

FACT SHEET ON ALCOHOL MISUSE

KEY FACTS

- 8.2 million adults age 16-64 (38% of men and 16% of women) are drinking above recommended maximum daily levels (2-3 units for women and 3-4 units for men per day) with 21% of men and 9% of women drinking more than twice this amount in a day.
- 7.1 million adults (32% of men and 15%) drink at hazardous or harmful alcohol levels and 1.1 million users (6% of men and 2% of women) are dependent on alcohol.
- Levels of drinking vary between different regions, with hazardous and harmful varying between 18% to 29% and alcohol dependence 1.6% to 5.2% of the adult population.
- Between 15,000 and 22,000 premature deaths in England and Wales each year are associated with alcohol misuse. Alcohol related liver disease accounts for over 4,500 of these – a 90% increase over the past decade.
- Nearly 5,000 (3.5%) cancer deaths per annum are attributed to alcohol. Alcohol is causally related to cancers of the oral cavity and pharynx, larynx, oesophagus and liver.
- Heavy drinking carries a severe risk of cardiovascular disease, with 1,200 deaths each year due to haemorrhagic stroke and 10% of all deaths due to hypertension associated with alcohol.

- 15-25% of suicides and 65% of suicide attempts are related to alcohol intoxication.
- 20-30% of all accidents and 1,700 associated deaths per year are linked to alcohol.
- Up to 35% of all A&E attendance and ambulance costs (around £0.5 billion) may be alcohol-related.
- Alcohol-related diseases account for 1 in 8 NHS bed days (around 2 million) and 1 in 80 NHS day cases (around 40,000).
- 150,000 hospital admissions each year are linked to excessive drinking 33,000 for alcohol-related liver disease. 30,000 and 36,000 of those admitted are diagnosed as alcohol dependent.
- Alcohol misuse is calculated to cost the health service £1.7bn per annum.

Inequalities exist

- More deprived communities are disproportionately affected by alcohol misuse. Whilst alcohol consumption is not any greater, admissions to hospitals and emergency hospital admissions for violence are higher in deprived areas.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- High-profile advertising campaign on binge drinking – Campaign to be launched 16th October 2006.
- Voluntary Social Responsibility Scheme for alcohol industry to run educational, community and campaigning functions – Agreement between Government and industry and health stakeholders to establish an independent Drink aware Trust announced by the Public Health Minister on 29th June 2006.
- National assessment of the need for alcohol services and a programme for their improvement – first-ever *Alcohol Needs Assessment for England and Guidance on the development of local programmes of improvement* published in November 2005. Models of care standards for alcohol treatment published in May 2006.
- Voluntary Social Responsibility Scheme for alcohol labelling – agreement reached with alcohol for introduction in 2007.

WHERE WE ARE HEADING

- Work with alcohol industry – government and the alcohol industry working together to promote culture change and target irresponsible practice including underage sales.
- Reducing health harms – GPs, A&E Departments and criminal justice settings working together to deliver screening and improve alcohol treatment and support for those drinking at a harmful levels.
- Young people and parents – targeting support at vulnerable teenagers and families affected by alcohol misuse.

- Policing and community safety – Police taking action to tackle alcohol related crime and disorder working with in partnerships with health and local licensing authorities.
- Promote greater awareness – providing information concerning the risks of alcohol misuse through national and local campaigns funded by the Government and alcohol industry.

WE WILL HAVE DELIVERED IF

- Most people understand alcohol units and the risks associated with drinking about the recommended low-risk levels.
- Alcohol related admissions to hospital stabilize and decrease over time. *This is a long-term aim as many conditions take years to develop. We may expect that this situation may get worse before we start seeing improvements in years to come.*
- Alcohol related attendances at A&E reduce and demand on GPs fall.
- Alcohol related criminal damage, serious violence and anti-social behaviour falls.
- Underage sales and harmful drinking levels in under-18s fall.
- The alcohol industry takes active steps to discourage drunkenness, enforce their industry standards for social responsibility and fund prevention activity.
- Fewer people, including young people regularly drink over low-risk levels or “binge” drink.
- Levels of alcohol-related violence, sexual assault and anti-social behaviour fall.

FACT SHEET ON

HELPING CHILDREN AND YOUNG PEOPLE LEAD HEALTHY LIVES

[See linked sheet on **sexual health**]

KEY FACTS

- The level of obesity in 2-10 year olds in England has risen from 9.9% in 1995 to 14.3% in 2004.ⁱ
- Rates of diagnoses of chlamydia in England have risen steadily since the mid-1990s. Rates are highest in young women aged 16-19.ⁱⁱ
- In 2004, one in ten 5-16 year olds had a clinically diagnosed mental disorder. The proportion of children with mental health problems has not changed since 1999.ⁱⁱⁱ
- Young people aged 16-24 are more likely than older groups to binge-drink. In 2004 33% of males and 24% of females in this age group reported binge drinking in the week prior to being surveyed.^{iv}
- Under 18 conception rates are reducing and are at their lowest level for over 20 years.^v
- Rates of regular smoking in 11 to 15 year olds have reduced from a peak of 13% in 1996 to 9% in 2005. In addition, the proportion who report never having smoked has increased over the last decade.^{vi}
- In 2005, 19% of 11-15 year olds reported having taken illegal drugs in the last year. This is down from a peak of 21% in 2003.^{vii}

- Since 1998 -99 the Government has reduced the number of children living in absolute poverty by a half and the number living in relative poverty by 700,000.^{viii}
- In 2005 the number of children (aged 0 -15, inclusive) killed or seriously injured in road accidents was 49% below the average for 1994-98.^{ix}

Early intervention lies at the core of driving forward a preventative approach to ill-health. Infancy, childhood and young adulthood are critical stages in the development of behavioural patterns that will affect people's health in later years. Investing in this generation of young people so that they grow to become stronger and better parents themselves will also benefit the generations to come.

Inequalities exist

- Early intervention plays a pivotal role in breaking the inter-generational cycle of health inequalities.
- Children and young people from disadvantaged backgrounds are more likely to experience poorer health outcomes as well as a range of broader effects such as lower educational attainment and poorer job prospects

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- Most areas who already have children's trust arrangements, have appointed a Director of Children's Services (DCS) and have a Lead Member for Children's Services in place. At June 2006, 141 local authorities reported having a DCS in post. Most local areas will have a children's trust by 2006 and all by 2008. (Children's trusts are partnership arrangements which bring together all services for children and young people in an area, underpinned by the Children Act 2004 duty to co-operate, to focus on improving outcomes for all children and young people). The children's trust planning and commissioning of services, including health services for children and young people, will be reflected in the Children and Young People's Plan.
- The Healthy Schools Programme is making good progress in engaging with schools. We are on track to achieve the *Choosing Health* commitment to have all schools gaining or working towards Healthy School Status by 2009. Already over 80% of schools are participating in the programme and we expect to have 55% of all schools meeting the new, more rigorous, criteria for Healthy Schools Status by December 2007.
- We are working with DfES to extend the Healthy School approach to early years settings and to increase the level of health promotion in a number of areas, particularly in supporting work to reduce obesity.
- The September target of 2,500 schools offering access to the core offer of extended services was exceeded and there are currently over 3,000 schools in this position (a large percentage of them based in areas of deprivation). The Training and Development Agency -Development (TDA-D) are now engaged with over 10,000 schools, and their Local Authorities, in developing extended services.
- As of 21 September 2006, 950 children's centres have been designated. We are on track to have 2,500 children's centres by March 2008. Children's centres provide advice to families of young children on opportunities to practice healthy lifestyles and can offer referral to more specialised health services where appropriate
- As outlined in *Youth Matters* (2005), *Youth Matters: Next Steps* (2006) and the *Social Exclusion Action Plan* (2006) the Government is committed to reforming and simplifying targeted support. This will enable a better service to be provided, built around young people's personal needs and circumstances and effectively reaching those who need support the most. Key to this will be drawing on and learning from best practice from a number of programmes that are running already, such as the Young People's Development Programme.
- International evidence demonstrates that intensive health-led home visiting during pregnancy and the first 2 years of life can radically improve outcomes for both mother and child, particularly in the most at-risk families. We therefore committed in the recent Social Exclusion Action Plan to establish 10 health-led parenting support demonstration projects to test these approaches in an English context.
- Four Teenage Health Demonstration Sites in Bolton, Hackney, Northumberland and Portsmouth were launched in August 2006. The sites will explore and evaluate how services can become better equipped and coordinated to meet the health needs of young people aged 11-19. The programme is being systematically evaluated and the learning will be fed into future commissioning frameworks and inspection systems so that it becomes embedded into mainstream activity. As outlined in *Our Health, Our Care, Our Say* (2006), the demonstration sites will be testing the Adolescent Life Check.
- We are working with the Royal College of Paediatrics and Child Health (alongside other relevant Royal Colleagues) to develop a training scheme in adolescent medicine for all doctors working with teenagers.

WHERE WE ARE HEADING

In recent years there has been unprecedented investment & priority given to children and young people and we need to continue to build on this investment and drive forward a:

- Strong focus on early intervention so that the causes of poor outcomes are effectively addressed.
- Reduction in health inequalities by reaching families who need the most support through delivery of the National Health Inequalities Programme, Choosing Health 2004), the National Service Framework for Children, Young People and Maternity Services (2004), Respect Action Plan (2006) and Social Exclusion Action Plan (2006).
- Society where all parents and families have access to information, advice and support and are confident and able to bring up their children in a way that promotes positive health and development and emotional wellbeing.
- Fully integrated and holistic service delivery approach for children, young people and their families.
- Workforce equipped to respond to the needs of children and young people.

WE WILL HAVE DELIVERED IF

- We reduce health inequalities by 10% as measured by infant mortality and life expectancy (cross-Government target).
- We halt the year-on-year rise in obesity among children under 11 by 2010 (DfES, DH, DCMS).
- We reduce the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health (DfES, DH).
- We reduce the use of Class A drugs and the frequent use of any illicit drugs among all young people under the age of 25, especially by the most vulnerable young people (HO, DfES, DH).

- We improve children's communication, social and emotional development so that by 2008, 50% of children reach a good level of development at the end of the Foundation Stage and reduce inequalities between the level of development achieved by children in the 20% most disadvantaged areas and the rest of England (DfES, SSU, DWP).
- We deliver by 2010 a 50% reduction in children killed or seriously injured in road accidents compared with the average for 1994-98 (DfT).
- We achieve improvements in a number of wider determinants of health such as educational attainment, employment and training opportunities and school attendance.

Data Sources

- i Health Survey for England, 2004. National Centre for Social Research and University College London.
- ii Diagnoses and rates of selected STIs seen at GUM clinics: 2001 – 2005. Health Protection Agency, 2006.
- iii Mental Health of Children and Young People in Great Britain, 2004. Office of National Statistics, 2005.
- iv General Household Survey 2004, Office for National Statistics, 2006.
- v Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies. Department for Education and Skills, 2006.
- vi Drug use, Smoking and Drinking among Young People in England in 2005. The Information Centre, 2006.
- vii Drug use, Smoking and Drinking among Young People in England in 2005. Ibid.
- viii Households Below Average Incomes (HBAI) 2004/05. Department of Work and Pensions, 2006.
- ix Road Casualties in Great Britain Main Results: 2005. Department for Transport, June 2006.

FACT SHEET ON DIET AND NUTRITION

[See linked sheets on **obesity** and **physical activity**]

KEY FACTS

- The School Fruit and Vegetable Scheme (SFVS) provides nearly two million four to six year old children in 16,000 local education authority (LEA) maintained infant, primary and special schools throughout England with a free piece of fruit or vegetable every school day
- Eating at least five portions of a variety of fruit and vegetables a day could lead to an estimated reduction of up to 20 per cent in overall deaths from chronic diseases, such as heart disease, stroke and cancer.
- Breastfed infants are 5 times less likely to be admitted to hospital with infections, such as gastroenteritis or respiratory infections, during their first year of life and are less likely to become obese in later childhood. Mothers who breastfeed are less likely to develop pre-menopausal breast cancer and are more likely to return to their pre-pregnancy weight.
- The evidence suggests that television advertising of food and drink has a direct impact of about 2% on children's food preferences and choices, and probably a much larger indirect impact.

- Salt intakes in the UK are around 9.5g per person per day. This is considerably higher than the 6g recommended by the Scientific Advisory Committee on Nutrition. High salt intake is associated with high blood pressure; and people with high blood pressure are three times more likely to develop heart disease and strokes and twice as likely to die from these diseases than those with normal levels.
- Processed foods contribute around 75% of salt to the UK diet.
- Saturated fat intakes exceed public health recommendations of 11% food energy (Committee on Medical Aspects of Food Policy). Excess intakes of saturated fat is associated with raised blood cholesterol levels and with coronary heart disease risk.

Inequalities exist

- There is evidence of higher fruit and vegetable consumption in more affluent social groups with 41% of AB's claiming they had eaten at least five portions yesterday, compared to 30% of C1C2's and only 24% of DE's (FSA Consumer Attitudes Survey 2005)
- The interim Infant Feeding Survey results 2005 reported an increase in the incidence of breastfeeding in England and Wales from 71% in 2000 to 77% in 2005.
- Those who are least likely to choose to breastfeed, are young, less well educated women and women from disadvantaged groups.
- Breastfeeding rates for 2005 have increased since 2000 among women from all socio-economic groupings. The largest increase is reported among women who have never worked 54% to 67%, and routine and manual workers 60% to 65%. Higher socio economic groupings also saw an increase with managerial and professional occupations from 86% to 89%, and intermediate occupations from 75% to 79%.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- There has been an increased focus on food in schools with the publication of the new standards for school food, development of new training qualifications for catering staff and establishing the School Food Trust. The Government has committed approaching £500 million between 2005 and 2011 to support the transformation of school food across the school day.
- In January 2006 we launched our 5 A DAY Young Independents campaign targeting young people between the ages of 16 to 24 who have left home and young mums and mums of young independents. The campaign aimed to encourage young people to 'just eat more' of a variety of fruit and veg every day through the promotion of the *Fuel for Living* recipe guide.
- We are working with FSA and industry to reduce the levels of salt in processed foods. Significant progress has been made and further commitments have now been received from 70 organisations across all sectors of the industry. In March 2006 the FSA published voluntary salt reduction targets covering 85 categories of processed foods that will help in reaching the average intake target of 6g per day by 2010.
- In March 2006, following extensive consumer research and consultation with stakeholders, the Food Standards Agency recommended an approach for front of pack labelling that uses traffic light colours to show at a glance whether the level of fat, saturated fat, salt and sugar in foods are high, medium or low.
- Sainsbury's, Waitrose and Co-op are already using the Agency's recommended approach and ASDA has also announced that it intends to use multiple traffic lights. McCains and Covent Garden Soup are applying our approach to their product range from September.
- We have implemented and evaluated Phase 1 of Healthy Start, a scheme that provides vouchers for children in low-income families that can be exchanged for fruit and vegetables as well as milk or infant formula.
- Ofcom concluded a consultation in June 2006 on options for restricting television advertising of food and drink products to children. It is currently considering responses and will make recommendations for further action in the autumn.
- We have established the Food and Drink Advertising and Promotion Forum in July 2005 made up of representatives from the advertising, food manufacturing and retailing bodies, academics and health and consumer organisations. The Forum is looking at how to strengthen rules for advertising in non-broadcast media including magazines and comics, cinema advertising, internet pop-ups, billboards, in-store promotions, packaging of foods and sponsorship

WHERE WE ARE HEADING

- We are considering how our universal programmes such as the School Fruit and Vegetable Scheme and Healthy Start can support targeted interventions for children who are overweight or obese.
- The School Food Trust is rolling out a series of events to help school cooks understand and implement the new school food standards.
- We are planning to extend the criteria for the 5 A DAY logo to be to processed foods that contain a portion of fruit or vegetables to support consumers in reaching their 5 A DAY. Guidance on applying the logo to children's foods will be published by mid 2007.
- The FSA is also leading on work with stakeholders, including the food industry, to identify ways to reduce the levels of saturated fat in the diet and address the current energy imbalance through product reformulation and consideration of portion sizes.
- The FSA will continue to encourage as many retailers and manufacturers as possible to follow its signpost labelling recommendations.
- Ofcom will announce the outcome of its consultation in the autumn, with new scheduling rules coming into effect in January 2007. New Committee on Advertising Practice (CAP) rules on content will follow shortly afterwards and will mirror, where possible, Ofcom's proposals.
- We are monitoring any change in the nature and balance of food advertising and promotion to children and will review the position in 2007. If we do not see significant progress as a result of voluntary action by 2007, then we will consider whether or not we need to take further action using new or existing legislation.

WE WILL HAVE DELIVERED IF

- We can establish good eating habits early in childhood as the evidence suggest this will have long-term impact on future diet, behaviour, health and wellbeing.
- We can translate public awareness of the 5 A DAY message into action. In 2005, only 30% of those questioned reported eating 5 portions a day, compared to 67% who were aware of 5 A DAY message (The FSA Consumer Attitudes Survey 2005). Simplifying messages on portion sizes and extending the 5 A DAY criteria to processed foods will assist in this process.
- All sectors within the food industry continue to work together with government to help consumers choose a healthy, balanced diet through:
 - increased availability of products with reduced levels of saturated fat, improved energy values (such as through improved total fat and/or sugars contents), and sensible portion sizes
 - more emphasis on the availability of fresh, healthier foods rather than processed foods relatively high in salt, fat and sugar, and
 - the use of front of pack nutritional signpost labelling which is shown to help consumers to make healthier choices at a glance in the shopping environment
- Breastfeeding rates increase by 2% a year and an increase in initiation of breastfeeding rates among women from lower socio-economic groups.
- We see a marked shift in the nature and balance of food and drink advertising and promotion to children across both broadcast and non-broadcast media that better reflects a healthy, balanced diet.

FACT SHEET ON HEALTH INEQUALITIES

KEY FACTS

- For life expectancy, although the national trend is for a widening gap between the Spearhead Group (the Local Authority areas with the worst health and deprivation indicators) and England, we are seeing signs of progress. Out of 70 Spearhead LAs, 13 are on track for both male and female life expectancy, a further 15 are on track for male life expectancy only, with another 14 on track for female life expectancy only.
- There are great differences in life expectancy, for example, males in Blackpool have a life expectancy eight years less than males in Kensington & Chelsea.¹
- The incidence of lung cancer among men and women in the most deprived areas is around twice that in the most affluent areas, and death rates are about two and a half times higher.²
- Death rates from circulatory disease (coronary heart disease, stroke and related diseases) are over 25% higher in the North West than in the South West of England.³
- Irish and Black Caribbean women are much more likely to have high blood pressure than women in the general population.⁴

- Infant mortality rates are falling in all socio-economic groups and the national rate currently stands at a historic low. It has fallen faster in higher social groups than in “routine and manual” groups resulting in a widening of the relative health inequalities gap since 1997-99. However, the latest data for 2002-04 show no further widening in the gap.⁵
- Mothers in “routine and manual” occupations are four times as likely as those in managerial and professional occupations to have smoked throughout pregnancy (29% and 7%).⁶ Smoking during pregnancy is a risk factor for low birth weight and premature births.
- In England & Wales, babies of mothers born in Pakistan have a death rate that is almost double the overall infant mortality rate.⁷
- Babies born to mothers who live in Birmingham are over six times more likely to die in their first year of life than babies born to mothers in Eastleigh, Hants.⁸
- In England, the proportion of Bangladeshi men who smoke is over 60% higher than the national average, and the proportion of Indian men who smoke is 20% lower.⁹
- Women in routine and semi-routine occupations are one and a half times as likely to be obese as women in managerial and professional occupations.¹⁰

Inequalities exist

- Health inequalities exist across a range of dimensions including social class, geographical area, gender, race and age as well as for a range of vulnerable groups.
- These inequalities are unacceptable and tackling them is a top priority for the Government. The most comprehensive programme ever in this country is in place to address them. While national action is important, the main contribution will be made locally.
- A key element in the Government's strategy to tackle health inequalities is the 2010 target to reduce infant mortality and improve life expectancy. While extremely challenging, this target is achievable.
- The focus for life expectancy inequalities is the Spearhead Group (the 70 LAs and the 62 PCTs that map to them). Achievement of the life expectancy element of the target will be assessed on the outcomes for this Group as whole in 2009-11.
- Wider action across government on social determinants, with a longer-term impact, is also important to ensure healthy behaviour throughout life so that the conditions that will cause future health inequalities are also addressed.
- This activity, encompassing programmes across many Government departments, along with longer-term disease prevention, was set out in the *Choosing Health White Paper (2004)*, the *Choosing Health Delivery Plan (2005)*, and in the national health inequalities strategy, *Tackling Health Inequalities – A Programme for Action (2003)*.
- Successfully completed the Early Adopter phase of the NHS Health Trainer programme at the end of March 2006. This included setting up the central project team, clarifying the objectives of the project and engaging with more than half the NHS (embracing all PCTs in Spearhead areas) to ensure the standards needed to make the initiative mainstream were rigorously assessed.
- Reviewed the life expectancy element of the 2010 target and developed a robust delivery plan. Although the gap is currently widening, it was concluded that the target is achievable and that the majority of Spearhead areas are on-track, or partially on-track, to meet the target.
- Made health inequalities one of the priorities for action in 2006-07 for the NHS, reflecting a growing recognition of the impact of social disadvantage on the health of the population.
- Reviewing the infant mortality aspect of the target with a view to sharpening local delivery. The review is being developed with support from DfES, DCLG, HMT and ONS and is expected to report in October 2006.
- Made health inequalities a mandatory target within Local Area Agreements (LAAs) from April 2007, helping to incentivise action across local partnerships to narrow the gap in mortality rates.
- Working with DCLG and other key departments, to roll out LAAs to a further 66 areas from March 2006. LAAs have shown great potential to deliver improvements in health and social care outcomes, and have proved an important catalyst for improved partnership working, particularly in areas with previously entrenched difficulties.
- Developing the new NHS Life Check project to provide people with an opportunity to assess key aspects of their health and well-being. There will be an initial focus on Spearhead areas with a wider rollout thereafter.
- Continue work with third party organisations such as the Army, the Prison Service and Initial Cleaning Services and engage other third party organisations to implement the Health Trainer concept in their environments
- Piloted the Communities for Health programme in 25 areas around England, to promote action across local organisations on a locally chosen priority for health. The pilots have implemented over 100 local activities to engage their local communities in improving their physical and mental health.
- Published, with DCLG, revised guidance on health and neighbourhood renewal to support local action to address health inequalities and deliver neighbourhood renewal.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- Reported developments against the target and the national cross-government headline indicators in *Status Report on the Programme for Action (2005)*. This highlighted the contribution of many DH and cross government programmes to the PSA target and to a long-term sustainable reduction in health inequalities.

- Commissioned the Improvement and Development Agency for Local Government to develop the capacity of local authorities to bring about transformational change on the ground. The programme will offer local authorities a range of capacity building support.
- Funded the Sustainable Development Commission's "Healthy Futures" programme to develop the capacity of NHS organisations to act as good corporate citizens. This included the development of a self-assessment model that, so far, 130 NHS organisations have registered to use.
- Implement NHS Health Trainers in Spearhead PCTs and engage those remaining PCTs not currently involved in the initiative in preparation for projected rollout in 2007/8.
- Work with the NHS Life Check project to develop the three Life Check products: Early Years, Adolescence and Mid-life.
- Including the health inequalities mandatory target in the final rollout phase for LAAs, and at the refresh stage of earlier LAAs.
- Rollout of the Communities for Health programme across England.
- Extending the healthy community collaborative approach to health inequalities Spearhead areas.

WE WILL HAVE DELIVERED IF

- At the same time as improving the health of the population and developing healthier communities across England, we meet the Government's 2004 PSA target to: *"reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth."*

Data Sources

- 1 Source: ONS data from NCHOD website, 2002-04 data used, figures being 72.8 Blackpool and 80.8 for East Dorset & K&C, difference = 8.0 years exactly.
- 2 Source: ONS cancer incidence and mortality registrations, presented in ONS "Geographic Variations in Health", 2001, based on 1991-93 data, Figs 9.6 and 11.5.
- 3 Source: ONS data from NCHOD website, 2002-04 data used, figures being 265.52 (NW) and 212.16 (SW) for persons all ages.
- 4 Source: Health Survey for England (HSFE) 2004, table 7.1, 7.3.
- 5 ONS Health Statistics Quarterly 28, and special analysis by ONS.
- 6 Source: Infant Feeding Survey 2005 early results.
- 7 Source: ONS Health Statistics Quarterly number 28 p 65, year being 2004, figures being 4.9 (England & Wales) and 8.9 (Pakistan) deaths per 1,000 live births.
- 8 Source: ONS data, published by National Centre for Health Outcomes Development (NCHOD) <http://www.nchod.nhs.uk>
- 9 Source: HSFE 2004 table 4.1, figures being 24/40 (higher) and 24/20 (lower).
- 10 Source: HSFE 2003, via British Heart Foundation (BHF) website <http://www.heartstats.org/temp/Chaptersp11.pdf>, Table 11.7 – 19% in professional/managerial, 29% in routine/semi-routine.

WHERE WE ARE HEADING

- Developing new, innovative, approaches and ways to systematise interventions and activities that will have the greatest – and fastest – impact on health inequalities.
- Further, refined, modelling of interventions within the Spearhead areas to reduce the life expectancy gap by 2010.
- More robust and rigorous performance management, to enable DH, SHAs and PCTs to drive successful delivery of the life expectancy element of the 2010 target.
- Developing National Support Teams for Health Inequalities and for smoking to disseminate best practice across all Spearhead areas, and to provide intensive support for those areas that need it.
- Linking the implementation of the infant mortality health inequalities review to the work on life expectancy element of the target and the national maternity delivery plan, due to be published in Autumn 2007.
- Completing the final rollout phase for LAAs so that all areas will have a LAA by March 2007.

FACT SHEET ON

HEALTH, WORK AND WELL BEING

KEY FACTS

- 35 millions working days per year were lost (28 million due to work-related ill health; 7 million due to injury) in 2004/05.
- Interventions can reduce sickness absence; the Port of London Authority introduced a sickness absence management policy which resulted in a 70 per cent drop in absence rates and Roll Royce plc has action plans which have reduced staff absence (saving £11 million in 2 years).
- The incidence rate of new cases of work-related ill health dropped by around 10% between 2000/01 and 2004/05.
- It is estimated that this costs the UK economy £12.7 billion per year.
- In addition to these costs, ill health among the working population places an additional burden on the NHS. This includes increased attendance at A&E for work related injury, increased burden on secondary care (e.g. musculoskeletal and mental health services) and increased attendances at primary care (e.g. GP visits for long term sickness absence).
- The Health and Social Care sector has one of the highest rates of sickness absence at 4.8%, where as the UK average is 3.4%.

- In 2005/6 212 workers were killed, a rate of 0.7 fatal injuries per 100 000 employed.
- 363,000 reportable injuries occurred, according to the Labour Force Survey, a rate of 1330 per 100 000 workers (2003/04).
- After two years on Incapacity benefit, a person is more likely to die or retire than return to work. Of those who reach their sixth week of statutory sick pay, one in five will stay off sick and eventually leave work.
- Musculoskeletal disorders and stress and other common mental health problems like anxiety and depression account for approximately 75 per cent of those suffering from work related ill health.¹
- Only 3% of companies have comprehensive provision of occupational health, safety and return-to-work support in place; 15% provide basic occupational health support. By improving access, we can make significant improvements to workplace health and safety.

Inequalities exist

- Sickness absence rates vary throughout the country with the area with the highest incidence, Yorkshire and Humber at 8.9 days lost per year per employer compared to only 5.1 days per employee per year in London.
- Health at work is one of the major levers for improvement in adult health and well-being (as set out in Choosing Health) and can contribute to PSA targets on coronary heart disease (diet, exercise and smoking) and cancer (smoking).

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- The Health, Work and Well-being Strategy was jointly published by the Department of Health, Department for Work and Pensions and the Health and Safety Executive in October 2005
- A National Stakeholders Council has been established including representatives of the key major stakeholders including the BMA, RCN, CBI, TUC.
- A Charter for Health, Work and Wellbeing has been launched and is available on the new HWWB Website www.health-and-work.gov.uk
- Well@Work is a two-year £1.6 million programme managed by the British Heart Foundation (BHF) and funded by Sport England, the Big Lottery Fund and the Department of Health.
- Investors in People UK are developing a Health and Wellbeing at Work Framework to incorporate within their accreditation standard and are piloting this in over 100 organisation.
- It aims to test the effectiveness of health promoting interventions in the workplace, relating to physical activity and other lifestyle behaviours such as diet and smoking; and develop and disseminate evidence based on what works in health promotion/ prevention in the workplace (in England), provided by 9 regional projects (started in Sept 2005 and due to run for 2 years).
- Professor Dame Carol Black has been appointed as the first ever National Director for Health and Work.

WHERE WE ARE HEADING

- We are working with the Department for Work and Pensions and the Health and Safety Executive to better link our existing programmes. Together we are also working to identify a number of work projects which can be developed as part of Health, Work and Well-being, where we can make the greatest impact on sickness absence and return to work in the shortest time. This will include work to identify "What is a good job", defining a good occupational health contract and how Government can lead by example. Further details of these work projects are being developed.
- A second pilot of the latest version of the H&W@Work Framework is underway with 100 organisations doing live assessments against the Standard alongside the H&W@Work Framework; and 20 organisations doing live assessments against liP's more sophisticated Profile tool. The evidence will help establish whether and how health and wellbeing can be rolled into the Standard and Profile when they are reviewed in 2007/8.
- As part of the national evaluation, baseline employee surveys and workplace audits were conducted between August 2005 and March 2006 and the process evaluation is ongoing. The majority of the two-year pilots are now half way through their funding period and are well-established within the various workplaces.

WE WILL HAVE DELIVERED IF

- Whilst much good work is already going on, both inside and outside of Government, in improving the health and wellbeing of working age people this strategy aims to bring all of this together. By working collaboratively on the Health, Work and Well Being agenda, highlighting the opportunities presented through closer working relationships across government, this ambitious strategy will effect real change for the working age population.
- As over 31% of the UK workforce is already working with the liP Standard, the adoption of H&W@Work Project would mean that health and wellbeing activity would need to be planned, evaluated and continuously improved for almost a third of the workforce, if organisations were to meet the new Standard of 2007/08.

- The aim of the Well@Work programme is to test the effectiveness of health promoting interventions in the workplace, relating to physical activity and other lifestyle behaviours such as diet and smoking. We will have delivered in relation to the 9 regional pilots if we have increased employee knowledge about health, provided opportunities for employees to participate in and become more involved in health promotion in the workplace and encouraged the development of a supportive work environment to encourage healthy choices. In addition, the programme will develop and disseminate an evidence base on what works in primary prevention/health promotion in the workplace in England.
- We have a network of larger, quality focused Occupational Health services in the NHS able to increase the delivery to small and medium sized organisations and to develop the highest quality of OH services to NHS workforce.

Data source

- 1 ESRC ESRC Seminar Series: *Mapping the public policy landscape 2006*

FACT SHEET ON OBESITY

[See linked sheets on **diet and nutrition** and **physical activity**]

KEY FACTS

- Obesity is one of the major public health issues in the developing world. It can lead to increased risk of heart disease, type 2 diabetes and some cancers.
- In 2003, 22% of men and 23% of women were obese. By 2010, without intervention, this figure will increase to 33% of men and 28% of women. In 2003, 43% men aged 16 and over and 33% of women within the English population were overweight.
- Childhood obesity in 2-10 year olds in England has risen from 9.9% in 1995 to 14.3% in 2004. If we do nothing, 20% of 2-10 year olds will be obese by 2010, or over 1 million children.
- Although the rise in obesity cannot be attributed to any single factor, it is the imbalance between energy in and energy out that is the root cause.
- The Health Survey for England 1998 showed that 37% of men and 24% of women met the current recommended physical activity target (participation in activity of at least moderate intensity for at least 30 minutes on at least 5 days a week).

- Children have more sedentary leisure pursuits than in the past. Other lifestyles changes have also had an impact, such as children being driven to school rather than walking and less outdoor play (both often due to parental fears about traffic and stranger danger).
- *Tackling Child Obesity – First Steps*, a joint report from the National Audit Office, Healthcare Commission and Audit Commission published earlier this year, put the cost of obesity to the NHS at around £1b a year, with an additional £2.3b – £2.6billion a year to the economy as a whole.
- Obesity is responsible for more than 9,000 premature deaths per year in England (6% of all deaths compared to 10% for smoking), 36% of cases of hypertension, 47% of cases of type 2 diabetes and 15% of angina. In addition, obese people are more likely to suffer from low self-image and confidence, social stigma, reduced mobility and a poorer quality of life.

Inequalities exist

- During the 1990s obesity was significantly higher amongst adults and children in lower socioeconomic groups. It is still highest in the lower socio-economic groups, but it is increasing for all. The strongest current indicator that a child will be obese is that both parents are overweight or obese.
- In 2001-2002 levels of childhood obesity were highest among semi-routine and routine households (17.1%) and lowest among managerial or professional households (12.4%) The National Statistics Socio-Economic Classification (NS-SEC) suggests that there could be a correlation between parental obesity and socio-economic status.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- A large number of people and organisations need to be involved in changing behaviours across society. That is why we have established a joint PSA target across the three Government departments with the greatest interest and capacity to address the problem – the Department of Health, the Department of Culture, Media and Sport and the Department for Education and Skills.
- We have introduced an annual national weighing and measuring exercise to record the heights and weights of pupils in Reception and Year 6 in primary schools. The data from this exercise will enable us to get a better understanding of children's needs in this area and will enable schools, PCTs, Local Authorities and other partners to target resources and interventions where they are most needed. We will be able to use this data to track local progress and target our efforts more effectively.
- Distribution of an Obesity Care Pathway in May 2006, including advice for GPs and a self help guide for their patients who are concerned about their weight.
- Taking forward proposals to change nature and balance of food advertising and promotion to children.
- Development of definitive guidance on prevention and management of obesity (NICE) due in November 2006.

- Development of a national healthy living social marketing programme, building on 'small change, Big Difference, for launch at the beginning of 2007.
- 75% of schools achieved or working towards *Healthy Schools* status.
- Investment in school sport and club links.
- Support for families through Children's Centres and extended schools.
- Introduction of new standards for school meals from September 2006 as well as the development of new training qualifications for catering staff and establishing the School Food Trust. The Government has committed approaching £500 million between 2005 and 2011 to support the transformation of school food across the school day.
- Providing 350 million pieces of fruit per year to schools in England.
- Supporting better information needs for consumers e.g. through front of pack signpost labelling.
- DCMS and DfES are making good progress on the National School Sport Strategy (with £1.5 billion being invested in the five years to 2008) and is on course to meet their target of at least 75% of 5 to 16 year olds doing a minimum of 2 hours of PE and school sport by the end of this year.
- Working with industry on salt, fat and sugar reduction in processed foods.

WHERE WE ARE HEADING

- Raising awareness through a social marketing campaign aimed at families and a proactive communications strategy aimed at key delivery stakeholders such as health professionals and teachers.
- Improved targeting of existing universal programmes, such as the School Sports strategy, Healthy Schools, Healthy Start etc so that, where possible, they provide additional support for children who are overweight or obese.
- Targeted interventions based on treatment and secondary prevention of overweight and obese children, based on the available evidence.

- Improved work across the delivery chain to ensure incentives and performance management is aligned at national, regional and local level, including further work on supporting the contribution Local Area Agreements can make to tackling obesity.
- We will be involving all levels of the delivery chain to ensure consistent messages, particularly to the NHS and front line professionals working with children and their families.
- Developing a National Support Team for Obesity to disseminate best practice across Spearhead areas, and to provide intensive support for those areas that need it.
- We are working to develop the evidence base about targeted weight management programmes and will be keeping a close watch on emerging evidence and disseminating the results quickly.
- We will also work with Primary Care Trusts to implement the forthcoming NICE guidance on tackling obesity, and incorporate the principles that the guidance shows to be effective.
- We will draw on the weighing and measuring data to produce a national report setting out national prevalence rates, providing regional and local reports to Strategic Health Authorities, PCTs and Local. We will encourage and support local agencies to better target existing programmes on obesity (e.g. some of the best performing School Sports Partnerships will use the data to target overweight and obese children as part of their programmes).
- Schools are healthier places – nearly 18,000 schools are already on the Healthy Schools Programme, of which nearly 10,000 have achieved healthy school status.
- Breastfeeding rates increased by 2% or greater each year.
- Advertising to children better reflects a healthy balanced diet.
- We launch the Healthy Living social marketing campaign linked to 'small change Big Difference' and promoting healthy active living messages, especially to parents/carers of under 11s resulting in healthy choices being made and fitter healthier children.
- 85% of 5 to 16 year olds spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum by 2008.
- All schools have school travel plans by 2010 and there is an increase in proportion of children walking and cycling to school.

WE WILL HAVE DELIVERED IF

- We halt the year on year increase in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole.
- PCTs/LAs and partners (through Local Strategic Partnerships) use the Weighing and Measuring data to monitor local performance and target action.
- People want to change their lifestyles and take responsibility for their health, with Government supporting people making these changes and influencing factors that fall within its remit.

FACT SHEET ON PHYSICAL ACTIVITY

[See linked sheets on **diet and nutrition** and **obesity**]

KEY FACTS

- An active lifestyle is the key to improving and maintaining health. However, at present only 37% of men and 24% of women are sufficiently active to gain any health benefit. Three in ten boys and four in ten girls aged 2 to 15 are not meeting the recommended levels of physical activity.
- Physically active people have 20-30 per cent reduced risk of premature death and up to 50 per cent reduced risk of major chronic disease such as coronary heart disease, stroke diabetes and cancer.
- It can reduce the risk of developing type 2 diabetes by up to 64 per cent in those at high risk of developing the disease.
- Regular physical activity is associated with a reduction in overall risk of cancer, including a clear protective effect on colon cancer, and is associated with a reduced risk of breast cancer after the menopause.
- Besides the human costs, the report highlighted an estimate for the cost of inactivity in England to be £8.2 billion annually. This excludes the contribution of physical inactivity to overweight and obesity, whose overall cost might run to £6.6–£7.4 billion per year according to recent estimates.

Inequalities exist

- People of higher socio-economic status take part in more physical activity in their leisure time. Rates of walking are two-thirds higher in professional classes compared with unskilled manual groups.

WHAT HAVE WE DONE SINCE CHOOSING HEALTH

- We have commissioned a Schools Physical Activity Toolkit to bring together all the different strands of physical activity in schools. The project will result in a user-friendly resource that guides schools toward meeting the criteria of the national Healthy school physical activity theme. Alongside the toolkit, deliverables will include training for Healthy Schools co-ordinators.
- The National School Sport Strategy is targeting action through School Sport Partnerships to increase sports participation by the groups that traditionally have been marginalised by sport e.g. increasing girls' participation in PE lessons and out of school activities by placing emphasis on communication, teamwork, problem solving and health-related exercise and creating a women's fitness group (which includes mother and daughter sessions).
- Cycling England has added to the £10 million of DfT funding from 2004/05 with a further £5.625 Million for the 'Links to Schools' programme which provides safe walking and cycling routes to schools from residential areas via the National Cycle Network. Over 450 schools are expected to benefit by 2007.
- Bikeability, the new cycling proficiency standard for the 21st century, has been developed by Cycling England and its partners. Bikeability will be rolled out across the country from Spring 2007, with the aim that by 2009 half of all year six pupils in England will be trained through schemes awarding the new standard.
- DfT has been working with large employers and employer organisations to promote the spread of employer-backed cycling schemes encouraging employees to cycle to their workplace, including the publication of 'Cycle to Work' guidance on tax-efficient cycle loan schemes.
- Through the joint DH/DfES/Youth Sport Trust 'Schools on the Move' initiative, we have piloted the use of pedometers in schools both as a tool to support a wide range of curriculum topics and to increase awareness amongst pupils of the need to be active. The initiative included resource materials for schools, teachers and young people to help integrate pedometers into the life of the school. The pilot demonstrated that pedometers can increase children's activity levels and encourage them to walk to school.
- DCMS has published *Time for Play: encouraging greater play opportunities for children and young people*. This document sets out what Government is doing on play and discusses recent changes in the delivery of children's services. The BIG Lottery Fund have made available £155m to Local Authorities to create, improve and develop play provision, and develop innovative practice.

WHERE WE ARE HEADING

- Finishing touches are being made to a National Delivery Plan to seize the opportunities for improving both physical and mental wellbeing, and tackling health inequalities, presented by London's hosting of the 2012 Olympic and Paralympic Games. This will help deliver a fitter Britain by 2012 and a lasting health legacy following the Games.
- The Minister of State for Public Health, Caroline Flint was asked by the Prime Minister in April 2006 to lead an inter-ministerial group to increase physically activity and fitness in the community. Initially her focus will be on emphasising the importance of ministers championing work that is already underway and a cross-government approach.
- The inter-ministerial group on physical activity is made up of DCMS, DCLG, DfT, DfES, Defra and delivery bodies such as Sport England. The group will encourage a 'Small Change Big Difference' approach, looking at supporting the public to make minor changes that will make a long-term difference to their health.
- The group will focus on adults who are least active and try to build physical activity into daily routines, including walking and cycling to work (active travel) and look at the role of employers. The group will also explore options for delivery mechanisms and how to optimise data collection.
- The biggest gains to health and to the economy will be made by encouraging more physical activity among the sedentary, the overweight/obese and older people. The Health Survey for England published in August, forecasts levels of obesity in adults and children for 2010. For men, obesity prevalence is expected increase from 22% in 2003 to 33% in 2010. There is also a clear link between sedentary, inactive adults and obesity.
- DCMS and DfES, are making good progress on the National School Sport Strategy (with £1.5 billion already invested over five years to 2008). The strategy is on course to meet their target of having at least 75% of 5 to 16 year olds doing a minimum of two hours of PE and school sport a week by the end of the year.

WE WILL HAVE DELIVERED IF

- The Healthy Living social marketing campaign linked to Small Change Big Difference, and promoting healthy active living is launched in 2007 with a focus on parents/carers of under 11s.
- 85% of 5 to 16 year olds spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum by 2008.
- Every school has a travel plan by 2010 and there is an increase in proportion of children walking and cycling to school.
- People have increased their levels of activity towards the target of 5 x 30 minutes moderately strenuous exercise every week.
- There is a reduction in the proportion of adults engaged in only 30 minutes or less of physical activity per week.
- The proportion of adults who walk and cycle either for travel, or for recreation increases.
- The proportion of adults engaged in sport increases by 3% by 2008, particularly from the priority groups.

FACT SHEET ON

SEXUAL HEALTH

[See linked sheet on **Children and Young People**]

KEY FACTS

- Some Sexually Transmitted Infections (STIs) continue to increase particularly among the under 25s and other high risk groups.
- Chlamydia is the most common STI and affects an estimated one in ten sexually active young women. If left untreated it can lead to pelvic inflammatory disease, ectopic pregnancy and infertility.
- Rates of diagnoses of chlamydia in England have risen steadily since the mid-1990s. Rates are highest in young women aged 16-19.ⁱ
- Delays in access to diagnoses and treatment lead to more people being infected with STIs.
- Estimated 58,300 people living with HIV in the UK at end of 2004. 34% (19,700) estimated to be unaware of their diagnosis
- 7,275 new HIV diagnoses in 2004. Gay and bisexual men continue to be the group most at risk of HIV transmission in the UK and there were 2,185 new diagnoses in 2004
- Heterosexually acquired HIV accounted for 4,287 new diagnoses in 2004. Nearly three-quarters (73%) of the total number of heterosexually acquired infections were probably acquired in Africa.

- Although teenage pregnancy rates are at their lowest for 20 years, England still has one of the highest rates in Western Europe.
- Nearly a quarter of all pregnancies in England and Wales end in abortion.

Inequalities exist

- STIs disproportionately affect young people. Both STIs and Teenage Pregnancy are more prevalent in those living in deprived areas with poor educational attainment and low aspiration. People living in London are also disproportionately affected by poor sexual health.
- HIV disproportionately affects young gay men (under 40) with lower educational qualifications and black African communities.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- Improving access to GUM services is one of the priorities for action in 2006-07 for the NHS,
- Targets to introduce a maximum 48 hour wait for all GUM appointments by 2008 are included in NHS delivery plans and are being closely performance managed by SHAs and DH. Waiting times have improved from 38% of patients seen within 48 hours in May 2004, to 57% in August 2006.
- We have established a National Support Team for sexual health to support delivery in the field and target those most challenged in making progress.
- We have introduced continuous data monitoring for GUM waiting times to enable more accurate data to be collected and strengthen performance management.
- We produced an extensive guide to rolling out the National Chlamydia Screening Programme (NCSP) across England which was distributed to every PCT. The aim of the guide was to facilitate the standardisation of the structures, processes, and outputs of the programme while still allowing local flexibility.
- We published the second annual report of the NCSP and held the second annual chlamydia screening conference which Caroline Flint the Public Health minister addressed.
- We have contracted Boots to undertake a two year pathfinder to test the acceptability of chlamydia screening in pharmacies. We have contracted TNS (expand) to undertake an independent evaluation of the pathfinder.
- We have published jointly with DFES "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies". The guidance asks local areas to review their strategies in the light of the findings from visits and new analysis and reflect them in their forward plans. It also sets out what support will be provided nationally to support local delivery.
- DFES have published *Teenage Pregnancy: Accelerating the Strategy to 2010* which has a stronger focus on tackling the underlying causes of teenage pregnancy. The document highlights that in future particular attention will be paid to the 21 areas with increasing rates of conceptions.
- In conjunction with the DfES, the DH has continued to deliver the *RU Thinking* campaign aimed at younger teenagers; launched the *Want Respect? Use a Condom* campaign aimed at those older teenagers most likely to become teenage parents and have developed a new, soon to be launched, sexual health campaign targeting 18 – 24 year olds who engage in sexually risky behaviour and who are most at risk of contracting STIs.
- We have seen uptake of HIV testing in GUM amongst gay and bisexual men increase from 64% in 2003 to 79% in 2004. In heterosexuals, uptake of testing increased from 54% in 2003 to at least 75% in 2004.
- We have strengthened national HIV health promotion work as a result of additional investment of £1million. A new African health promotion campaign on condom awareness was launched in May 2006.
- We have supported the implementation of guidance from the National Institute for Clinical Excellence (NICE) on long acting methods of contraception.
- We have developed an assessment toolkit for competencies for providing more specialised sexually transmitted infection services within primary care. This is a toolkit for assessing the range of competencies in skills, knowledge and attitudes required to manage STIs, when delivering more specialised sexual health services within primary care. The toolkit is transferable to any primary care setting. It complements the "Competencies for providing more specialised STI services within primary care" (2005) and provides a framework for assessing the competencies in that document.

WHERE WE ARE HEADING

- We will closely monitor progress towards the GUM access target with a focus on those who need to make most progress. And we will provide a range of support in the form of good practice guidance and for those facing the biggest challenge more intensive help via the Sexual Health National Support teams.
- We will use opportunities from the new Commissioning agenda to improve the quality of commissioning in sexual and reproductive health and ensuring local needs assessments are undertaken.
- Through the new campaign increase the acceptance of condoms as a 'must have' item; individuals being prepared to use condoms and carry them as part of their 'going-out kit' and an understanding of why using a condom is essential.
- We will continue work to ensure that the offer and uptake of HIV testing is increasing.
- We will be monitoring the progress of all areas towards their teenage pregnancy reduction target with a particular focus on areas with high and increasing rates.
- We will improve national and local data and metrics through the development of the new GUM waiting time data and the rollout of the Common Data Set for sexual health.
- We will continue to develop a high quality multi-disciplinary workforce in particular ensure that nurses are working in new and innovative ways in sexual and reproductive health. More sexual health nurses are now working in primary care settings, helping to improve access to services for patients. We are pursuing inclusion of sexual health in the pre-registration nursing curriculum nationally a core group of sexual health nursing experts have devised suggested core criteria for inclusion in the future pre-registration nursing curricula. We will also be approaching the Council of Deans to accept these criteria for inclusion in the programmes they deliver.

WE WILL HAVE DELIVERED IF

- High quality sexual health services are easily accessible in all parts of the country and we have met the target that nobody has to wait more than 48 hours for a GUM clinic appointment from 2008.
- We have a well trained, flexible and creative multi-disciplinary workforce able to deliver optimum care in all health care settings, where services can be taken to the people, and a variety of models of delivery can be considered.
- There is an increased focus on prevention and high quality health promotion material is widely available and the stigma surrounding sexual health and STIs is reduced.
- Chlamydia prevalence reduces through the achievement of high screening volumes in the National Chlamydia Screening Programme.
- We stop and reverse the increase in STIs.
- We achieve, in the long term, the normalisation of condom use and a steady reduction in the rate of STIs among the target group.
- Reductions in proportion of HIV remaining undiagnosed continues.
- New HIV transmissions reduce and reductions in late diagnosed HIV as awareness of benefits of testing increases.
- There is improved access to a wider range of contraceptive methods, particularly long-acting methods and see a reduction in numbers of unintended pregnancies and rates of repeat abortions.
- We stop and reverse the rates of increase in teenage pregnancies in the worst performing areas and reduce rates of under 18 conception in all areas in line with the PSA target.

Data source

- i Diagnoses and rates of selected STIs seen at GUM clinics: 2001 – 2005. Health Protection Agency, 2006.

FACT SHEET ON TOBACCO

KEY FACTS

- Smoking is the UK's single greatest cause of preventable illness and early death. More than 106,000 people in the UK die from smoking each year.
- Around 10 million adults in England smoke.
- There are now around 1.2 million fewer smokers than in 1998.
- 25% of adults smoke (23% of women, 26% of men).
- 9% of 11–15 year olds are smokers.
- Over 70% of smokers say they want to give up.
- Smoking causes a wide range of illnesses, including various cancers (lung cancer is the most significant), respiratory diseases and heart disease.
- Smoking costs the NHS between £1.4 and £1.7 billion a year in England.
- Secondhand smoke causes lung cancer, heart disease among other conditions.

Inequalities exist

- Smoking is the single biggest cause of health inequalities.
- People in lower socio-economic groups are more likely to work in places where they will be exposed to secondhand smoke.
- Some 31% of people in routine and manual groups smoke, compared with 26% of the total population.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- A recently published independent assessment of effective tobacco control policies across Europe placed the UK top of all 25 EU countries. And second only to Iceland across a wider group of European countries.
- NHS Stop Smoking Services have expanded to help more people than ever before successfully make a supported quit attempt, with over 800,000 people remaining quit at 4 weeks in the three years to April 2006.
- Legislated to ban internet advertising of tobacco products.
- A public consultation on introducing picture warnings onto tobacco packs has recently finished. Picture warnings will start to appear on tobacco products from later in 2007.
- The Health Act 2006 provides Ministers with the power to increase the age of sale from 16 to 18. A public consultation on increasing the age of sale to 18 has recently finished.
- Brought forward proposed legislation to create new powers to ban retailers from selling tobacco products if they repeatedly flout the law. A public consultation on how best to implement this has recently finished.
- The Tackling Tobacco Smuggling Strategy was launched in March 2000, investing more than £200m in new staff and new technology. By 2003/04 the strategy had succeeded in cutting the illicit cigarette market by a quarter, to 16%.
- A refreshed strategy "*New Responses to New Challenges: Reinforcing the Tackling Tobacco Smuggling Strategy*" was announced in Budget 2006 aimed at reducing the illicit cigarette market still further, to 13%, and reducing the size of the illicit hand rolling tobacco market by 1200 tonnes by 2008.
- Heavyweight innovative and effective campaigns have continued to be a central plank of tobacco control activity. The tobacco campaign won two gold awards for effectiveness at the Institute of Practitioners in Advertising awards.
- In 2004 the *Choosing Health* White Paper set out the Government's commitment to shift the balance significantly in favour of smokefree environments.
- In summer 2005 a detailed consultation on the exact make up of the proposed smokefree legislation was published. Some 57,000 plus responses were received.
- In autumn 2005 the Health Bill containing the smokefree clauses was published and, as a result of the consultation, the implementation date was brought forward to summer 2007.
- In January 2006 a free vote on the smokefree clauses in the Health Bill was announced for Labour MPs.
- In February 2006 MPs voted, by a 200 majority, to extend the smokefree provisions of the Health Bill to include all licensed premises and private membership clubs.
- In July 2006 the Health Act received Royal Assent.
- A consultation on the detailed smokefree Regulations under the Health Act 2006 has recently finished and legislation is on track to be in place for summer 2007.
- The NHS and Government Departments are on track to become smokefree by the end of 2006.

WHERE WE ARE HEADING

- To successfully deliver reductions in smoking levels to those set out in the Government's PSA target the tobacco programme needs to: first, continue to do those things it is currently doing effectively, that is, in particular, run effective hard hitting mass media campaigns and ensure NHS Stop Smoking Services are performing to a high standard and NRT and new cessation aids appearing on the market are offered appropriately to smokers. Second to introduce new evidence based policies to enhance the current programme alongside continuing to deliver well those policies that are working.
- We will have established a national support team on tobacco control to disseminate best practice across all Spearhead areas, and to provide intensive support for those areas that need it.
- We will continue to target routine and manual groups to contribute to delivering reductions in health inequalities, in addition to specific work in Spearhead areas.
- The key new initiatives moving forward are:
 - Through summer 2007 legislation, have eliminated the health risks from secondhand smoke in virtually all enclosed public places and workplaces.
 - Introduced hard-hitting picture warnings onto tobacco products to better communicate the health risks of their addiction to smokers.
 - Decide whether and when to increase the age of sale from 16 to 18.
 - Introduce new powers to ban retailers from selling tobacco products if they repeatedly sell to underage children.
 - Continue to reduce the availability of cheap smuggled tobacco.
 - Work with our EU partners to introduce a standard for reduced ignition propensity cigarettes to cut home fires caused by cigarettes.
 - Work through the WHO FCTC process to improve the effective regulation of tobacco products, tackle international smuggling and combat cross-border advertising.

WE WILL HAVE DELIVERED IF

- We hit our overall target of reducing adult smoking rates to 21% or less by 2010; and smoking rates among routine and manual groups to 26% or less by 2010.

FACT SHEET ON WORKFORCE

KEY FACTS

- The public health workforce includes staff from a wide range of organisations and agencies across the NHS, local government and other sectors.
- Public health practice spans the 3 domains of health improvement, health protection and health and social care quality. The delivery of public health extends from health promotion and health improvement to tackling the wider/social determinants of health, measures to protect health and ensuring effective evidence based commissioning of health and social care services.
- The public health workforce includes:
 - the wider workforce who have a role in improving health and reducing inequalities e.g. teachers, social workers, housing officers
 - front line public health practitioners e.g. health visitors, school nurses, community development workers and environmental health officers
 - public health consultants and specialists who provide strategic leadership to the public health effort
 - academics who contribute research evidence on what works to improve health.

- The Public Health Workforce development strategy is about building up a vision to strengthen the capacity (headcounts) and capability (skills and competence) across these groups, in order to meet public health goals.
- The Workforce development strategy is also about matching workforce numbers and functions to public health need, including the needs highlighted by new policy developments e.g. *Our Health, Our Care, Our Say*.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- Developed a comprehensive career framework for public health which is competency based and can be applied to the whole range of public health roles across NHS and non- NHS organisations.
- Strengthen leadership for public health across the wider workforce, including at senior levels of organisations through the provision of dedicated programmes.
- Supported the modernisation of competence based public health specialist training and assessment programmes.
- Established 9 regional 'teaching public health networks' to strengthen the public health skill building across undergraduate, postgraduate and lifelong learning programmes of study offered by the higher and further education sectors.
- Highlighted the contribution and training and career development needs of the health improvement/health promotion workforce through the publication of *'Shaping the Future of Public Health: Promoting health in the NHS'*.
- Established a plan to increase school nurse capacity and modernise their roles through the publication of *'School Nurse: Practice Development Resource Pack'* and *'Looking for a school nurse?'*
- Increased public health specialist capacity through top up training for specialists who are competent across all 3 domains of public health, as well as for specialists with expertise in specific and highly complex areas of public health practice.
- Developed the skills of the wider workforce to undertake public health roles e.g. engaging with pharmacists to increase their health improvement work with the local community.
- Improving public health skills in key health care professions such as sexual and reproductive health workforce, sports and exercise medicine and dentistry.
- Funded additional F2 training posts for medical graduates to increase exposure to public health principles early in their careers.

- Established Sports and Exercise Medicine as a speciality discipline.

WHERE WE ARE HEADING

Building on the current developments we are planning to:

- Strengthen the competence of the workforce to tackle the whole range of lifestyle and social determinants of health. Including on the one hand issues such as nutrition and physical activity, and on the other, planning future transport and built environment which are conducive to health improvement.
- Embed public health into the commissioning agenda of the NHS.
- Work with the regulators to review how regulation may be strengthened and improved for the whole public health workforce.

WE WILL HAVE DELIVERED IF

- We have a well trained and highly motivated public health workforce who can deliver on the national priorities for health.
- Other professionals and agencies are engaging with and contributing fully to improving and protecting health and improving the quality of health and social care.

FACT SHEET ON MENTAL HEALTH

KEY FACTS

- One in six adults may suffer with a mental health problem in England.
- The total number of patients receiving care from MH services for 2004-05 was approx 1,100,000.
- General practitioners spend on average 30 per cent of their time on mental health problems.
- Stress related conditions are the second commonest reported cause of sickness absence.
- Of the 2.72m working age people that were claiming incapacity benefits in August 2005 over 1m listed mental and behavioural conditions as their main disability.

Inequalities exist

- People with severe and enduring mental illnesses such as schizophrenia and bi-polar disorder are at increased risk of a range of physical illnesses and conditions, including coronary heart disease, diabetes, infections and respiratory disease and greater levels of obesity. They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease.
- The recently published Disability Rights Commission (September 2006) report into physical health inequalities experienced by people with mental health problems confirms that people with a mental illness are much more likely than others to have significant health problems.
- Black and minority ethnic communities have poor access to and are less satisfied with mental health services.
- Although women more frequently consult their GP for mental health problems, men are three times as likely to take their own lives. Suicide remains the leading cause of death among young men, and in this age group the risk is four times that for women.
- In January 2005, we published a five- year action plan to build on and take forward the proposals in *Delivering Race Equality: A Framework for Action*, which outlined a whole-system approach to tackle the inequalities experienced by people from Black and minority ethnic communities in their access, experience and outcome of the mental health system of care. We also published guidelines for promoting mental health with black and minority ethnic communities (*Celebrating Our Cultures – 2004*).
- In October 2005, NIMHE published *Making it possible – a good practice guide to improving people's mental health and well-being*. The document is designed to assist people who work in local communities to raise the profile of public mental health and to help focus their efforts on the activities which are most likely to make the most impact.
- The importance of mental health and emotional well-being in people's capacity to get the most out of life is also recognised in the White Paper *Our Health, Our Care, Our Say*. It highlights the positive steps everyone can take to improve their mental health and well-being that were set out in *Making it possible: Improving Mental Health and Well-being in England*, and makes a commitment to ensure that mental well-being is included in the social marketing strategy currently being developed to support Choosing Health.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- The national suicide prevention strategy, first published in 2002, takes a public mental health promotion approach to reducing suicide and made it a key goal to promote mental health. We have funded three mental health promotion pilots focused on exploring how better to meet the needs of young men, and published the evaluation report *Reaching Out* in 2006. The latest annual report on progress with the suicide prevention strategy published in 2006 shows suicide at an all-time low, with a welcome small downturn in the rate for young men.
- Progress has been made on delivering the Social Exclusion Unit report's (June 2004) recommendations on mental health and social exclusion, concerning employment of people with mental health problems through the National Social Inclusion Programme (NSIP) *Pathways to Work* programme.
- The NSIP has recently published commissioning guidance on vocational service for people with severe mental health problems This guidance has been developed in liaison with the Department for Work and Pensions.

- Earlier this year, the Chief Nursing Officer's review of mental health nursing recommended that mental health nurses attain the skills required to improve the physical well-being of people with mental health problems. £7 million is in baselines for 88 "spearhead" PCTs to employ well-being nurses for the next two years. We have recently published new guidance to help PCTs plan for, design and commission and monitor services that will deliver improved physical health and well-being for people living with severe mental illness.

WHERE WE ARE HEADING

- We would wish to see service users provided with more information, through information prescriptions and the care planning process, giving service users more control over their care and their choice of treatment.
- Create a tariff or equivalent effective payment system for mental health services, which would ensure that any tariff of services provides incentives to commissioners to invest in public mental health and in the physical health of those with mental health problems.
- Provide stronger primary care commissioning, informed by better patient feedback, across a broad range of mental health services, not just acute care, to take greater account of physical health care needs.
- Provide better integration of health and social care services around the needs of individuals with mental health problems, by means of moving to better community – based services in line with Creating a patient led NHS and *Our health, Our care, Our say*.
- Provide better access to 24/7 services for mental health emergencies.

WE WILL HAVE DELIVERED IF

- We improve the mental health and the well-being of the general population, and reduce mortality rates 'from suicide and undetermined injury by at least 20% by 2010' (2004 Government PSA target).

FACT SHEET ON SOCIAL MARKETING

KEY FACTS

- In 2004 we held one of the biggest consultation exercises amongst people in England asking the population what information/advice they needed from government to help them lead healthier lives. The results demonstrated that the public wanted advice and information about health issues to be both better targeted and more relevant to their actual circumstances.
- The White Paper that followed, committed Government to a new promoting health strategy – underpinned by social marketing techniques and values. This cross government strategy would begin the gradual process of delivering behavioural change by putting people, especially people living in disadvantaged communities at the centre of policy and service development.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- Launch of Small Change, Big Difference in April 2006 by the prime Minister. This was the first initiative to recognise the need for a paradigm shift in emphasis and approach in order to achieve behavioural change. The core message was that for many people, small changes in behaviour could have significant impact on their overall health outcomes. This was particularly relevant for audiences between 40-60 yrs and is the first example of the value of deeper audience understanding and segmentation.
- With the active support of the DCMS, DFES and DfT we are currently developing the first 'promoting health' social marketing strategy for England. An extensive piece of work over the last few months has involved the scoping and mapping of PSA targets, policy priorities and existing clinical and consumer focussed research in order to begin the process of developing detailed audience segments. These segments will enable us to more accurately pin-point those people that have traditionally proved hardest to reach especially in deprived communities.
- Better understanding of what lies at the root of the behaviours is how we we will achieve lasting change. One of the core insights of the obesity social marketing strategy that we are currently developing with DCMS, DFES and DfT was that people do not want more or better information in order to change their behaviour. Research is showing us that people often have deep-rooted behaviours and we cannot tackle these with simple and efficiently targeted messages, alone. More importantly, these behaviours were found not to be issue specific but a recurring indicator of combined behavioural problems in relation to drugs, alcohol and sexual activity.
- We have concluded that it is the underpinning behaviour that we must tackle and this cannot be achieved through purely an issue-based approach. Evidence has been particularly compelling on teenage mums where sexual activity goes hand in hand with alcohol and drug abuse and where single issues campaigns will likely fail.

WHERE WE ARE HEADING

- We will launch our new strategy early in 2007. A critical part of our new approach is ensuring that we target people through more appropriate means than traditional government rhetoric. For many audiences we fail to achieve 'traction' on a number of issues simply because they are not willing or prepared to be told 'what to do' by government. The combined power of the voluntary and commercial sectors, in partnership with government, will deliver more appropriate channels and means to influence and change entrenched behavioural norms.
- Health improvement partnerships will be flexible and enable the partner organisations to use the combined knowledge, service or reputation as a recognised brand, expert or NGO to make a lasting impression on the behaviours and choices that each person, within a targeted group, makes about their lifestyle choices.

WE WILL HAVE DELIVERED IF

- We have developed new ways of working within the directorate that enable us to develop our new cross issue social marketing programmes that are based on real understanding of how people live their lives and what they want in order to help them change.
- We have achieved measurable impacts on PSA targets across the health improvement agenda by developing a range of audience 'insights' and galvanised our partners in other government departments and key external stakeholders to help us deliver a number of new cross issue promoting health social marketing programmes.
- We have established genuine two-way partnerships agreements between ourselves and the business and NGO/charity sectors in order to maximise the potential impact of our work programme.

FACT SHEET ON

LOCAL GOVERNMENT & COMMUNITIES

KEY FACTS

- Seventy local authorities form the health inequalities Spearhead Group – the fifth of areas with the worst health and deprivation indicators.
- Local and central government have agreed “shared commitments” where local government can make a real difference and contribute to national priorities, including promoting healthier communities and narrowing health inequalities.
- Four local authorities were awarded Beacon Council status for healthier communities in 2005.
- Under the Comprehensive Performance Assessment, the Audit Commission will assess what local authorities have done, with their partners, to achieve their ambitions for the promotion of healthier communities and the narrowing of health inequalities.

WHAT WE HAVE DONE SINCE CHOOSING HEALTH

- Working with DCLG and other key Departments, built on the 21 pilot Local Area Agreements (LAAs) agreed in March 2005, to roll out LAAs to a further sixty six areas from March 2006. Although still early days, the LAAs in place have already shown great potential to deliver improvements in health and social care outcomes and have proved an important catalyst for improved partnership working, particularly in areas with previously entrenched difficulties. LAAs have been extremely valuable in bringing people together, and providing a framework for joint working to address local issues.
- Piloted the Communities for Health programme in 25 areas around England, to promote action across local organisations on a locally chosen priority for health. The pilots have implement over 100 local activities to engage their local communities in improving their physical and mental health.
- With DCLG, published revised guidance on health and neighbourhood renewal, to support local action to address health inequalities and deliver neighbourhood renewal.
- Commissioned the Improvement and Development Agency for Local Government (IDeA) to develop the capacity of local authorities to bring about transformational change on the ground. The programme will offer local authorities a range of capacity building support, including: peer review, comprising an intensive organisational health check against a benchmark; a new health module for the existing Leadership Academy; special advisers/peer support through the Peer Clearing House; and a programme to develop understanding of commissioning.
- Funded the Sustainable Development Commission's Healthy Futures programme to develop the capacity of NHS organisations to act as good corporate citizens. This included the development of a self-assessment model that will help NHS bodies to assess their progress towards becoming a good corporate citizen. Launched in February 2006, the web based inter-active model enables organisations to self assess their performance, receive a score of their progress and receive advice. So far, 130 NHS organisations have registered to use the model.

WHERE WE ARE HEADING

- Complete the final roll out phase for LAAs so that all areas will have a LAA by March 2007.
- Include the health inequalities mandatory target in the final roll out phase for LAAs and at the refresh stage of earlier LAAs.
- Roll out the Communities for Health programme across England.
- Agree a compact to guide the way DH will work with the NGO Forum, a member organisation of a wide range of not-for-profit organisations involved with public health working at the national level.
- Extend the healthy community collaborative approach to health inequalities Spearhead Areas.

WE WILL HAVE DELIVERED IF

- In addition to developing healthier communities across England, we reduce health inequalities.