Work Programme

Resolved - The Board received the updated work programme and agreed to keep it under review.

HWB13 Date of Next Meeting

Resolved – To note that the next meeting of the Board would be held at the Town Hall, Warrington, at 1.30pm, on Thursday 19 July 2018. The agenda for this meeting to include a report on delayed discharges

Signed:
Date: 19 July 2018

Warrington **Health & Wellbeing Board** 19th July 2018 1.30 pm, Council Chamber, Town Hall, Warrington	
Report Title	**Cheshire and Merseyside Population Health Framework**
Agenda Section	☐ A. Standard Items and Governance Matters ☐ B. Promoting Integration ☐ C. Development and Delivery of Health and Wellbeing Strategy ☒ D. Oversight of Important Strategies and Reports ☐ E. Information and Context ☐ F. Concluding Business
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	To provide the Health and Wellbeing Board with the Framework for Population Health (and Prevention) in Cheshire and Merseyside. This forms an important context to Warrington Together and place based population health.
Report of	Dr Muna Abdel Aziz, Director of Public Health Dr Andrew Davies, Clinical Chief Officer, Warrington CCG Simon Kenton, Programme Director, Warrington Together
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	For the Health and Wellbeing Board to note and endorse the Framework adopted by C&M Health & Care Partnership and which has relevance to Warrington Together and the refresh of the Health and Wellbeing Strategy. H&WB members are asked to refer to the framework in recommending priorities for the H&WB Strategy.

1. CONTEXT AND BACKGROUND

The Cheshire and Merseyside Population Health Framework was developed in conjunction with Cheshire and Merseyside Health & Care Partnership Prevention Board, Public Health England, Local Authorities, NHS CCG representatives, NHS providers, NHSE, the voluntary sector and third sector and seeks to support the delivery of the prevention challenge.

Traditionally efficiencies have been delivered through improved delivery of care but meeting the current goals of saving lives, reducing morbidity, improving quality, being more cost effective and reducing inequalities requires a new solution and a focus on stemming demand through delaying or preventing the onset of need.

It sets out evidence based guidelines partners can use to create a transformational and sustainable shift in the health and wellbeing of the Cheshire and Merseyside population. The guidelines are not prescriptive; they aim to support prevention within local place based settings. They can therefore be adapted and interpreted at a local level.

This approach promotes the integration of health, mental health and social care services, the development of multidisciplinary and multisector teams working together to improve population health. This includes individual care management, the mobilisation of community assets, committing to integrated care models, and making every contact count across sectors, as well as population level interventions like access to employment and workplace health and education.

- Systems Leaders.
- Primary Care.
- Tertiary or Secondary Care.
- Communities.

Practical steps for this could be put in place regarding the areas of prevention that have been agreed across the H&C Partnership

- Control of blood pressure, cholesterol and risk of cardiovascular disease
- Tackling alcohol harm
- Anti-microbial stewardship
- Support for people to give up smoking and cancer prevention initiatives that have particular relevance to Warrington

2. APPENDIX:

The Cheshire and Merseyside Population Health Framework is attached.

Cheshire and Merseyside Population Health Framework

About this Population Health Framework

In order to support the delivery of the prevention challenge across the sub region the Cheshire and Merseyside Health and Care Partnership requested the development of a Population Health Framework.

Traditionally efficiencies have been delivered through improved delivery of care but meeting the current goals of saving lives, reducing morbidity, improving quality, being more cost effective and reducing inequalities requires a new solution and a focus on stemming demand through delaying or preventing the onset of need.

The Cheshire & Mersey Population Health Framework has been developed in conjunction with Cheshire and Merseyside Health & Care Partnership Prevention Board, Public Health England, Local Authorities, the NHS, the voluntary sector and third sector. It sets out evidence based guidelines partners can use to create a transformational and sustainable shift in the health and wellbeing of the Cheshire and Merseyside population.

The guidelines are not prescriptive; they aim to support prevention within local place based settings. They can therefore be adapted and interpreted at a local level.

The Population Health Framework promotes the integration of services, the development of multidisciplinary and multisector teams working together to improve population health. This includes individual care management, the mobilisation of community assets, committing to integrated care models, and making every contact count across sectors, as well as population level interventions like access to employment and workplace health and education.

In support of this approach the prevention framework provides practical suggestions for each Place Based Care System for working on population health with:

- Local system leaders.
- General Practices or Primary Care Hubs.
- Local tertiary and acute providers.
- Communities

Systems Leaders Framework

1. To embed Prevention within corporate governance structures, appoint a board level champion for prevention and ensure health is in all policies.

2. To prioritise a relentless focus on wellbeing, prevention and early intervention.

3. To develop the workforce so they deliver on prevention and embed *Making Every Contact Count* (*MECC*) within all contracts and commissioning, ensuring data collection and contract management reflects MECC outcomes.

4. To work in partnership through Health and Wellbeing Boards to develop clear prevention and lifestyle service pathways with a single point of access.

5. To tackle unwarranted variation across clinical services, and reduce exception reporting within the Quality Outcomes Framework.

6. To adopt an inclusive approach to prevention with targeted resources for areas of acute deprivation and need.

7. To have a digitally mature system with shared care records so health issues are identified sooner and people are treated more effectively.

8. To recognise that the residents of Cheshire and Merseyside are key agents in supporting and achieving better health outcomes.

9. To develop a Corporate Social Responsibility Strategy with social value and prevention at its heart to maximise the organisation's impact for prevention across its staff, estates and corporate activity.

10. To consider **system, scale** and c**onsistency** in implementation, delivery, marketing and communication of population health programmes.

Primary Care Framework

1. Health and Wellbeing staff including: health trainers, youth workers, drug and alcohol staff, social workers, mental health staff, as required, be part of the Primary Care Hubs and the Multi-Disciplinary Team model.

2. Public health nurses, health visitors, family nurse practitioners and school nurses are linked to Primary Care Hubs.

3. Systematic referral to sources of non-clinical support through social prescribing and community connecting roles and stronger partnerships with voluntary organisations.

4. Embed shared decision making and enable choice, so that people are knowledgeable and supported as equal partners in decisions about their care and treatment.

5. People are supported in the way they need to manage their health in a way that suits them best, tailored to their level of knowledge, skills and confidence. This includes health coaching, self-management education and systematic access to peer support options; measured through tools such as the Patient Activation Measure.

6. Hospital specialists have a more holistic understanding of patients by linking into Primary Care Hubs and participating in MDTs, offering phone advice, electronic advice and delivering training.

7. Provide personalised care and support planning as a proactive process, bringing together people's physical, mental health and wellbeing needs into a single conversation focused on what is important to them and co-ordinating better access to personalised care and treatment, alongside psychosocial and community based support.

8. Have integrated personalised commissioning, including personal health budgets and integrated personal budgets, enabling people who could benefit to take control of resources to meet their health and care needs.

9. Increase awareness of the value of national screening programmes and increase uptake.

10. In house training and education programmes for staff, patients and clients on self-management, health literacy, behaviour change, MECC and specialist topics.

Tertiary or Secondary Care Framework

1. Tertiary and secondary prevention that reduces the impact of established disease through interventions such as lifestyle advice and cardiac or stroke rehabilitation programmes embedded in all Trusts.

2. Commonality of prevention pathways across all Trusts.

3. Have holistic approaches to history taking to address lifestyle and other risk factors and use this information in care planning and include in discharge summaries.

4. To share information on clinical and lifestyle risks in referral and discharge summaries to ensure that prevention is addressed at all points in pathways and that patients are included on relevant disease registers as early as possible.

5. Systematically adopt a Making Every Contact Count (MECC) approach with the delivery of all services supported by necessary staff training and IT infrastructure to record activity and outcomes.

6. Mandatory common competency and training frameworks on prevention for the patient facing workforce.

7. All Trusts aligned to the national preventing ill health CQUINs on alcohol, tobacco and diet. Ensure healthy food provision within all premises, removing sugary snacks and beverages from vending machines in public sector buildings.

8. A regional dashboard to compare and contrast outcomes from prevention work.

9. Hospital specialists and Community Trust specialists increasingly run joint ambulatory clinics in the community and be part of primary care Multi-Disciplinary Teams.

10. A holistic approach to health care for all integrating physical and mental health during consultations and treatment.

Community Framework

1. To utilise the local community as a key asset for prevention.

2. To co-create health and wellbeing initiatives with Cheshire and Merseyside communities, social networks and the voluntary sector.

3. To build capacity and increase the use of local non health workforces to deliver prevention: fire & rescue services, housing associations, sports clubs, community development teams, social prescribing, voluntary and third party sector, etc.

4. To work with local companies to engage with the local community, deliver the workforce health charter and offer workplace health initiatives.

5. To work with planners to develop healthy neighbourhoods that encourages an active lifestyle and is dementia and disability friendly.

6. To train and accredit community champions, volunteers and advocates in health and wellbeing topics, such as, dementia friend training.

7. To work with local retailers to retail products that have an impact on health responsibly.

8. To work with local schools and early years providers to give children a healthy start in life.

9. To offer integrated wellness and lifestyle programmes in the community including: diet, exercise, reducing harm from alcohol, stopping smoking and improving emotional resilience.

10. To enable local communities to access information digitally and in hard copy on local assets.

References

- Resilient Communities 2018, John Moores University.
- Lambeth Connecting Care Evaluation 2016, Kings College London.
- Rotherham Social Prescribing Model Evaluation 2017, Sheffield Hallam University.
- Integrated Care 2017, International Advisory Board.
- Addressing Prevention through the Development of New Care Models. 2016, Public Health England, Dr Marilena Korkodilos.
- New Models for Paediatric and Child Health 2016, RSPCH, Dr Hilary Cass.
- Addressing Inequalities in Child Heath 2018, Prof. David Taylor Robinson.
- Memorandum of understanding for Personalised Care Network Sites. NHSE 2018
- Meeting the Prevention Challenge, East Midlands PHE and NHS Clinical Senate 2015
- Cumbria and Lancashire Population Health Model 2016

Warrington **Health & Wellbeing Board** 19th July 2018 1.30 pm, Council Chamber, Town Hall, Warrington	
Report Title	**Refreshing the Health and Wellbeing Strategy**
Agenda Section	☐ A. Standard Items and Governance Matters ☐ B. Promoting Integration ☒ C. Development and Delivery of Health and Wellbeing Strategy ☐ D. Oversight of Important Strategies and Reports ☐ E. Information and Context ☐ F. Concluding Business
Type of Decision Required	☒ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☐ Note or Endorse a Report or Action by Others
Report Purpose	To provide the Health and Wellbeing Board with an update on the on-going work to refresh the Health and Wellbeing Strategy
Report author	Dr Muna Abdel Aziz Director of Public Health Warrington Borough Council
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	For the Health and Wellbeing Board to note the work undertaken to date to refresh the Health and Wellbeing Strategy and identify Board Members to participate in further in-depth insight gathering

1. Report purpose

1.1 To provide the Health and Wellbeing Board with an update on the review and refresh of the Health and Wellbeing Strategy that is currently underway.

1.2 To provide feedback on the first stage of stakeholder feedback that has been undertaken with JSNA Leads and others who were very involved in the development of the current strategy.

1.3 To provide an overview of the stakeholder workshop that is planned as a further feedback gathering exercise from those whose role means they are responsible for delivering on aspects of the current strategy.

1.4 To seek support from the Board for the next stage of the review which will involve gathering insight from Board members on the emerging themes identified to date.

2. Introduction/background

2.1 The paper that came to Health and Wellbeing Board in March set out the proposal for refreshing the Health and Wellbeing Strategy. The suggestion was for a 'light-touch' refresh, led by the JSNA Steering Group, which reviews and refocuses work where necessary, but maintains the consistency needed to deliver on long-term strategic outcomes.

2.2 The first stage of the refresh is to undertake a review of the current strategy. The proposal was to use a range of methods to review progress across the strategic themes. Progress to date includes:

- A refreshed high level assessment of population need based on intelligence generated through the JSNA programme
- Stakeholder feedback; initial insight gathered on the views and perceptions of the current strategy from JSNA Leads and others who were involved in the development of the current strategy
- Wider stakeholder workshop planned; gathering insight from partners involved in delivering the current strategy

2.3 Further work is proposed with Health and Wellbeing Board Members to share insight gathered to date and develop ideas on the form, structure and content of the refreshed strategy.

3. Reviewing the current strategy

3.1 A piece of work has been undertaken by external health consultants to gather insight from the JSNA Leads and others involved in the development of the current (2015-2018) strategy. Qualitative methods were used to obtain the views and perceptions of the current strategy and key issues for the strategy refresh. Secondary research was undertaken to identify components of an effective Health and Wellbeing strategy. Information was structured around four key aspects: Effectiveness of the current HWB Strategy and the role of the HWB Board, barriers and enablers in the delivery of the current HWB Strategy, and priorities and considerations for the future HWB strategy. Data was analysed thematically and compared to published literature. Some of the pertinent findings include:

- All respondents felt the current strategy was relevant to Warrington's needs
- There was general consensus that structuring the strategy along a life-course approach was appropriate
- The need for a continued focus on inequalities, poverty and socio-economic deprivation was emphasised, and the opportunity to embed health and wellbeing in all policies was highlighted
- It was suggested that the current strategy is quite detailed and lacks some consistency in terms of depth and structure. It was felt that there is opportunity make the refreshed strategy more concise, focussing on overarching principles and the system-wide change and innovation needed to deliver sustainable improvements in health.
- Participants regarded stakeholder representation on the HWB Board as adequate. However, some felt that role of the Board in strategy delivery, ownership and accountability could be strengthened, with opportunities for closer interaction between the HWB Board and JSNA Steering Group
- The importance of stakeholder engagement and triangulation of evidence when identifying priorities was highlighted.

3.2 The JSNA Core document has been refreshed, providing a high-level assessment of population need. Appendix 1 provides a brief overview of some of the key points.

4. Next Steps

4.1 A workshop is planned to obtain stakeholder feedback at this early stage of the strategy review process. The aim of the workshop is to share some of the information gathered to date with stakeholders involved in the delivery of the current strategy. The workshop will provide an opportunity for stakeholders to inform and challenge thematic leads around emerging principles and priorities. An outline agenda is included at Appendix 2.

4.2 Input and feedback from HWB Members is sought. It is proposed that to gather some in-depth insight, Members participate in semi-structured interviews to share views on the proposed structure, content and format of the refreshed strategy. Opportunities to explore how to strengthen mechanisms for governance and accountability would also be explored. A suggestion is that board members volunteer to participate in an insight interview (maximum duration of an hour) to discuss feedback to date and share views and advice on the above points. It is proposed that these interviews take place from mid-August. A minimum of five interviewees from across sectors is suggested in order to provide some breadth of insight.

4.3 Insight gathered from all stakeholders will be considered alongside local intelligence on need and research evidence, in order to develop principles for effective system-wide working and draft priority themes.

4.4 A refreshed strategy will be developed and a draft will come to Board in the autumn.

5. Recommendations

5.1 For the Health and Wellbeing Board to note progress made to date, support the approach outlined for refreshing the Health and Wellbeing Strategy, and identify five representatives to participate in further insight gathering.

6. Background Papers

None

Contacts for Background Papers:

Name	E-mail	Telephone
N/A	N/A	N/A

Appendix 1: Overview of main findings from the JSNA summary on population health need

High-level health outcomes: Average life expectancy at birth in Warrington is improving, but the pace of improvement has slowed in recent years, and the gap between Warrington and England has not narrowed. Internal inequalities in life expectancy are stark and linked to socio-economic deprivation. Comparing life expectancy for those living in the most and least deprived wards of Warrington, there is a gap of 9.8 years for males, and 11 years for females.

The major causes of reduced life expectancy and premature death and in Warrington are cancer and cardiovascular disease (CVD). Premature CVD mortality has more than halved over the last 13 years, and rates are now in-keeping with the England average, but it is still a leading cause of death. On the whole, the rate of premature mortality from cancer had been reducing in Warrington. Latest data, however, suggests these long-term improvements may be stalling.

Evidence shows that a range of factors impact on life expectancy and on the risk of premature death. These factors include; individual lifestyle and health-related behaviour, access to and quality of health and care services and wider factors related to socio-economic status such as education and employment. The JSNA Core document includes updated information on these aspects where available, an overview is provided below.

Health Related Behaviour - Smoking: At borough-wide level, estimates suggest that smoking prevalence has continued to decrease and estimates suggest that current rates for Warrington overall are around 13% - lower than the average for England. Findings from the 2013 local survey showed that prevalence remained high in more deprived areas and amongst certain population groups. The rate of smoking-related deaths within Warrington is higher than the average for England.

Health Related Behaviour - Alcohol consumption and related harm: Nationally derived estimates for Warrington as a whole suggest that just over a quarter of Warrington adults drink more than the recommended safe levels of alcohol consumption, this is similar to the average for England. However, the proportion binge drinking is significantly higher than England. Admission rates to hospital for alcohol related conditions are significantly higher in Warrington, with approximately 4,500 episodes per year. The rate of premature death from liver disease is increasing and local rates are significantly above the average for England.

Health Related Behaviour - Obesity prevalence: is an issue locally, and rates are increasing. Estimates suggest that 65% of Warrington adults are overweight or obese. This is higher than the average for England. Almost a fifth of adults in Warrington are physically inactive, this is lower than England. Around half of Warrington adults eat the recommended 5 portions of fruit or veg per day. This is lower than the average for England. Obesity and leading a sedentary lifestyle are major risk factors for conditions such as diabetes and Type 2 diabetes. Estimates suggest that if obesity prevalence continues to rise at current rate then by 2030 there could be as many as 15,000 diabetics in the borough, and the number of people living with high blood pressure could rise to over 55,000.

Wider determinants of health - Employment: The percentage of the working age population who are claiming out of work benefits has been slowly reducing nationally, regionally and locally. Latest figures in Warrington are lower than national and

regional averages, but there are stark internal inequalities between different population groups, and people with various long-term conditions and health issues.

Wider determinants of health – Housing: The number of homelessness households living in temporary accommodation in Warrington is significantly lower than the average for England. However, there is a real shortage of affordable homes within the borough.

Wider determinants of health – Educational attainment: This is closely linked to life chances, and evidence shows this in turn impacts on health. Over 70% of local young children achieve a good level of development at the end of Reception, which is better than the average for England. However the gap between those children entitled to free school meals (FSM) and the rest is significantly wider than the gap across England as a whole. The picture is similar in terms of GCSE attainment. Overall Warrington fares better than the average for England but there is a significant inequalities gap between children eligible for FSM and the rest.

Wider determinants of health – Social Mobility within Warrington is below average. The national Social Mobility Index incorporates a range of indicators to help better understand which areas provide young people from disadvantaged backgrounds the most opportunity to do well as adults. This data shows that Warrington is ranked within the lowest third of local authorities nationally. This is in contrast to the strong economy where Warrington ranks as one of the strongest economies in the country.

Analysis of health indicators across the life course shows a mixed picture for children and young people and highlights poorer outcomes for older people in Warrington compared to national averages. Some key points include:

Children and Young People: Indicators for children and young people show a slightly mixed picture:

- Infant mortality is in-keeping with the average for England and has continued to decrease over recent years.
- Breastfeeding rates are lower than the average for England across Warrington overall and substantially lower in more deprived areas of the borough.
- The percentage of Warrington mothers smoking during pregnancy is relatively low. However there are stark differences within Warrington, with much higher rates amongst more deprived populations.
- Childhood obesity levels are lower than the average for England, but still an issue for priority, given the long-term potential impact on health. Over one-fifth of 4/5 year olds, and almost one-third of 10/11 years are classed as overweight or obese.
- Hospital admissions resulting from self-harm and substance misuse for young people in Warrington are significantly higher than the average for England whilst admissions for from alcohol specific conditions are slightly higher.

Older People: Headline indicators suggest that the health of older people in Warrington is worse than the national average:

- Life expectancy at age 65 is significantly lower than the average for England for both males and females. Although rates are reducing, deaths from the major killers for people aged 65+ such as cancer, CVD and respiratory

disease are higher than the average for England, with CVD and respiratory being significantly higher.

- As age is a risk factor for many conditions, it is likely that the numbers of people with chronic and long-term conditions will increase substantially over coming years. Identifying people early is key to halting or slowing disease progression where possible and, for conditions like dementia, enabling appropriate information and support to be provided.
- Recorded prevalence of dementia within Warrington is currently lower than both regional and national averages. Disease prevalence models suggest that there are 2,300 residents with the condition; however just under 70% of these have received a diagnosis. This suggests there may be approximately 700 people with dementia as yet undiagnosed.
- People aged 65 and older have the highest risk of falling; around a third of people aged 65 and over, and around half of people aged around 80 and over fall at least once a year. Falling is a cause of distress, pain, injury, loss of confidence, loss of independence and mortality.
- The rate of emergency hospital admissions for hip fractures resulting from a fall amongst people aged over 65 in Warrington is significantly higher than the England average, with approximately 240 emergency admissions per year. Trend analysis shows consistently higher admission rates for injuries due to falls over the last 7 years.

Appendix 2: Outline Agenda for Health and Wellbeing Strategy Review Workshop

Health and Wellbeing Strategy Refresh – Stakeholder Workshop
Tuesday 17th July 2018 13.30 – 16.30
Winmarleigh House, 15 Winmarleigh Street Warrington WA1 1NB

AGENDA

1.) **Welcome**

2.) **Setting the context for a refreshed HWB Strategy**

3.) **Approach taken to the review and feedback to date**

4.) **What are the data telling us about population need?**

5.) **PLENARY DISCUSSION ON TABLES – Principles and long term aspirations of the strategy**

BREAK

6.) **Themed Workshop Sessions**
Starting, Living and Ageing Well & Strong Resilient Communities

7.) **Plenary feedback of key points from each group**

8.) **Next steps and close event**

Warrington
Health & Wellbeing Board
19 July 2018

Report Title	**Making Every Contact Count (MECC) Report**
Agenda Section	☐ A. Standard Items and Governance Matters ☒ B. Promoting Integration ☒ C. Development and Delivery of Health and Wellbeing Strategy ☐ D. Oversight of Important Strategies and Reports
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	To provide an overview of the MECC philosophy and make recommendations for moving forward with the MECC approach for Warrington.
Report author	Katie Donnelly - Health Improvement Specialist
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	1. To note MECC overview and lessons learnt for embedding locally 2. Support the recommendations.

Purpose

The purpose of this report is to provide the Health and Wellbeing Board with an overview of Making Every Contact Count (MECC), progress to date and proposals for moving forward. The board are asked to consider the lessons learnt to date and support the recommendations for further implementation.

1. Introduction

- The importance of investing in prevention and behaviour change approaches is increasingly emphasised in health and social care guidance and strategy[1]
- The promotion of health and wellbeing should be at the core of an organisation's design and service culture. MECC is not a separate entity but part of an overall behaviour change approach.
- The Warrington population should expect conversations which enquire about their health and wellbeing with advice and support being offered when appropriate.
- Making Every Contact Count is an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing.
- Organisations need to build a culture and operating environment that supports continuous health improvement through the contacts it has with individuals.
- Implementing the MECC approach will improve health and wellbeing amongst service users, staff and the general public and reduce health inequalities. MECC can assist organisations in meeting responsibilities towards their workforces, for example by improving staff health and wellbeing; and in enhancing staff skills, confidence and motivation.

2. MECC Overview

The fundamental principle underpinning the MECC approach is simple. It recognises that staff across health, local authority and voluntary sectors, have thousands of contacts every day with individuals and are ideally placed to promote health and healthy lifestyles. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

- **For organisations**, MECC means providing their staff with the leadership, environment, training and information that they need to deliver the MECC approach.
- **For staff**, MECC means having the competence and confidence to deliver healthy lifestyle messages, to help encourage people to change their behaviour and to direct them to local services that can support them.
- **For individuals**, MECC means seeking support and taking action to improve their own lifestyle by eating well, maintaining a healthy weight, drinking alcohol sensibly, exercising regularly, not smoking and looking after their wellbeing and mental health.

MECC focuses on the lifestyle issues that, when addressed, can make the greatest improvement to an individual's health e.g stopping smoking, healthy eating, improving mental health and wellbeing etc. MECC also allows conversations to take place around broader issues (wider determinants) that may impact on an individual's health and wellbeing , this can be effective in helping to tackle health inequalities. For example, some local services are using the MECC approach to engage local populations in managing debt, action towards gaining employment or in tackling housing issues.

3. National and Regional Context

The Five Year Forward View calls for a radical upgrade in prevention and public health. It outlines the importance of increasing the support available to help people to manage and improve their own health and wellbeing and emphasises the importance of ensuring that behavioural interventions are available for patients, service users and staff to support them to understand the impacts of behaviours on their health and to make behaviour changes to address these.

[1] Department of Health (2014) 'NHS Five Year Forward View'. The Care Act, 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The current expectation is that all NHS organisations will commit to MECC. From 2016 NHS England included MECC in its NHS Standard Contract Service Conditions in section SC8 on page 11:
The Provider must develop and maintain an organisational plan to ensure that Staff use every contact that they have with Service Users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in Making Every Contact Count Guidance. There are also national commitments put forward for a MECC approach in the recent CQUIN's for the hospital trust most notably around smoking and alcohol misuse.

Regionally the CHAMPS Public Health network, under the direction of the Directors of Public Health have prioritised the development and embedding of the MECC approach for the region across NHS, non-NHS organisations, voluntary sector and the wider community. A learning event has taken place to map current activity and to make pledges for moving forward across the region. Warrington are committed to be part of this process to ensure how we can align with best practice, learning and consistent implementation for the region.

4. MECC Benefits

There are clearly identified benefits in using MECC approaches at every available opportunity:

Organisational benefits:

- Implementing MECC can support organisations in meeting their core responsibilities towards their local population health and wellbeing and to meet obligations e.g. within the NHS standard contract, Accountable Care Organisations, Voluntary Sector Contracts etc.
- From a local systems perspective MECC can provide a useful tool for commissioners and providers to facilitate local discussions on how behaviour change activity can be supported and undertaken. The benefits of MECC can include improving access to healthy lifestyles advice, improvement in morbidity and mortality risk factors within the local population; and cost savings for organisations and the local health and social care economy.
- MECC activity can be incorporated as part of existing health improvement or workforce improvement initiatives. It provides a means of maximising the benefit from existing resources for improving population health. For example, it can include advice on low or no-cost activity, such as persuading parents to walk their children to school; or, as part of physical activity advice, encouraging increased use of existing community resources such as leisure centres and swimming pools.

Staff benefits:

- Knowledge, skills and confidence to have MECC conversations, to have consistent health and wellbeing information available and being able and supported to refer appropriately.

National/Population benefits:

- The population level approach of MECC can also help address equity of access, by engaging those who will not have otherwise engaged in a 'healthy conversation' or considered accessing specialised local support services, such as for weight management.
- It can also support health improvement activity within local communities, and provide an approach that reaches out to community members and groups. MECC can provide a lever to support communities in collaborating together.

Individual benefits:

- Opportunity to have regular conversations about health and wellbeing, have the most up to date/consistent information and advice and awareness of support available.
- Increased confidence and motivation to change, feeling empowered and supported to make changes to their behaviour.

5. MECC Warrington History

Warrington has been implementing MECC since approximately 2011, when initial strategic discussions took place and a MECC training package purchased from Stockport Primary Care Trust[2]. An implementation plan was initially overseen by a small task and finish group and activity included:

- A cascade trainer model developed across partners including the development of MECC resources
- An incentive to develop innovation and quality around MECC (CQUIN) with Acute Trust & Bridgewater, setting output and outcome measures for MECC delivery – this was for a 2 year period from 2012.
- Expectation to attend MECC training was built into public health and adult social care contracts
- Development of an evaluation framework including post training follow up

More recent developments have included:

- Delivery of training to over 1,500 staff from a range of organisations inc. health, local authority and third sector bodies.
- Development of a community MECC training package and community champion role
- Re-development of the training session and resources based on feedback from participants
- Embedding MECC within the Warrington Brand to ensure staff from primary care attend MECC training
- Working with Warrington Voluntary Action to explore how MECC can be embedded within their organisation, including cascade trainers for the third sector and MECC being built into voluntary organisations pledges.

6. MECC Lessons Learnt & Implementation Guide

The implementation model to help achieve the MECC ambition has three core components: organisational readiness, staff readiness and enabling and empowering the public. A number of lessons have been learnt from implementation to date, that can be considered under these three areas to inform future MECC developments:

Organisational readiness

- **Organisational buy in** - although there has been positive MECC activity it is has not had true organisational buy in to fully embed within organisational systems and processes. There is a need for organisations to understand MECC as a whole approach rather than just a training session for staff. To do this organisations need to build a culture and operating environment that supports continuous health improvement through the contacts it has with individuals.
- **Leadership –** key strategic leads need to be identified within partner organisations who are committed to a sustainable MECC approach and take responsibility to embed within their organisation culture and systems. Mechanisms need to be developed to ensure that the training and skills are utilised, staff are proactively supported and encouraged within the organisation to utilise, implement and further develop the skills they learn. Important that the MECC approach is consistently applied throughout the organisation.
- **Co-ordination & Processes** – Systems need to be in place to enable MECC conversations to take place and for activity and outcomes to be reported, for example, embedding within documentation, reporting system, HR policies, personal development plans etc.
- **Workforce development** – a commitment needs to be given by organisations to allow time, capacity and resource for workforce development to give teams the skills and confidence in the MECC approach.
- **Available information** – we need to ensure that there are appropriate resources available e.g. My Life Warrington, Happy? Ok? Sad?, MECC factsheets, Service cards etc and that these are kept up to date.
- **Responsive services –** if we are identifying people with lifestyle and wellbeing needs we need to ensure that we have got the services and pathways to support people as relevant and in a timely fashion. The development of Warrington Wellbeing over the last year has been a useful addition for this area.

Staff readiness

- **Ownership** - for staff to be engaged they need ownership of the implementation process themselves. They need to be included in any organisational roll out plans.

[2] The Stockport Health Chats model was the best practice example at the time.

- **Training** - Staff training is important to give staff skills and confidence to have health and wellbeing conversations. Although lots of staff are very skilled in having conversations, they feel less confident talking about specific topic areas. As we have a comprehensive public health training offer we are fortunate to offer not just MECC training but also topic specific training for additional development needs.
- **Staff support** - Need to consider; organisation support, how staff feel about their own health and wellbeing, environment they deliver in, time and capacity to have MECC conversations.

Enabling and empowering the public

- **Expectation** – conversations about health and wellbeing should be standard practice and established in such a way that the public expect to be asked about their health and wellbeing. The re-development of community MECC and the Community Champion role is key to this so the public are more aware of health and wellbeing and can offer peer support.
- **Self Care** – MECC isn't just about getting people into service but giving them the skills, confidence and empowerment to look after their own health and wellbeing. Again the health champion role is key to this. Isn't just about getting people into service but giving them the skills and confidence to self manage. It also highlights the importance of MECC not being seen as something that is 'done' separately to people but is part of an overall behaviour change approach.
- **Multiple Needs** - People often have more than one need for which they would like information, guidance and support. It is important that MECC addresses the wider determinants of health.

A MECC Implementation Guide has been developed to support people and organisations when considering or reviewing MECC activity and to aid implementation. A self-assessment checklist is available to support organisations in implementing and sustaining MECC programmes. It has been designed to be a simple check list that provides organisations with a set of quality markers to develop new training materials and to evaluate existing training against and highlight where changes or additions could be made to enhance the MECC approach. This guide would be useful for organisations to complete and develop plans for their organisation that can be shared and collated across Warrington.

7. MECC Evaluation

The biggest challenge is to measure the impact of local MECC activity and interventions. The response rate for our local follow up surveys have been low, so although we have got output data of the numbers trained over the years and from which organisations, we have got low post training response about the MECC conversations that have taken place as a result and the outcome of these conversations. As we acknowledge that evaluation is important to develop the programme, a robust evaluation framework needs to be developed moving forward. This is a piece of work that CHAMPS have acknowledged could be developed collaboratively. There is also some new national Public Health England guidance, a MECC evaluation framework, developed to support implementation and evaluation.

8. Current Costs

- A cascade trainer model has been implemented in Warrington, as part of this approach existing staff from a range of organisations deliver MECC training as part of their current role. It is important to develop and retain this commitment from organisations to enable MECC roll out at scale across Warrington. Without this commitment from organisations a greater financial investment will be required or training delivery will be a potential risk.
- Some external delivery is currently commissioned at a cost of £1,500 per annum (10 sessions). This will not be required if we have strong and consistent commitment to the cascade trainer model.
- Training materials and resources approx. £2,000 per annum

9. Recommendations

- Accountable Care Organisation partners and Health and Wellbeing Board to give strategic buy-in for the MECC approach to be embedded across all organisations / programmes of work.
- Each individual organisation to identify a MECC champion who will complete the MECC implementation checklist and develop an associated action plan for their organisation. This includes CCG, NHS, Local

Authority and the Third Sector. These leads will then need to work collaboratively to embed a consistent MECC approach for Warrington.

- Continue to support the work of the CHAMPS collaborative ensuring the resource across the region is utilised from maximum impact and learning, making use of any regional funding bids. This will ensure a consistent approach to MECC across the region which will support provider organisations such as hospital trusts who cover a broader footprint. One example of this will be a requirement for the Hospital Trust to embed the MECC cancer materials (developed through the regional network) across their organisation.
- Local Authority and partners to build MECC into the local health in business agenda ensuring it is a core part of the health and wellbeing agenda and that staff are given the time to attend MECC training and that the work environment is conducive to having MECC conversations.
- Local authority to make MECC training mandatory for staff.
- Partners (NHS, CCG, Third Sector) to also adopt MECC training as mandatory, with the taught session being the gold standard but all staff to complete the on-line training as a minimum requirement.
- Third Sector to adopt the MECC approach and build and embed the MECC principles across the voluntary sector. This will include building MECC into the volunteer pledge, and promoting MECC as best practice across all voluntary groups.
- Identify resource and capacity locally across the partnership for the cascade trainer model. Each organisation to identify a minimum of 2 cascade trainers to deliver a minimum of 4 sessions a year for the benefit of the Warrington partnership.
- All commissioners, CCG, Local authority etc to build MECC as an important behaviour change approach into provider contracts. Ensuring staff are identified as cascade trainers, that staff are trained and that the behaviour change ethos is adopted throughout the organisation.
- Agree a robust evaluation framework which is currently in development both at a regional and local level. This will require each organisation to build MECC evaluation into their existing systems and processes. Organisations need to consider how they will record MECC conversations and how they are going to report this. This needs to become consistent recording and reporting practices for all organisations.
- Options for how we best make this approach sustainable will continue to be explored. Partners in the Health and Wellbeing Board and Warrington Together are urged to create a collaborative model to sustain the MECC approach and maintain momentum.

10. Conclusion

It is clear that the MECC approach has already been adopted in Warrington although not to a scale that has led to true cultural and organisational change to sustain the MECC approach. Foundations are certainly in place to build on and with strong leadership and strategic buy in across the partnership, as well as making best use of the resource available through contracts and regional activity, we could effectively embed the MECC approach across our organisations and communities.

Warrington **Health & Wellbeing Board** 19th July 2018 1.30 pm, Council Chamber, Town Hall, Warrington	
Report Title	**Position statement on smoking and vaping**
Agenda Section	☐ A. Standard Items and Governance Matters ☐ B. Promoting Integration ☒ C. Development and Delivery of Health and Wellbeing Strategy ☐ D. Oversight of Important Strategies and Reports ☐ E. Information and Context ☐ F. Concluding Business
Type of Decision Required	☒ Formal Decision as to a Statutory Function ☒ Non-Statutory Advice, Guidance or Recommendation to Other Body ☐ Note or Endorse a Report or Action by Others
Report Purpose	To update the Health and Wellbeing Board on the current position for smoking and vaping in Warrington and key challenges.
Report of	Dr Muna Abdel Aziz, Director of Public Health
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	For the Health and Wellbeing Board to note and endorse the proposed recommendations regarding support to switch to vaping for adult smokers, alongside vape free and smoke free policy to protect others.

1. Background and context in Warrington

In Warrington, significantly fewer adults smoke than England and the North West. Warrington has had significantly better prevalence rates than England in the past three years. Based on the adult population survey 2016, 16.8% of adults (957,991 people) in the North West smoke, significantly higher than the England average of 15.5%. Adult smoking prevalence has fallen between 2012 and 2016 down from 20.4% in the North West and down from 19.7% in England. Warrington has had significantly better prevalence rates than England in the past three years.

There has been a small upward trend in smoking in Warrington in the routine and manual occupation group since 2014, compared to reducing trends regionally and nationally. Prevalence is higher in the routine and manual occupation group, 26.4% in Warrington compared to 26.5% in England and 26.8% in the North West.

The percentage of mothers living in the 20% most deprived areas of Warrington who continued to smoke at the time of delivery is significantly higher than other areas of Warrington. Across the North West, 13.4% of mothers smoke at time of delivery, significantly higher than the England average of 10.7%. During 2016/17 in Warrington, 122 women (8.3%) who gave birth said that they smoked at time of delivery (SATOD). This was significantly lower than both England and the North West. There has been a downward trend in England and the North West. This was also true for Warrington, apart from a slight rise in 2014/15. However, 16% of mothers from the most deprived areas said that they continued to smoke to the time of delivery; this steadily reduces to practically none in the least deprived areas.

Warrington has consistently had significantly better rates of smoking attributable hospital admissions than England for several years.
In the North West in 2016/17, there were 78,336 smoking attributable hospital admissions, 14.3% higher than the national average. Warrington had a rate of 1,390 hospital admissions per 100,000 population, compared to 1,685 in England.

Warrington previously consistently had significantly higher levels of smoking attributable mortality than England. However, the trends in Warrington and England have been gradually reducing, and Warrington is no longer significantly higher than England. In 2014-16, Warrington had a rate of 287.4 deaths per 100,000 population, compared to England's rate of 272.0.

Lung cancer is a big killer in Warrington in particular in the deprived areas and linked to smoking. The Warrington rate for cancer mortality in 2013 to 2015 was significantly higher than England. Cancer is now the leading cause of death in Warrington, and in the 3 years 2013-2015, there were 1,547 deaths due to cancer. The most common cancer causing death (2013-2015) was lung cancer (390 deaths) equivalent to the numbers of deaths from colorectal, breast and prostate cancer combined.

The rate of new cases of lung cancer diagnosed in Warrington (93.4 per 100,000) were significantly higher than the England rate (80 per 100,000). Additionally, the rate of new cases of lung cancer diagnosed in women from Warrington (83.5 per 100,000) was significantly higher than England (65.9 per 100,000).

Nationally and in Warrington, there is a strong relationship between the incidence rate of lung cancer and levels of socio-economic deprivation. This is likely to be a result of higher smoking rates in the most deprived areas.

More young people are trying e-cigarettes in Warrington, as young as 14 and 15. The Trading Standards Northwest Survey 2017 highlights an 8% increase in young people in Warrington claiming to have tried e-cigarettes compared to the 2015 survey. In 2017, 64% of young people surveyed had never tried an e-cigarette, and a quarter have only tried them once or twice. Meanwhile, 74% have never smoked. Most notable increases for e-cigarette use are amongst females and 15 year olds. Young males are more likely to have tried than females.

Early results indicate that young people are increasingly trying e-cigarettes before real cigarettes; more so among 14 year olds than 15-16 year olds. No significant differences by gender were identified in Warrington.

Despite being illegal, young people report mostly getting e-cigarettes from friends. A relatively lower number were buying themselves, and where they are it is mostly from off-licences, local shops and e-cigarette shops.

2. Highlights from the North West public health roundtable on e-cigarettes, June 2018

Safety

- There was a clear message that e-cigarettes are safer for smokers to switch to and that this is only for adult smokers. There are clear messages that e-cigarettes are not safer for non-smokers as they do not have prior nicotine addiction nor tobacco-related harm.
- There is no place for e-cigarettes for children and it is illegal to buy or sell under the age of 18. There is a worrying trend of marketing that appears appealing to young people and evidence of experimentation as young as 14 years. Anecdotal evidence was provided regarding branding and appeal that seem to be normalising vaping and seen to be ‘cool’.
- The group considered other vulnerable groups like pregnant women and inequalities where tobacco harm is clear and recognised the place for vaping within this for harm reduction in these disadvantaged groups where smoking prevalence is particularly high and engrained.
- All 15 North West prisons have become smoke free from 31 October 2017. E-cigarettes have played a major role accessible from the canteen with specific vaping policies and support from specialist smoking cessation services.

Licensing

- There is a requirement to notify the Medicines and Healthcare Products Regulatory Agency (MHPRA) but this does not constitute licensing, regulation or compliance.
- There remains a need to advocate for testing of specific products regarding their composition and potential health impacts; also to advocate for medicinal licensing for smoking cessation use as this will allow specific marketing only to this segment. At the moment, advertising rules mean they cannot claim health benefits or safer than tobacco. We would like to advocate for plain packaging and other ways to curb the marketing on ‘appeal’.

Commercial interest

- Smokers in the North West spend roughly about £2,050 per smoker, and it is costing the society an estimated £1.69 billion each year just in the North West. This represents one and a half times the tobacco duty revenue raised.
- The Independent British Vape Trade Association are independent of tobacco industry and are pushing for responsible trade and market position. However, there remains a commercial interest in vaping products.

- This commercial interest appears to be driving sponsorship in sports and marketing to non-smokers. The group consensus was clearly **not** to undermine smoke free policies (even though vaping does not come under this legislation). So there is a need for agreed position statements and policies for vaping in public places, workplaces, hospitals, including exposure to second-hand vapours).

Further work

- Public health lead organisations and trading standards continue to work together in the North West to advocate for reducing harm of smoking and protecting the health of smokers, non-smokers and disadvantaged groups, while building on the emerging evidence and the balance of risk.

3. Recommendations

Due to the emerging and sometimes conflicting evidence and the different perspectives on this issue, there is a balance required for the commercial interests and the health interests of smokers and non-smokers.

As local leaders, health and wellbeing boards should agree the position for their local area with regards to people and place, and the acceptable balance of risk.

In conclusion, the Warrington Health and Wellbeing Board are recommended to:

1. Continue to prioritise disadvantaged groups in reducing the harm of smoking. This includes specific actions in tobacco control and smoke free policies as well as recommending switching to vaping with the support of specialist smoking cessation services. The target audience for this focused work are the more disadvantaged groups in Warrington to augment smoking cessation advice and support; including adult smokers in disadvantaged areas, pregnant women who choose to vape rather than continue to smoke, and smoke free prisons.

2. The Board to recognise that disadvantaged groups in Warrington also have the highest challenges with regard to starting well and we should protect children and young people from both the harms of smoking and the harms of second hand vaping as a precautionary principle;

3. To note the attractiveness to young people of experimenting with vaping and/or smoking, and to lobby Public Health England, Department of Health and MHPRA regarding testing of specific products and licensing as medicines for nicotine replacement and smoking cessation.

4. The Board to advocate smoke free and vape free public places, in particular enclosed places and workplaces. To reference vape free policies into smoke free initiatives would seem to offer a sensible precautionary way forwards.

5. The position recommended by the Warrington Health and Wellbeing Board should be incorporated into the Warrington Health and Wellbeing Strategy.

HEALTH AND WELLBEING BOARD WORK PROGRAMME 2018/19

19th July 2018 REPORT DEADLINE – 9th July 2018				
Issue	**Methodology, Details, Purpose**	**Lead Officer(s)**	**Further Action(s)**	**Committee coding**
Health and Wellbeing Strategy progress update	*Feedback from the stakeholder workshop on developing new strategy*	Tracy Flute/ Muna Abdel Aziz		
Health and Social Care integration/transformation updates	*Various regular update items – for example STP, ACO, BCF. Lead officer: As appropriate – Andy Davies, Simon Kenton, Mike Alsop*			
Standing agenda items	*Update from reference groups Issues of strategic importance / key policy updates*			
Making Every Contact Count		Dr Muna Abdel Aziz		
Cheshire and Merseyside Prevention Framework		Muna Abdel Aziz		
Update on position with PHE regarding smoking/vaping	*Request at meeting in May, following concerns about use of vaping as a PHE-endorsed smoking cessation tool*	Muna Abdel Aziz		
Update on new hospital	*Standing agenda item*	Mel Pickup		

13th September 2018 REPORT DEADLINE – 3rd September 2018				
Issue	**Methodology, Details, Purpose**	**Lead Officer(s)**	**Further Action(s)**	**Committee coding**
Health and Wellbeing Strategy progress update	*Update on New Health and Wellbeing Strategy 2018-21*	Dr Muna Abdel Aziz		
Health and Social Care integration/transformation updates	*Various regular update items – for example STP, ACO, BCF. Lead officer: As appropriate – Andy Davies, Simon Kenton, Mike Alsop*			
Standing agenda items	*Update from reference groups Issues of strategic importance / key policy updates*			
Partner Duties under Homelessness Reduction Act	*new duties for partners under the new Homeless Reduction Act 2018 how that process would work and the possible use of housing champions within partner organisations*	Muna Abdel Aziz/Dave Cowley		Issues of strategic importance
JSNA annual update report		Tracy Flute		
Armed Forces Covenant		Bryan Magan		
Report from Healthwatch	*Schedule for summer 2018 as per request at Nov 17 meeting, postponed to September due to provider change*			
DAAT Update report	*Report from Mike Alsop DAAT Board*	Mike Alsop, Cathy FitzGerald		
System wide approach to dealing with hospital pressures	*Report postponed from May meeting*	Steve Peddie		
WSAB Annual Report	*Request as per 9 July 18*	Shirley Williams		

15th November 2018 REPORT DEADLINE – 5th November 2018				
Issue	**Methodology, Details, Purpose**	**Lead Officer(s)**	**Further Action(s)**	**Committee coding**
Health and Wellbeing Strategy progress update	*Final document for sign off HAWBS 2018-21*	Muna Abdel Aziz		
Health and Social Care integration/transformation updates	*Various regular update items – for example STP, ACO, BCF. Lead officer: As appropriate – Andy Davies, Simon Kenton, Mike Alsop*			
Standing agenda items	*Update from reference groups Issues of strategic importance / key policy updates*			

24th January 2019 REPORT DEADLINE – 14th January 2019				
Issue	**Methodology, Details, Purpose**	**Lead Officer(s)**	**Further Action(s)**	**Committee coding**
Health and Wellbeing Strategy progress update	*Theme updates (Living Well)*	Relevant theme lead		
Health and Social Care integration/transformation updates	*Various regular update items – for example STP, ACO, BCF. Lead officer: As appropriate – Andy Davies, Simon Kenton, Mike Alsop*			
Standing agenda items	*Update from reference groups*			

	Issues of strategic importance / key policy updates			
Update on Flu vaccination and flu-pandemic related issues	*As per discussion at meeting on 31st May 2018*	Muna Abdel Aziz		

28th March 2019 REPORT DEADLINE – 18th March 2019				
Issue	**Methodology, Details, Purpose**	**Lead Officer(s)**	**Further Action(s)**	**Committee coding**
Health and Wellbeing Strategy progress update	*Theme updates (Living Well)*	Relevant theme lead		
Health and Social Care integration/transformation updates	*Various regular update items – for example STP, ACO, BCF. Lead officer: As appropriate – Andy Davies, Simon Kenton, Mike Alsop*			
Standing agenda items	*Update from reference groups Issues of strategic importance / key policy updates*			

Future Work Programme Items			
Issue	**Rationale**	**Anticipated Timescale**	
Mental Health	*This remains a key issue for services in the borough.*	TBD	
Warrington Local Plan	*Update to board on the Warrington Local Plan and potential impact.*	Michael Bell	
New Hospital	*Short update to be added to each meeting going forward*		