Report to:	**Audit, Best Value and Community Services Scrutiny Committee**
Date:	**10 June 2014**
By:	**Acting Director of Public Health**
Title of report:	**Business case proposals for one off funding from Public Health**
Purpose of report:	**To provide Scrutiny with fuller clarity of the four business cases receiving one off funding from the Public Health unallocated spend.**

RECOMMENDATION: The Committee is recommended to note the business cases (appendices 1 – 4) and the overview of the agreed funding options.

1. Financial Appraisal

1.1 There are no specific additional financial implications associated with this report. Activity is within the scope of the agreed public health budget allocation funded through the ring-fenced public health grant.

2. Background

2.1 The Public Health Commissioning Group reviewed four outline business cases in autumn 2013 relating to suicide prevention, addressing obesity, safer streets and reducing tobacco consumption. The group agreed to the proposed option for each business case. An update was provided at the March Scrutiny meeting and Scrutiny requested that the business cases be brought back to ensure a thorough understanding of what each business case entailed. Scrutiny requested that it be kept more closely informed of future one-off projects and be involved in the discussion where appropriate. It was agreed that any new business cases would be brought to a meeting at an early stage to allow appropriate Scrutiny review and input. The total costs of the agreed proposals are set out below:

Business Case	Cost	Appendix
Suicide Prevention	£988,500	1
Safer streets	£1,000,000	2
Tobacco free East Sussex	£430,000	3
Addressing obesity	£285,000	4
Total	**£2,703,500**	

3. Business Cases

3.1 Suicide prevention: It was estimated in 2009 that the average cost per completed suicide for those of working age in England is £1.67m. This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals. The financial costs incurred by the coastguard, police, chaplaincy and SPFT are substantial.

The East Sussex suicide rate is significantly higher than the England rate and has been for many years. On average there are 25 – 30 deaths a year, at cliffs in East Sussex. Approximately 40% of the deaths that take place at these cliffs are East Sussex residents. However the proportion of Section 136[1]s cases that are local residents is higher at 60% to 70%. There is good evidence to support increased investment to prevent suicide at cliffs in the Eastbourne area and to reduce suicide rates in East Sussex. Reducing access to the means of suicide, with a particular emphasis on high-risk locations, is one of the key areas for action in the influential cross-government outcomes strategy 'Preventing Suicide in England', published in 2012.

This business case was made for five interrelated strands at a cost of £988,500:

- infrastructure development and associated actions in hotspot areas
- secondment of a mental health nurse or similar to support voluntary agency
- training for community organisations and primary care staff
- support for those affected by suicide, or attempted suicide, and their families and carers

[1] Section 136 of the Mental Health Act gives the police authority to remove a person from a public place and take them to a 'place of safety' if they believe the person is suffering from a mental illness and is in need of immediate treatment or care.

- pilot non-statutory 'place of safety' to address aftercare issues and reduce Section 136 cases.

3.2 Safer Streets: East Sussex as a County, and four of the five Districts and Boroughs have significantly higher rates of people killed and seriously injured (KSI) on the road. Causality of KSI's is complex, however regardless of cause, accidents which happen at lower speeds are less likely to cause serious injury than those at higher speeds. Analysis of KSI data in East Sussex indicates that around half of all KSIs take place on roads were the legal road speed is 30mph. Evidence from across the UK and elsewhere suggests that in areas where 20mph speed limits have been implemented KSI rates have reduced in those areas. Reducing road speeds in residential areas can have other public health benefits such as increasing walking and cycling and increasing social connectedness.

The business case was made for a resource of £1 million to be set aside to support a multi-agency, behaviour change approach to Safer Streets enabling a Countywide phased roll out of 20mph road speed in appropriate residential areas, subject to the agreement of partners. Given the multi- agency nature of Safer Streets this project is ideal to demonstrate the Council's commitment to its new public health duties and aligning resource to the most pressing public health issues for the local population.

3.3 Tobacco free East Sussex: Smoking kills more people than alcohol, suicide, road accidents and illegal drugs put together. Whilst rates of smoking are decreasing across East Sussex as whole in line with the national experience, smoking rates in Hastings and Eastbourne have not declined between 1997 and 2011. Most people who smoke start smoking when they are children. Smoking rates in young people have not decreased. 17% of young people in East Sussex as a whole, and 25% of young people in Hastings aged 14/15 say that they smoke occasionally or regularly. Evidence suggests that the best way to prevent people from taking up smoking and supporting smokers to stop smoking is through co-ordinated multi- agency approaches.

This business case was made for one-off investment of £430,000 in three strands of work identified by the Tobacco Partnership as priorities:

- Social marketing campaign to increase awareness of harms of illegal and illicit tobacco and increase reporting of where these products are being sold
- Training for partner agencies staff to understand harms to them and their communities of illegal tobacco (and smoking) and convey this to people they are in contact with
- Increased enforcement activity e.g. Test Purchasing in priority locations based on increased intelligence generated through social marketing

3.4 Addressing Obesity: Weight management services were not commissioned by the Primary Care Trust. People need to access support and services and make lifestyle changes as early as possible and we need to ensure that the services they access are the least resource intensive for their level and type of need. We need to intervene early to prevent children developing lifestyles which make them more likely to become obese when they are older. It is anticipated that over time demand for weight management services will increase. To manage this expected demand more needs to be done now to make sure that people access support and services and make lifestyle changes as early as possible, and the services they access are the least resource intensive for their level and type of need.

In East Sussex, levels of obesity are similar to the England average, with around one quarter of all adults estimated to be obese (with the exception of Hastings, which has significantly higher rates). In 2010/11, 20.5% of Reception Year and 31.4% of Year 6 pupils measured were recorded as overweight or obese across East Sussex. For both year groups, there was a strong positive relationship between deprivation and obesity prevalence.

The business case was made for a referral management system and additional primary prevention in children and young people for one year at a cost of £285,000 (plus £15k recurrent from the Public Health budget). This will be to test the impact prior to developing a service.

4. Recommendations

4.1 Scrutiny is recommended to note the business cases (appendices 1 – 4) and the overview of the agreed funding options.

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SUICIDE PREVENTION

Executive summary

The business case includes five interrelated work streams.

The areas are:

- infrastructure development and associated actions in hotspot areas
- secondment of a mental health nurse or similar to support voluntary agency
- training in ASIST (Applied Suicide intervention skills training) and MHFA (Mental health first aid) for community organisations and primary care staff
- support for those affected by suicide, or attempted suicide, and their families and carers
- pilot non-statutory 'place of safety' to address aftercare issues and reduce Section 136[2] cases
- in addition, project management and independent evaluation of these activities was agreed.

The focus of this work is addressing both the overall suicide rate and suicide hotspot issues. East Sussex has a significantly higher suicide rate than other areas of the country. On average there are 25 – 30 deaths a year, at cliffs in East Sussex.

The Section 136 activity associated with cliffs is high. In the first three months of 2013/14 a total of 30 people were taken to a place of safety in Eastbourne. Of these, 17 were taken to hospital and 13 into custody. Approximately 40% of the deaths that take place at these cliffs are East Sussex residents. However the proportion of Section 136s cases that are local residents is higher at 60% to 70%.

The focus of the work is based on:

1. recommendations of the cross-government National Suicide Prevention Strategy prepared by the Department of Health
2. national guidance and evidence on actions to be taken at suicide hotspots and the impact on localities of suicide hotspots
3. the public health evidence review for the Annual Public Health Report 2013
4. observation of factors reducing suicidal activity at Beachy Head e.g. there were no recorded suicides during the time the area was restricted due to the outbreak of foot and mouth disease
5. consideration of the costs of looking after those covered by Section 136 of the Mental Health Act
6. recommendations from national and local experts
7. consideration of funding principles applied to NICE guidance on quality adjusted life years
8. the local East Sussex Suicide Prevention Plan.

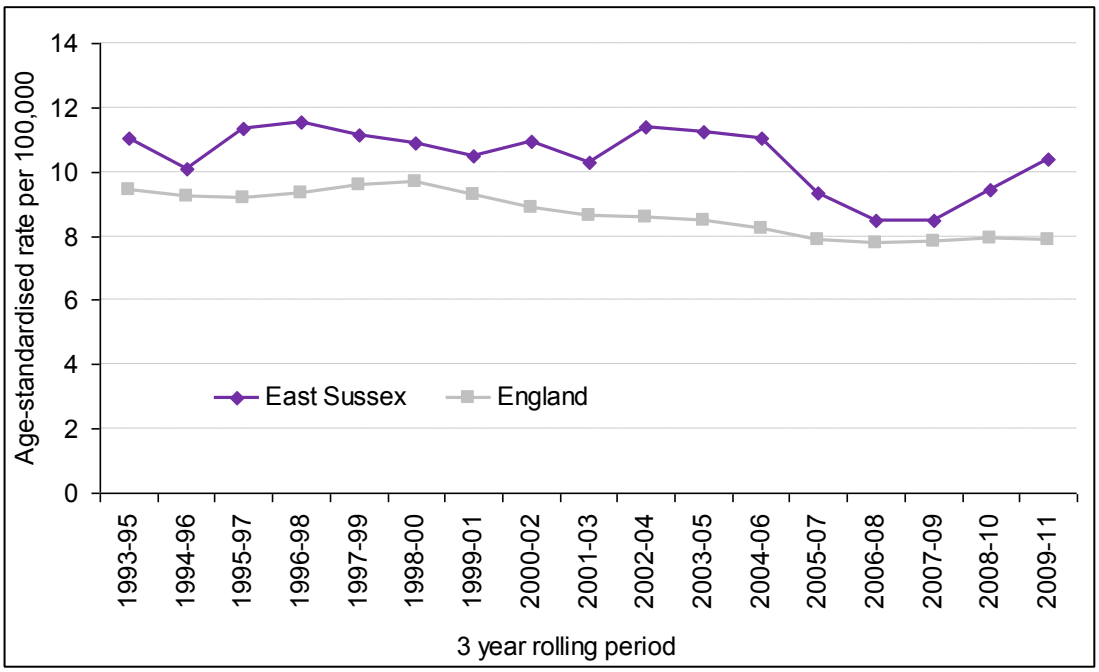
[2] Section 136 of the Mental Health Act gives the police authority to remove a person from a public place and take them to a 'place of safety' if they believe the person is suffering from a mental illness and is in need of immediate treatment or care.

1. Strategic context

There has been limited statutory investment in suicide prevention in Eastbourne. Big Lottery funding for back-up third sector support, in the form of the Survivors of Suicide programme, ended three years ago. The only service dedicated to supporting suicide prevention associated with Beachy Head is the Beachy Head Chaplaincy Team which is a voluntary organisation that provides patrols at the site.

Research has shown that suicide hotspots tend to increase overall suicide rates in local areas. As the chart below demonstrates, the suicide rate in East Sussex – which is a Public Health Outcome Framework indicator – is significantly higher than the England average and has been for many years.

Figure: Mortality from suicide and injury undetermined



Source: Compendium of Population Health Indicators, Health & Social Care Information Centre www.indicators.ic.nhs.uk/webview/

Nationally, the single largest cause of death in suicide is hanging and this pattern is also found in East Sussex, although jumping is a proportionately larger cause in East Sussex.

The very high number of suicides at cliffs in the Eastbourne area is considered by the multi-agency Risk Management Group to be linked to the ease of driving and parking a car so close to the cliff edge. In some places the road comes within 50 meters of the cliff edge. During the foot and mouth outbreak deaths reduced significantly, due to lack of access. There have been recent changes in car parking arrangements at the site and a longer term assessment of the need to move roads due to cliff erosion has been undertaken. These developments help to make possible the infrastructure changes proposed in our bid.

An environmental survey of the cliff area was conducted on the advice of Professor David Gunnell, Bristol University in 2010. The purpose of an environmental survey of a suicide hotspot area is both to recommend feasible measures to restrict access to the means of suicide and to provide accountability, demonstrating that solutions have been thoroughly investigated. It is necessary to commission a further more detailed report to examine the potential for technological support and infrastructure changes to the area.

Reflecting national concern regarding a potential increase in suicide rates, an influential cross-government outcomes strategy 'Preventing Suicide in England' was published in 2012. Reducing access to the means of suicide, with a particular emphasis on high-risk locations, is one of the key areas for action in this strategy.

It was estimated in 2009 that the average cost per completed suicide for those of working age in England is £1.67m. This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals.[3]

[3] Knapp, M. et al. 2011. Mental health promotion and mental illness prevention: The economic case.

2. Aims, Objectives and Rationale

The aim of this work is to reduce suicide rates in East Sussex and in particular at cliffs. The objectives and rationale for the different aspects of the bid are set out below.

2.1 Infrastructure development and associated actions

Objectives:

2.1.2 To commission an independent expert assessment of potential changes to technological facilities, road and parking access at cliff areas in Eastbourne in order to delay the approach to the cliff edge. This delay will give the person time to reconsider their decision and offers an opportunity to intercept those who are suicidal.

2.1.2 Implementation findings from the assessment

2.1.3 Project management to enable involvement and evaluation to ensure future service improvements.

Rationale: One of the six areas of action identified by the cross-governmental strategy is to reduce access to the means of suicide with high risk locations cited as one of the methods most amenable to intervention. It is specifically stated that suicide risk can be reduced by limiting access to these sites and making them safer. This is further corroborated in 'Preventing suicide in England: One year on' (2014) which is the first annual report on the cross-government outcomes strategy.

2.2 Training in Applied Suicide Intervention Skills Training (ASIST)[4] and Mental Health First Aid (MHFA)[5] for community organisations and primary care staff

Objectives:

2.2.1 To ensure all local community and primary care staff who may have a role in helping to prevent suicide are appropriately trained.

Rationale: Approaches identified in the cross-governmental strategy that can contribute to a reduction in suicide rates include ensuring that front-line staff working with high-risk groups receive training in the recognition, assessment and management of risk and fully understand their roles and responsibilities. In addition, findings from three mental health promotion pilot projects launched in 2006 to address the raised suicide risk in young men show that front-line staff feel better able to engage with young men if they receive training.[6]

2.3 Staff placement with voluntary agency

Objectives:

2.3.1 Additional statutory sector staff support within the BHCT for a time-limited period to provide extra capacity for cliff patrols; support with training; and to provide an opportunity for both the secondee and the BHCT to share ideas and ways of working.

2.3.2 The secondment will work in partnership with the Sussex Police-led Street Triage pilot; a national pilot where mental health nurses accompany police officers to incidents when the police believe people need immediate mental health support. Evaluation of both the Street Triage pilot and the BHCT secondment can be provided by the Mental Health Research Network grant overseen by Professor Gillian Bendelow, a medical sociologist and researcher in mental health at the University of Brighton who is already working in collaboration with SPFT and Sussex Police.

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[4] ASIST (Applied Suicide Intervention Skills Training) is a two-day course that aims to help caregivers (both professionals and lay people) to become more willing, ready and able to recognise and help persons at risk of suicide. ASIST is intended as 'suicide first-aid' training, and is focused on teaching participants to recognise risk and learn how to intervene effectively to reduce the immediate risk of suicide. Research into the effectiveness of ASIST carried out by the Scottish Government in 2008 strongly suggested that the programme could have a long term future in Scotland. The evidence from the evaluation suggests that, to make the greatest impact, suicide prevention training should be targeted at those individuals and groups who have most opportunity to use the skills because they work with, or live beside, people from sections of society most at risk of suicide.

[5] MHFA (Mental Health First Aid) is a two day course that helps participants to feel confident when approaching someone that is in mental distress. There have been many studies on the effectiveness of the MHFA training from around the world reporting increased knowledge, enhanced sensitivity, and increasing confidence of helping behaviours among the participants with recommendations to expand the reach and range of participants.

[6] HMG / DH. 2012. Preventing Suicide in England: A cross government outcomes strategy to save lives

Rationale: The BHCT was founded in 2003 by a local pastor. It is a Christian organisation specialising in search and rescue and crisis intervention. The volunteers are from local churches. The BHCT have good working relationships with the statutory services in the town and often support the police with negotiations at the cliff tops. They do not receive statutory funding.

2.4 Non-statutory support for those affected by suicide

Objectives:

2.4.1 To improve outcomes for people with severe mental illness and to provide support for their carers and family

2.4.2 Ensuring support care is delivered in a timely fashion

The service will be aimed at anyone affected by suicide or attempted suicide, their families and carers. The psycho-social support addresses the immediate crisis and provides ongoing support to help manage mental health problems and improve wellbeing. The service will offer one-to-one and group support to equip people to safely maintain good mental health in challenging circumstances.

It would provide an East Sussex-wide service.

Rationale: As highlighted by the national suicide prevention strategy, family and friends bereaved by a suicide are at increased risk of mental health and emotional problems and are at higher risk of suicide themselves. Therefore, to provide better information and support for those bereaved or affected by suicide is one of the six areas for action cited in the cross-government outcomes strategy.

2.5 Pilot options for additional 'place of safety space' that does not require Section 136

***Objectives*:**

2.5.1 To provide alternative options for support for those with suicidal thoughts, following being met at Beachy Head

Rationale:

East Sussex has one of the highest rates Section 136 use in the country. The key statutory services involved with Section 136 that sit on the Beachy Head Risk Management Group, namely, Sussex Police and the Emergency Duty Service of East Sussex County Council have stated that additional non-statutory aftercare in the form of a 'safe house and place of safety' space, that does not require a Section 136, may be of value and also save resources by reducing the number of Section 136s.

The professional view is that to detain people under the Mental Health Act who are distressed, but not necessarily mentally disordered, is damaging and may further exacerbate their condition. In addition, while the use of police cells for Section 136 cases is lower in East Sussex than some areas of the country, the figures are still too high and the government has recently stated that police cells should no longer be used.

3. Viable options

The overall impact of 'no action' is potentially increasing suicide rates in East Sussex and diversion of clinical resources from other areas of mental health provision and policing to address needs that should be preventable.

Pros and cons in relation to the six elements are provided below.

ACTION		PROS	CONS
1.	**Infrastructure development and associated actions: £600,000**	The commissioned environmental report will provide assurance that all options have been rigorously investigated. Delay in access to Beachy Head and cliffs will reduce suicide and reduce activity of all services involved.	Initially high capital costs may be needed. Effective measures may cost more than bid which may mean the prioritisation of actions.
2.	**Community organisations' and primary care training: £50, 000**	Recognised training packages available	Staff changes and dissipated impact
3.	**Staff placement with voluntary agency: £70,000**	Supports a service valued by Sussex Police and the coroner. Enables good statutory joint-working. Supports further evaluation of preventive measures.	May be difficult to recruit
4.	**Survivors of Suicide – 3rd sector support: £98,500**	The delivery model is working successfully elsewhere. Ensures people in distress get support that will meet their needs while reducing the risk of them carrying out further attempts.	Sustainable longer term funding may be difficult to obtain.
5.	**Pilot 'place of safety not requiring section 136'. £100,000**	More appropriate aftercare is provided. Reduces Section 136s which leads to better patient care, including reduced use of police cells and financial savings.	Sustainable longer-term funding may be difficult to obtain
6.	**Project management and independent evaluation of activities: £70,000**	Ensures delivery	Takes money away from direct prevention activity

4. Costs and funding of viable options

The overall cost is £988,500 and as described above in 'Viable Options', it has a potential to increase, depending on parking and road change options. The project work was designed with the non-recurring nature of the funding in mind.

The guideline for interventions used by NICE is £30,000 for every year of life saved. The age group with the highest recorded number of deaths at cliffs 40-49 years and this reflects the national picture with the highest suicide rates in the 35 – 49 years age group. On average those who die are losing approximately 20 years of life.

The financial costs incurred by the coastguard, police, chaplaincy and SPFT are substantial.

5. Risks

ACTION		RISKS	MITIGATION
1.	**Infrastructure development and associated actions**	• Plans rejected by interested parties such as English Heritage or councillors • Adverse publicity • Costs significantly underestimated • Technical blocks.	Public Health to meet with the senior team at Eastbourne council and senior officers in other relevant agencies to agree a strategic direction.
2.	**Community organisations' and primary care training**	• This is a low risk area.	
3.	**Staff placement with voluntary agency**	• There is a risk of not recruiting to this position • Complex evaluation of effectiveness.	• Internal and external trust recruitment • Additional support from Sussex University on evaluation
4.	**Survivors of Suicide – 3rd sector support**	• Due to high profile and impact of suicides at Beachy Head residents may feel that it doesn't serve people of East Sussex. • Without this support people are not given the specialist levels of support required by someone at this stage of anxiety • A delay in support could lead to another attempt on their life	Although it would support the Beachy Head client group the project would market itself as county-wide support and ensure support is offered proportionately across East Sussex.
5.	**Pilot 'place of safety not requiring section 136'**	• Financial sustainability • Voluntary sector support for safe house is not available.	Project manager to work closely with mental health joint commissioning team to ensure all viable options have been reviewed

Overall mitigation: In addition project management and independent evaluation of these activities is required to reduce risks of ineffective delivery.

Criteria for inclusion of proposals were:
- inter-agency support;
- one-off funding;
- feasible to deliver.

6. Conclusion

There is good evidence to support increased investment to prevent suicide at cliffs in the Eastbourne area and to reduce suicide rates in East Sussex. The national suicide prevention strategy provides a robust evidence-based guide for local areas and this has been referred to in development of the priorities for investment.

The rationale for the work has included an assessment of the Public Health Outcomes Framework areas where East Sussex is most out of line with the rest of England.

The planned developments have been drawn up by a wide range of agencies working together.

SAFER STREETS

Executive Summary

Rates of people killed and Seriously Injured (KSI) on the roads in East Sussex have been consistently higher than the England average for many years. Whilst KSI rates in East Sussex have decreased for car passengers they have remained fairly constant for all other user groups, and have risen in recent years for cyclists.

Partnership work is well developed in East Sussex and a considerable amount of good work has been undertaken to address KSI rates in East Sussex. However despite this good work rates of KSI remain high.

Causality of KSI's is complex, however regardless of cause, accidents which happen at lower speeds are less likely to cause serious injury than those at higher speeds. Analysis of KSI data in East Sussex indicates that around half of all KSIs take place on roads were the legal road speed is 30mph. Evidence from across the UK and elsewhere suggests that in areas where 20mph speed limits have been implemented KSI rates have reduced in those areas.

In addition 20mph areas have been shown to offer additional health benefits such as increasing walking and cycling, and community connectedness.

Changes to road speed has implications for a range of agencies and any proposals to implement 20mph will need to be with the agreement of and input from all key partners e.g. Sussex Police, East Sussex Fire and Rescue, District and Borough Authorities.

Initial costs of rolling out 20mph in appropriate areas are relatively high compared with ongoing maintenance costs. One-off investment is likely to have an impact on an area where East Sussex is significantly worse than England and support long term health gain.

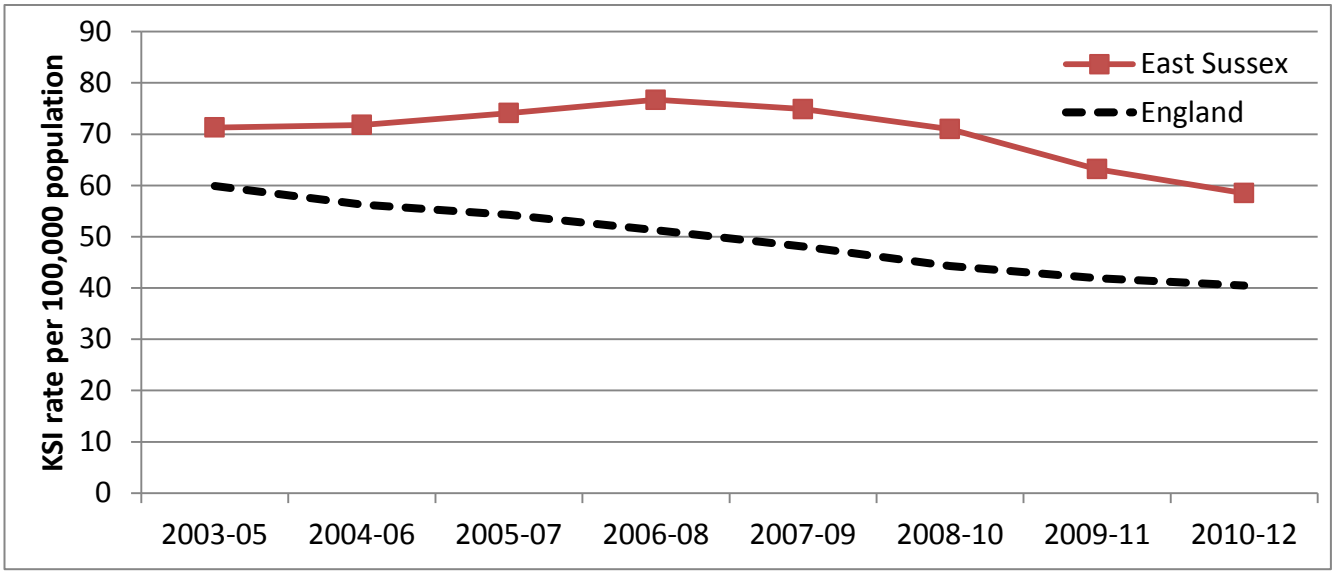
This business case proposes allocating up to £1 million to be made available should partners agree that taking forward implementation of 20mph areas in East Sussex is the agreed approach. Effective approaches to implementing 20mph (should this be agreed) will need to consider ways and means of changing motorists behaviour in relation to road speed to ensure compliance and reduce the need for enforcement. Therefore the approach proposed in this business case is:

- A short term project manager to gather the views of all partners and develop a fully costed comprehensive business and implementation plan for the project
- Development of a social marketing approach to implementing 20mph . Evidence from other social marketing campaigns e.g. THINK campaign suggest that using sophisticated social marketing approaches is likely to improve compliance with 20mph areas should they be implemented.
- Agreement of plans through the East Sussex Safer Roads Partnership

1. Strategic Context

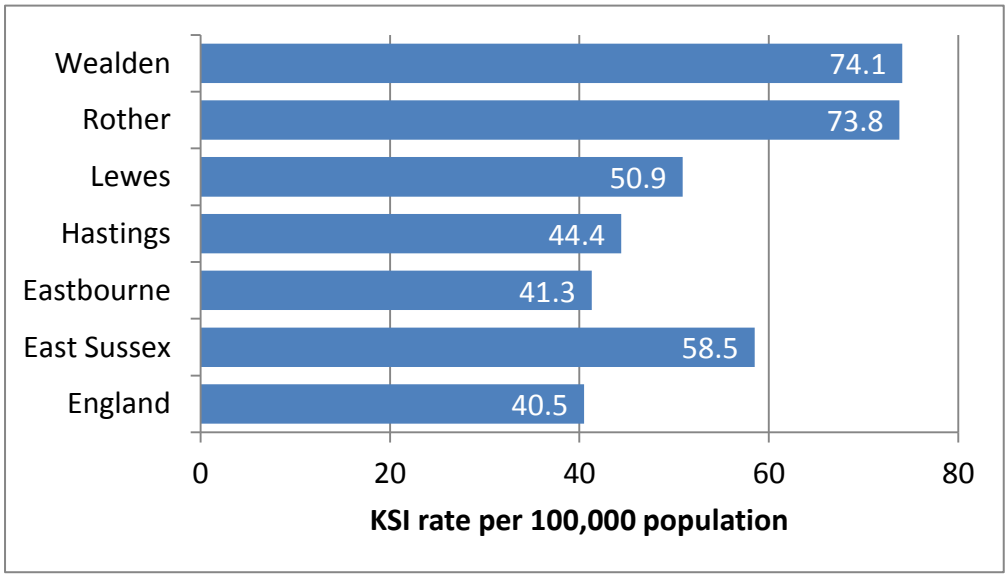
The Public Health Outcomes Framework (PHOF) highlights that the rate of people Killed or Seriously Injured (KSI) on the roads per 100,000 population is significantly worse in East Sussex than the national rate.

Figure 1: Public Health Outcomes Framework indicator 1.1
Killed or Seriously Injured Casualties on England's roads, rate per 100,000 population (2003-05 to 2010-12)



East Sussex is significantly worse for the majority of indicators in the national injury profiles, including many of the road related indicators, and this has been the case for many years. Rates of adults and children Killed or Seriously Injured (KSI) on the roads are higher than the national average in all Districts/Boroughs in East Sussex, other than Eastbourne. Rates of hospital admission due to motor vehicle traffic incidents are also higher in all areas other than Eastbourne, and significantly higher in Hastings and Wealden (2010/11 data). There are well developed partnership mechanisms across East Sussex and much good work has been done to address road casualties, however despite this good work, rates of KSI remain persistently high.

Figure 2: Public Health Outcomes Framework indicator 1.1
Killed or Seriously Injured Casualties on England's roads, rate per 100,000 population (2010-12)



KSIs in East Sussex

In depth analysis of road traffic data for East Sussex indicates that the highest rates of KSI accidents are associated with accidents:

- Where speed is recorded by the attending officer as a factor in the incident
- Involving young drivers (17-25 years)
- Involving powered 2 wheelers (e.g. motorbikes)

These categories are based on information recorded by the Police Officer attending the incident, they are not necessarily the cause but are a factor in the incident, they are not mutually exclusive so all 3 could be recorded in 1 incident.

Nationally there is, in general, a downward trend in rates of KSI for all groups except cyclists. In East Sussex whilst KSI rates for car occupants have fallen, rates for all other groups have remained fairly constant, with a rise in rates for cyclists in recent years.

Figure 3: Fatal and serious casualties on East Sussex Roads by road user type, 2005 to 2012

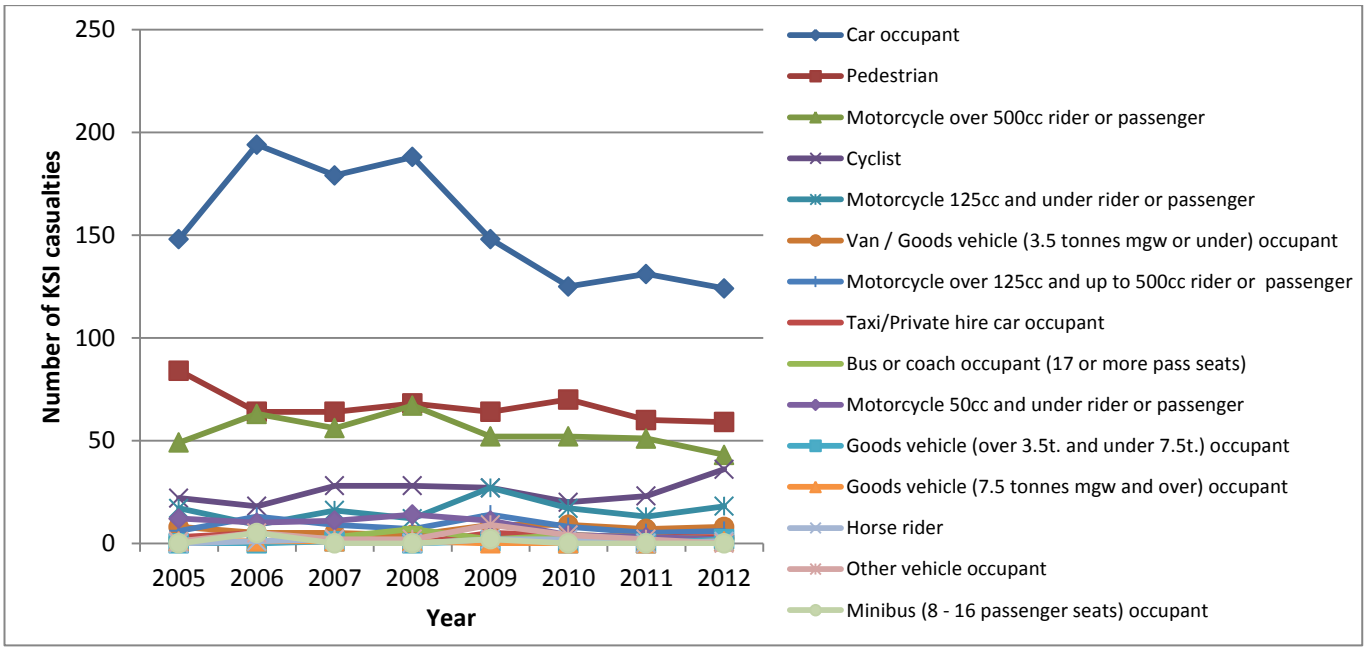


Figure 4: Number of people KSI by location type road speed and casualty age East Sussex 2010 -2012

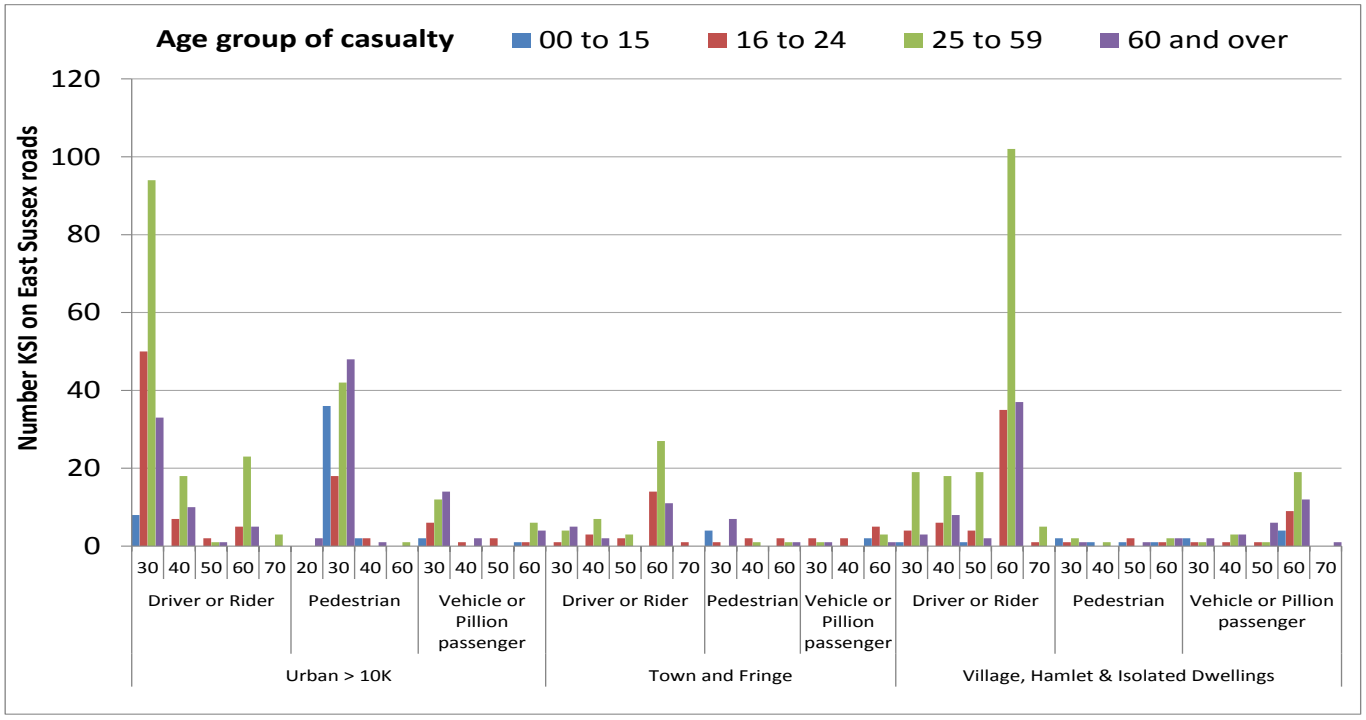


Figure 4 indicates that around one fifth of all road accidents in 2010 -2012 (1200/5138) were in young people aged 16-24, and the majority of these are injury to driver or passenger, with around half occurring in urban 30mph areas . In the period 2010-2012 there were 635 injuries to pedestrians with around one third of these being children aged 0-15. On average 26 cyclists are Killed or Seriously Injured on East Sussex roads each year, with 79% of these on 30mph roads. For accidents where someone is Killed or Seriously Injured (KSI) (passenger, driver of pedestrian), over half occur on urban 30mph roads, with a second group in rural areas in 60mph zones.

Figure 5: KSI data by District Borough and Road Speed East Sussex 2010 and 2012

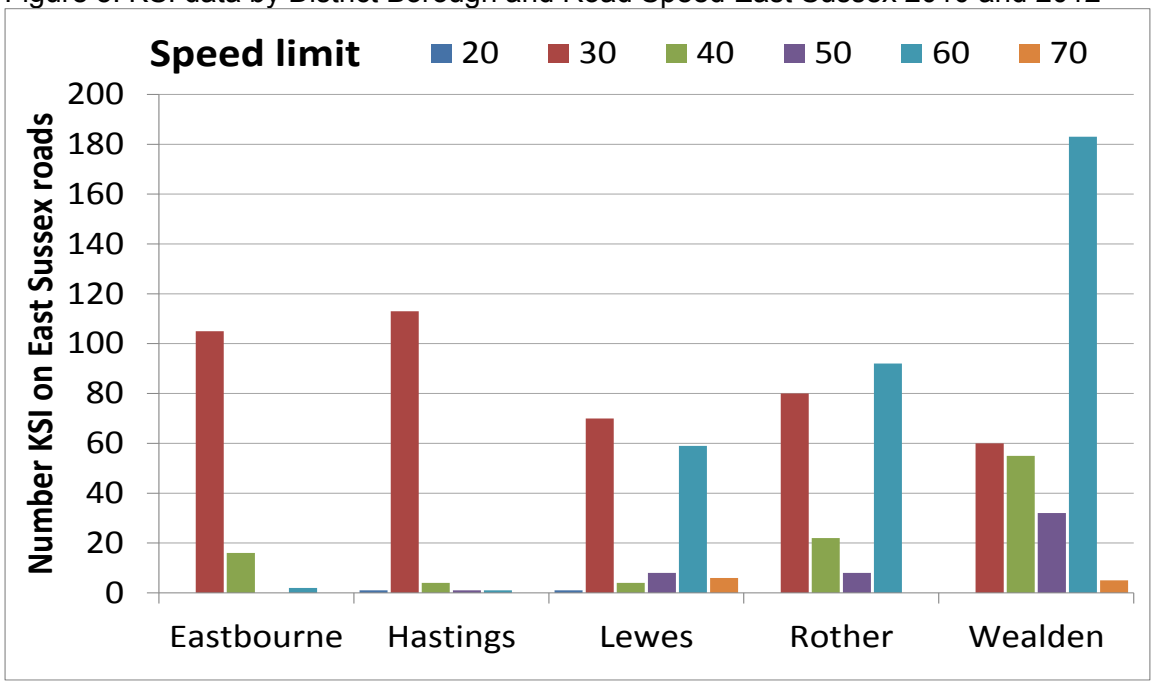


Figure 6: KSI's by road speed East Sussex 2010 to 2012

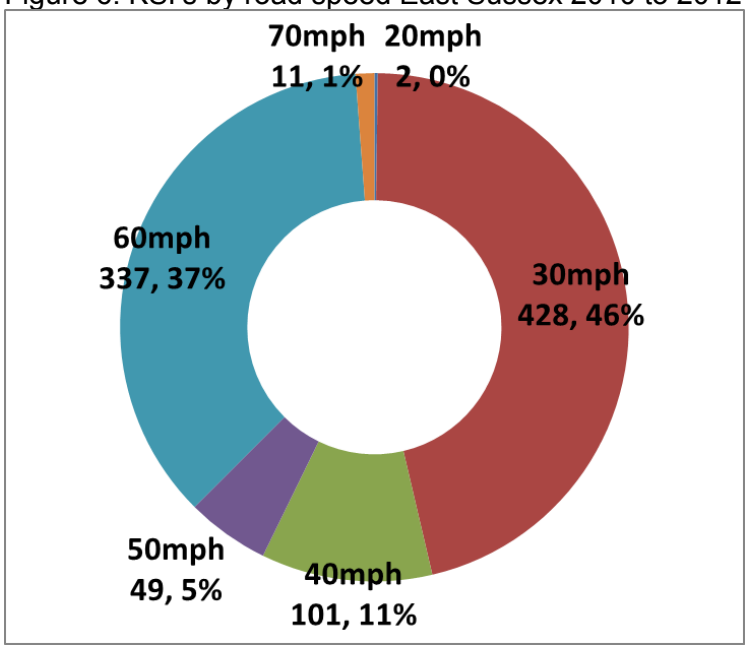


Figure 5 indicates that, as might be expected with the nature of roads in East Sussex, there is variation across the county with road speed of accident sites differing in rural compared with urban areas. However Figure 6 shows that when all KSIs are combined the largest single group are in areas where the road- speed in 30mph.

Pedestrian and pedal cycle casualties

Overall accidental injury rates are decreasing in line with the national trend, however rates of accidents for cyclists are increasing. National analysis of all causes of preventable childhood death in 06/07 identified that 15% of all preventable deaths in 11-16 year olds were associated with roads, and half of all deaths by external causes were associated with roads (Grundy 2009). Childhood pedestrian road accidents tend to be on minor roads, away from crossings with peak times being journey to school (but not within typical 'school zones') and Fridays in particular.

National data shows that males of all ages are more likely to be pedestrian casualties than females. However features of pedestrian casualties differ between adults and children. In all age groups (over 2 years) males are more likely to pedestrian casualties than females. However child casualties are more likely to be on an unclassified road and less likely to occur at or near a crossing. Friday is the peak day for all ages groups, children are less likely to have an accident in winter months and adults more likely.

Pedestrian accident rates in children peak at age 12 (peak ages 9-16) and pedestrian accidents are more likely in deprived groups of all ages, but this is most marked in children with almost ¼ (23.6%) of child pedestrian accidents nationally occurring most deprived 10%.

On average 26 cyclists are Killed or Seriously Injured on East Sussex roads each year, with 79% of these in 30mph zones.

2. Objectives – what are we trying to achieve?

- A reduction in the rate of people Killed or Seriously Injured on roads where the current road speed is 30mph
- An increase in the ability of people to lead healthy lifestyles by increasing physical activity, active travel options and connecting with their communities
- A reduction in the number of people admitted to hospital/reduction in length of stay for road traffic accidents

3. Proposed Interventions

Initial partner consultation to identify the benefits, drawbacks, issues, facilitators and appetite for an East Sussex approach to Safer Streets through 20mph areas. If an approach is agreed this would be followed by:

- Designating appropriate 30mph streets as 20mph streets to slow traffic speed to reduce road traffic accidents and reduce the severity of road traffic accidents when they occur.
- Implementing a winning hearts and minds/behaviour change approach to implementing 20mph areas to enable the public to understand the benefits of reduced speed, to understand the true impact on journey times and to support voluntary compliance with the legal road speed.

Evidence of effectiveness 20mph[7]

Lower road speed is associated with a reduction in rates and severity of road casualties. One study found that at 20mph there was a 2.5% chance of being fatally injured, compared to a 20% chance at 30mph (Ashton and MacKay, 1979). A study in Sweden concluded that the risk of fatal injury at 50kph (31mph) is twice as high as at 40kph (25mph) and five times as high as 30kph (19mph) (Rosén and Sander, 2009). In London, the introduction of 20mph zones has led to a 42% reduction in road casualties after correcting for underlying trend, with the greatest reduction in serious injuries and deaths of younger children (Grundy, 2009). In Portsmouth the introduction of 20mph signs- only limits led to a 22% reduction in casualties, compared to a national reduction of 14% in comparable areas (Atkins, 2010).

DfT guidance

Department of Transport draft guidance states '20 mph zones are very effective at reducing collisions and injuries. Research has shown that overall average annual collision frequency may fall by around 60%, and the number of collisions involving injury to children may be reduced by up to two-thirds. Zones may also bring further benefits, such as a modal shift towards more walking and cycling and overall

[7] Delivering soft measures to support signs-only 20mph limits
Report on research findings
Sarah Toy Research Fellow Bristol Social Marketing Centre, University of West of England June 2012

reductions in traffic flow, where research has shown a reduction by over a quarter (Webster and Mackie, 1996). There is no evidence of migration of collisions and casualties to streets outside the zone. (Grundy et al, 2008; Grundy et al, 2009)'.[8]

National Institute of Health and Clinical Excellence (NICE) Guidance[9]

NICE reviews evidence on effective interventions to improve health and has issued guidance on interventions which are most likely to be successful in preventing unintended injuries in children 0-15. This guidance indicates that local highway authorities and other partners (though local partnerships) should:

- Introduce engineering measures to reduce speed in streets that are primarily residential or where pedestrian and cyclist movements are high. These measures could include:
    - speed reduction features (for example, traffic-calming measures on single streets, or 20 mph zones across wider areas)
    - changes to the speed limit with signing only (20 mph limits) where current average speeds are low enough, in line with Department for Transport guidelines.
- Implement city or town-wide 20 mph limits and zones on appropriate roads. Use factors such as traffic volume, speed and function to determine which roads are appropriate.
- Consider changes to speed limits and appropriate engineering measures on rural roads where the risk of injury is relatively high, in line with Department for Transport guidance.

Behaviour Change approaches

Key to the effectiveness of implementing 20mph areas is ensuring that road users comply with the road speed. Behaviour change and social marketing approaches have been successfully used in other road safety interventions where voluntary compliance with the law is a key element e.g. the extremely successful DfT THINK campaign is based on understanding what motivates and how best to communicate with different groups or 'segments' of the population and identifying what is most likely to be effective in ensuring the appropriate response in each group. This segmentation and behaviour change approach would be a central element of ensuring that different kinds of road users understood the benefits to them of complying with the speed limit (e.g. protecting children, nicer place to live, complying with the law, better traffic flow, helping others etc.). The Department for Transport has established a behavioural insight team to ensure that these kinds of approaches are embedded in national road safety and transport behaviour work.

Department for Transports Behavioural Insight Toolkit indicates,

"Enabling behavioural choices is a central part of much of what DfT and other government departments do. Behavioural insights are potentially valuable in enabling government and its delivery partners (including local authorities) to achieve their objectives in more efficient and effective way"[10]

Alongside behavioural insight success of this scheme will be dependent on effectively engaging with successful local projects such as Community Speedwatch. Community consultation would be embedded in to delivery plan (and included in the full business plan) for the East Sussex safer streets approach ensuring that where 20mph is implemented it is with the full agreement and approval of local residents.

[8] DfT guidance SETTING LOCAL SPEED LIMITS Draft: July 2012

[9] PH31 Preventing unintentional road injuries among under-15s

[10] Behavioural Insights Toolkit. Social Research and Evaluation Division, Department for Transport. 2011

4. Viable options

1. Do nothing – maintain the status quo of 30mph road speeds
2. Pilot 20mph zone in small area/group of streets – implement 20mph in a small area to test the approach
3. County wide roll out
4. Develop a full implementation plan and implement across the county at the same time
5. County wide phased roll out
6. As above but roll out in phases across the county
7. Full work up before final decision
8. Undertake a preliminary piece of work with all relevant partners to identify the issues, barriers, facilitators etc. of rolling out 20mph in appropriate areas

5. Options Appraisal

Option	**Pro's**	**Con's**
Do nothing	No additional resource required	No impact on health
Pilot in small area	Limited cost, opportunity to test approach	Costs likely to be higher for small areas, particularly winning hearts and minds e.g. social marketing in a small area. Wider roll out requires repeating activity done previously, resource may not be available for roll out. Partners not fully engaged
Countywide roll out	Opportunity to plan for whole- county at once. Simultaneous communication across whole-county	Resource intensive for project management elements. Lead in time much higher as all areas commence at once. More resource intensive for countywide agency partners Partners not fully engaged
Countywide phased roll out	Can benefit from economies of scale but limits project management input. Resources and learning recycled through phased implementation in each area. Can target highest priority areas first, and areas where there is already demand. Can halt or reshape intervention in light of learning from previous phases.	Some areas have to wait longer than others for implementation Partners not fully engaged
Full work up before decision	Identify a short term project manager to work up a full business case with relevant partners with funding earmarked for countywide roll out, subject to partners agreement	Delay to implementation phase

6. Costs, benefits and funding of viable options

The estimated cost for implementation of 20mph areas varies from around £1.80 per head of population to £3.50 per head using experience from areas such as Lancashire, Warrington and Bristol. Varying amounts of social marketing and behaviour change activity were included in the different projects in these areas. This would translate to between £900,000 and £1.75 million for East Sussex.

In addition to the reduction in road deaths and injuries and costs associated with these, area wide 20mph in residential areas has been shown to substantially increase walking and cycling. Bristol found of its 20mph limits, using a mean of a 23% increase in walking and a 20.5% increase in cycling that for each £ spent the return on investment for walking is £24.72 and cycling is £7.479. The DfT states that any schemes giving a return on investment of more than £2 for every pound spent give high returns

Evaluation of implementing 20MPH across Bristol suggests, with a road death valued at £1.689m and a serious casualty at £189k, the policy need only prevent 1 death or 3 serious casualties to pay back its one off implementation cost for a 190,000 population, which would equate to 3 deaths or 9 serious casualties over its lifetime for East Sussex. Studies in London demonstrate 41.9% reduction in casualties compared with neighbouring zones and Warrington reported an 800% rate of return on investment in its 20mph pilots on casualties avoided.

7. Expected outcomes and potential risks

Expected Outcomes from implementing 20mph areas

- A reduction in mortality and morbidity associated with accidents and injuries in all age groups, but particularly in child pedestrians in the East Sussex population
- A reduction in % of population KSI on East Sussex roads to move towards the 95% confidence interval range for England
- A reduction in hospital admissions
- Establishing 20mph as the norm in residential streets
- Wider health benefits associated with increased walking and cycling

Potential Risks

- There is a risk that the public may not perceive the benefits of 20mph once implemented
- There is a risk that there will not be political will/interest in prioritising this agenda
- There is a risk that partner organisations e.g. District and Borough authorities may not prioritise this agenda
- There is a risk that responsible authorities e.g. Sussex Police may perceive this as requiring significant additional resource from them
- There is a risk that it will take time to see the benefits of 20mph areas
- There is a risk that drivers will ignore 20mph areas without significant enforcement
- There is a risk that social marketing activity may fail to win hearts and minds
- There is a risk that if we do nothing road accidents will continue to take a high toll on the population of East Sussex.

The majority of the risks above are associated with buy in by relevant organisations/partnerships. To enable this a planned series of information and engagement would need to take place. It is likely that a phased approach with the potential to evaluate Phase 1 to inform any subsequent roll out may be preferred by partners but it is proposed that all partners views are captured and fully explored before an implementation plan is developed. Implementation of 20mph speed limits in appropriate areas would need to be closely aligned to community speed watch interventions in development through the community safety/safer roads partnerships.

8. Conclusion and recommendations

East Sussex as a County, and four of the five Districts and Boroughs have significantly higher rates of people killed and seriously injured on the road. The causes of high rates of KSI are varied, however there is strong evidence that where accidents happen pedestrians, vehicle drivers, passengers and cyclists are all likely to sustain less severe injuries if vehicle speeds are lower. Reducing road speeds in residential areas can have other public health benefits such as increasing walking and cycling and increasing the social connectedness of people living in those areas.

Although reducing speed on streets will not address all causes of high KSI rates and high relative rates of childhood injury from road accidents in East Sussex, many of the other interventions that would be effective in addressing local need are already in place or could be addressed within existing resource if prioritised. The high one off costs of implementing the safer streets programme make ideal for consideration for funding from PH grant unallocated resource. Alongside this there are existing multi agency partnerships to take this work forward (community safety partnership, safer roads partnership) an essential feature of the success of this kind of intervention. There is sufficient learning from the literature and from implementation elsewhere to support the effectiveness of this intervention. Given the multi-agency nature of Safer Streets it is an ideal candidate to demonstrate the Council's commitment to its new public health duties and aligning resource to the most pressing public health issues for the local population.

Any formal proposal for resource through the RPPR process would need to be agreed through the East Sussex community Safety Partnership and Safer Roads group. A full implementation timetable would need to be developed through this group and a detailed costed plan itemising all elements of expenditure developed by a project manager prior to RPPR agreement.

It is recommended that Option 5 is the most appropriate way forward and that a project manager is resourced to work with partners and to draw up a full business case. It is recommended that a resource of £1 million is set aside to support a multi-agency, behaviour change approach to Safer Streets enabling the roll out of 20mph road speed in appropriate residential areas, subject to the agreement of partners. To enable this a full business case and implementation plan would need to be agreed with relevant groups e.g. Community Safety Partnership. The allocated budget should be available to fund all relevant costs associated with implementing the programme e.g. project management, behaviour change/social marketing and initial enforcement and additional community speed watch activity if required.

TOBACCO FREE EAST SUSSEX

Executive summary

Tobacco smoke is a significant cause of avoidable mortality in East Sussex. Smoking kills more people than alcohol, suicide, road accidents and illegal drugs put together. Whilst rates of smoking are decreasing across East Sussex as whole in line with the national experience, smoking rates in Hastings and Eastbourne have not declined between 1997 and 2011.

Most people who smoke start smoking when they are children. Smoking rates in young people have not decreased. 17% of young people in East Sussex as a whole, and 25% of young people in Hastings aged 14/15 say that they smoke occasionally or regularly.

Preventing people from taking up smoking is a cost effective way of improving health, reducing health inequalities, and addressing preventable mortality. Evidence suggests that the best way to prevent people from taking up smoking and supporting smokers to decide to stop smoking is through co-ordinated multi- agency approaches. These approaches should include making smoke-free the norm, helping people to understand the harms from illegal and illicit tobacco, reducing the supply, availability, and acceptability of illegal and illicit tobacco, making addressing tobacco everyone's business, and helping those in contact with smokers or potential smokers understand the risks.

Prior to transfer of public health services to East Sussex the PCTs invested funds in smoking cessation services, but had not prioritised funding for wider tobacco control interventions.

The price of cigarettes has been shown to be a major factor in reducing smoking prevalence in young people. The availability of low cost illegal and illicit tobacco undermines the positive effect that increased cost of cigarettes has had. The availability of illegal and illicit tobacco is widespread and the sale of these products is often thought to be victimless and is not perceived to have significant impact on communities.

This business case proposes investment in 3 strands of work identified by the Tobacco Partnership as priorities and through which one off investment will have a significant impact on the public's health. One-off investment in additional tobacco control measures will enable approaches to be tested in East Sussex, engage wider agencies in the tobacco control agenda to support sustainability, and educate local people to understand the implications of illegal and illicit tobacco sale in their communities. Proposed interventions:

- Social marketing campaign to increase awareness of harms of illegal and illicit tobacco and increase reporting of where these products are being sold
- Training for partner agencies staff to understand harms to them and their communities of illegal tobacco (and smoking) and convey this to people they are in contact with
- Increased enforcement activity e.g. Test Purchasing in priority locations based on increased intelligence generated through social marketing

1. Strategic context

Smoking remains a major preventable cause of disability and premature death, reducing tobacco use is the single most effective means of improving the health of local communities. The impacts of smoking nationally are stark:

- More than 80,000 people die each year from active smoking
- A further 10,000 people die as a result of second-hand smoke
- Smoking kills more people than alcohol, suicide road accidents and illegal drugs put together
- One half of long-term smokers will be killed by their addiction
- Over 200,000 children start to smoke each year and many go on to be addicted for life
- Smokers lose an average 10 years of productive life.
- Exposure to passive smoking during pregnancy is an independent risk factor for low birth weight.
- Babies exposed to their mother's tobacco smoke before they are born, grow up with reduced lung function.
- Parental smoking is also a risk factor for sudden infant death syndrome (cot death).[11]

In East Sussex a new multi-agency Tobacco Partnership was established in 2013 which brings together key partners and agencies with a role in addressing and reducing tobacco use in East Sussex.

East Sussex Council Public Health Systems Partnership approved the establishment of this group to take forward evidence based work to reduce the harm caused by smoking. The East Sussex Tobacco Control plan 2013/14 has been developed to deliver co-ordinated action to tackle tobacco control through this partnership.

Actions outlined in this business case support delivery against the local action plan and will be co-ordinated through this partnership.

'Healthy Lives, Healthy People - A National Tobacco Plan for England set out the governments ambitions for reducing the harm caused by tobacco which are:

- Reduce the preventable mortality and morbidity from smoking tobacco
- Reduce smoking prevalence in the population
- Reduce exposure to second hand smoke
- Increase knowledge of harms of second smoke
- Increase knowledge of harms of illegal/illicit tobacco
- Increase reporting of sale of illegal tobacco
- Increase perception that those engaging in trade will be caught and prosecuted
- De normalise tobacco use

These underpin the 6 evidence based strands for tobacco control:
1) Stopping the promotion of tobacco
2) Making tobacco less affordable
3) Effective regulation of tobacco products
4) Helping tobacco users to quit
5) Reducing exposure to second-hand smoke
6) Effective communications for tobacco control.

The East Sussex Tobacco Partnership has developed a plan for local action against the six strands.

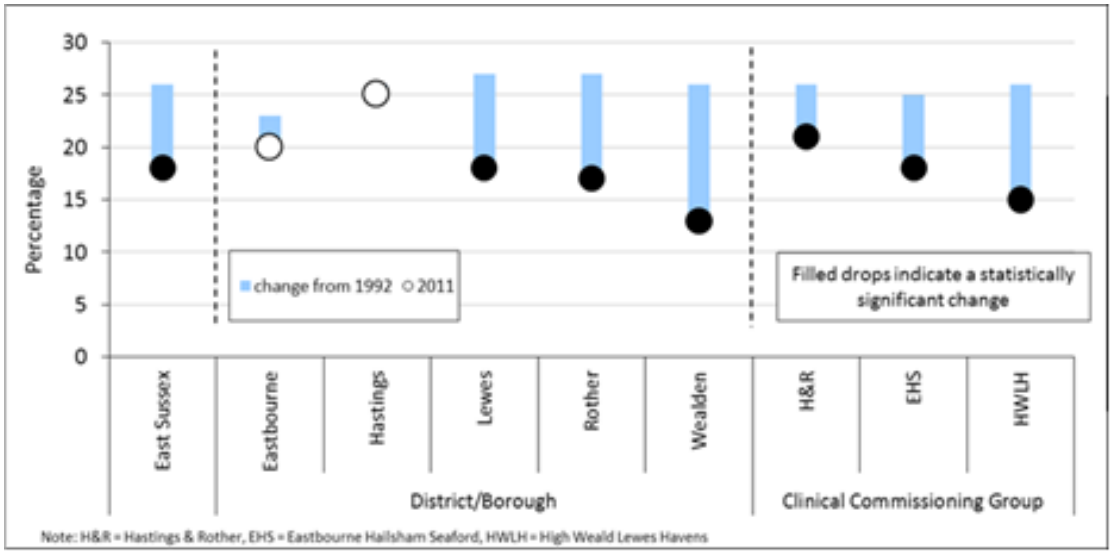
1.1 Current commissioning in East Sussex

Whilst resource has been available for stop smoking services, limited resource has historically been allocated to wider tobacco control interventions in East Sussex, despite national policy drivers and evidence supporting this approach.

[11] Gilliland FD et al (2000) Maternal smoking during pregnancy, environmental tobacco smoke exposure and childhood lung function. Thorax 55: 271-276

2. Tobacco Use in East Sussex

Whilst rates for smoking are decreasing across East Sussex as a whole in line with the national picture, smoking rates in Hastings and Eastbourne have not declined significantly between 1992 and 2011. In 2011 almost one quarter of adults in Hastings smoked.



2.1 Smoking in young people

Smoking in young people is of particular concern because of the immediate health impact and also because the majority of adult smokers start when they are children. The earlier smokers start smoking, the less likely they are to give up in adulthood. Despite falls in adult smoking prevalence between 2007 and 2012 there was no significant change overall in the proportion of pupils describing themselves as occasional or regular smokers in East Sussex. In 2012, 18% of pupils who responded described themselves as occasional or regular smokers compared with 17% in 2007. However, a significant increase was reported for Hastings, from 17% in 2007 to 25% in 2012. Overall, 50% of those young people who smoke regularly say they would like to give up. Rates of smoking vary by gender and by district with almost 1/3 (30%) of girls in Hastings saying that they smoke occasionally or regularly.

2.2 Smoking in the home

Becoming a smoker is strongly influenced by parental smoking. On average, around two fifths of pupils in East Sussex live in a home where someone smokes each day , and this rises to over half of 14 -15 year olds in Hastings.

2.3 Smoking in pregnancy

Across East Sussex, 15% of mothers are known to be smoking at delivery compared to 13% nationally. At district and borough level, the figure varies from 1 in 10 (11%) in Lewes to nearly one in four (23%) in Hastings. Smoking during pregnancy increases the likelihood of babies being born at a low birth weight. Low birth weight is a major cause of infant mortality and has implications for child and adult health. Across the county, 7% [12]of babies are born at low birth rate (under 2,500 grams).

3. Objectives – what are we trying to achieve?

The aim of this proposal is to reduce smoking prevalence in the population and reduce the preventable morbidity and mortality from smoking and tobacco use. This will be achieved through meeting the following objectives:

- De normalisation of smoking and tobacco within the community through locally amplified mass media campaigns and targeted social marketing activity
- Increased community knowledge of harms of second smoke and how to avoid exposure to second hand smoke through locally amplified mass media campaigns and targeted social marketing activity
- Increase knowledge of harms of illegal/illicit tobacco through targeted and effective enforcement action
- Increase reporting of sale of illegal/illicit tobacco through campaigns and effective enforcement action

[12] East Sussex JSNA.2013

- Evaluation of a multi-strand approach to local tobacco control in order to make the case for further future investment

4. Proposed Interventions

A key component for effective tobacco control is to focus on tobacco de-normalisation by shifting the social and cultural norms of tobacco use. Such approaches have been shown to be successful internationally e.g. the Californian state tobacco control programme whose model adopted a 'social norm change' approach by 'creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible' .

The proposed business case will establish a localised set of plans and interventions which adopt a social norm change approach to tobacco use with particular focus on creating greater community awareness of the impact of illicit and illegal tobacco and by using proven approaches[13] i.e. Mass media campaigns, social marketing, local partnership working with key statutory and enforcement agencies.

In addition, the business case includes support for the wider public health workforce and community to support partnership and agency involvement in the work to deliver the tobacco control action plan

Following a review of effective interventions, the public health team working with East Sussex tobacco partnership, identified effective interventions which would make a substantial contribution to the tobacco agenda and could be implemented with one-off investments. The interventions identified are summarised in the table in section 5 together with the proposed investment level.

Intervention	**Objective**
Sustained and targeted behaviour change and communications approach (social marketing).	Programme of work to generate insight into and segment and address specific needs of the following groups: 1. Smoking population 2. Purchasers/places for illegal /illicit tobacco(people and where they buy it) 3. Motivational drivers for change in each group according to preference (e.g. fear of prosecution, financial, impact on family) 4. Motivational drivers to improve provision of intelligence for example the location of 'tab shops' selling illegal and illicit tobacco 5. Targeted activity for each segment e.g. approaches for pubs and shops, approaches for small scale sellers, approaches that increase reporting approaches to de-normalising smoking in pregnancy in key communities, approach to de-normalising smoking in homes and cars.
Training to key community organisations and agencies including police and neighbourhood management	Tobacco control training resource. Tailored package for each agency member of TC partnership (and their key contacts where appropriate) e.g. by adding tobacco elements to existing training
Enhanced enforcement activity for test purchasing with retailers, timed appropriately within campaign schedule	Additional one off resource to test whether increased resources alongside increased intelligence can generate reduction in illegal activity for example through increased seizures by Trading standards/Sussex Police (including purchase of resources and staff time.)

4.1 Evidence of effectiveness across the six strands of tobacco control

There is a strong evidence base for the effectiveness of NHS stop smoking services underpinned by effective mass media and social marketing campaign to increase uptake of services by priority groups and increasing knowledge of other harm reduction approaches such as managing nicotine dependence[14].

Raising awareness of the dangers of exposure to second hand smoke through mass media and social marketing campaigns to win public support for smoking cessation and behaviour change actions that de-normalise smoking in homes, families and communities are shown to be effective.

[13] NICE 2008 PH 14. Preventing the uptake of smoking in children and young people.
[14] NICE 2013. Harm Reduction Approaches to smoking guidance.

The availability of cheap and illicit tobacco undermines taxation policy as a major deterrent to smoking, particularly in young people and those living in deprived circumstances. The implementation of national legislation with local enforcement through regulatory authorities (HMRC, Licensing and Trading Standards) operated within the scope of the law is effective.

The key components of this work include interrupting informal markets and the supply chain, raising awareness of the harms of tobacco and raising awareness with retailers and wider community of the penalties for non-compliance.

The combined effect of implementation of national legislation of tobacco products (point of sale advertising, taxation policy), supported by local enforcement to ensure full legal compliance, is shown to have a clear impact on reducing both the appeal of tobacco use and reducing smoking prevalence. Local media and campaign work to promote awareness of the harms of illegal and illicit tobacco by increasing the perception within the community of traders and home sellers will be caught and prosecuted and increased awareness and reporting to relevant agencies from the public of harms of illegal and illicit tobacco.

The evidence shows that key component for effective tobacco control is to concentrate on tobacco denormalisation[15] and explicitly focus on shifting the 'social norms' of tobacco use[16]. These approaches have been shown to be successful internationally e.g. the Californian state tobacco control programme whose model adopted a 'social norm change' approach by 'creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible. This is achieved through a mix of legislation enforcement and mass media campaigns as well as promoting access to smoking cessation services. In California adult smoking rates reduced from 22.7% in 1988 to 11.9% in 2009, amongst the lowest reported rates in the western world[17]. Lung cancer rates have also declined four times faster in California than the rest of the United States of America.

4.2 Example of co-ordinated multi-strand approach

Since 2005, 'Fresh' a multi-sector partnership based in the North East of England has developed work across on a wide range of tobacco issues including commissioning work to support quitting, marketing and publicity on the ill health effects of smoking, protection of children from second-hand smoke, reducing the demand and supply of illicit tobacco, advocacy for smoke free legislation and supporting point of sale retail display legislation. In addition with partners in the North West and Yorkshire and Humber regions Fresh developed a strategic action plan to tackle illicit and illegal tobacco in 2009[18].

The use of real people (rather than actors) to speak out on behalf of the programme and also to use local spokespeople from a range of disciplines and agencies has been instrumental in achieving consistently high, positive media coverage of tobacco issues. In 2010/11 around £3 million PR value (earned media) was achieved, whilst paid for integrated mass media campaigns have all delivered a high return on investment given the clear economies of scale achieved by media procurement across the regional media footprint[19]. In addition the local authority allocated funding to roll out a schools based tobacco control programme 'Assist'.

Allocation of one off resource would enable evidence based approaches to be tested in East Sussex, establishing the value of multi-agency approaches and potentially creating a case for future funding from other agency or department budgets.

[15] Chapman, S, Freeman, B. Markers of the denormalisation of smoking and the tobacco industry. Tobacco Control 2008;17:25-31 doi:10.1136/tc.2007.021386

[16] Zhang et al 2010. The impact of Social Norm change strategies on smokers quitting behaviours. The Journal of Tobacco Control 2010;19(Suppl 1):i51ei55. doi:10.1136/tc.2008.029447.

[17] Kuiper NM et al 2005. Evidence of Effectiveness A summary of state tobacco control programme Evaluation Literature. Centre for Disease Control and Prevention. US Department of Health and Human Services.

[18] Rutter et al 2009. North of England tackling illicit tobacco for better health. Programme Action Plan 2009-2012.

[19] Fresh North East. 2014. Accessed at http://www.freshne.com/what-we-do/our-campaigns/every-breath/results.

5. Options appraisal

Option	Pro's	Cons
1.Do nothing	NIL direct cost	costs to the population and system from increasing tobacco use, continued preventable mortality and morbidity
2.Campaigns and social marketing components only	Long term actionable evidence based knowledge to inform better use of tobacco control resources and existing activity.	Some health gain but less than could be expected from full intervention Does not address major cause of continued high levels of smoking (low cost illegal/illicit tobacco
3.Full programme	Multi component intervention to enhance existing expenditure on stop smoking services. All agencies engage in tobacco plan interventions which evidence suggests give greatest chance of meeting the objectives in the proposal.	Higher initial resource investment

6. Costs, benefits and funding of proposed options

Option	benefit/drawback	Estimated cost
1.Do nothing	NIL direct cost but costs to the population and system from increasing tobacco use.	
	TOTAL	NIL
2.Campaigns and social marketing components only	Long term actionable evidence based knowledge to inform better use of tobacco control resources and existing activity.	£300,000
	TOTAL	£300,00
3.Full programme	Multi component intervention to enhance existing expenditure on stop smoking services. All agencies engage in tobacco plan interventions which evidence suggests give greatest chance of meeting the objectives in the proposal.	£430,000
	TOTAL	£430,000

6. Expected Outcomes and Potential Risks

6.1 Expected outcomes

- An increase in awareness amongst the general public of the harms of illegal and illicit tobacco.
- A reduction in the availability and demand for illegal and illicit tobacco
- An increase in the confidence of staff across agencies to advise clients on smoking and wider tobacco control issues
- Cross agency agreed approaches to wider tobacco control across East Sussex
- Increased knowledge and ability to undertake cost effective tobacco control activities and campaigns as part of routine activity

6.2 Potential risks

- The public do not respond to targeted social marketing messages and required intelligence is not generated
- Partners do not wish to participate in tobacco control activity/have their staff trained

6.2.1 Mitigation

- Social Marketing approaches will test the likelihood of participation before campaigns are agreed
- The tobacco partnership has agreed this proposal so partners are unlikely to change their support

7. Conclusion and Recommendation

Tobacco control interventions are an effective way of reducing the burden of disease through reducing tobacco use. Investment in generating evidence, knowledge and insight to underpin future tobacco control interventions will enable more targeted and effective investment in future.

Additional tobacco control measures will enable their effectiveness to be tested in East Sussex and support the East Sussex Tobacco partnership to understand and agree priorities and roles, including allocating resource to tobacco control where this can be shown to be effective.

Commissioning of stop smoking services is expected to release some resource which would enable the partnership to utilise this resource to implement any initiatives that are proven to be effective and selected as priorities. The committee is asked to approve option 3 outlined in the business case.

Option 3 is recommended as the most appropriate approach to take forward tobacco control work in East Sussex.

ADDRESSING OBESITY

Executive summary

Obesity and the rising costs of obesity are a significant challenge in East Sussex, excess weight costs the NHS more than £5billion per year in England, and estimated costs to the wider system are expected to rise to £50 billion per year by 2050. This would equate to around £0.5 billion per year to the East Sussex economy.

Weight management services have only been commissioned in East Sussex since April 2014. It is anticipated that over time demand for weight management services will increase. To manage this expected demand more needs to be done now to make sure that people access support and services and make lifestyle changes as early as possible, and the services they access are the least resource intensive for their level and type of need.

To ensure services are cost effective they need to offer the right level of support, to the right people, at the right time. Behavioural science tells us that some people are able to make lifestyle changes following simple brief advice and information, whilst others will need a more intensive intervention. There is evidence that understanding peoples motivational preferences and confidence to change can inform the level of support that it might be appropriate to offer.

In addition to supporting people to access the right service once they have becomes overweight or obese we need to intervene early to prevent children developing lifestyles which make them more likely to become obese when they are older. Additional one off resource to improve the knowledge, skills and confidence of staff working in early years setting and parents of young children will enable good habits to be developed in early life and contribute to reducing the rising prevalence of obesity.

This business case recommends funding:

A triage system:

- A triage system is a way of directing patients into the right intervention (including self- care) for their need.
- Patients will be assessed by the system and an appropriate intervention will be recommended. The type of intervention available will include self –care e.g. directing to NHS Choices, community health promotion (walking groups, leisure centres etc.); referral to Health Trainer service; referral to Weight Management service; referral to G.P.
- It is expected that a triage system will be able to be accessed by individuals via a website and via telephone e.g. through Social Care Direct
- The costs included here are for development of the system, ongoing running costs will be met by funds already allocated for addressing obesity in the public health grant
- One –off investment will enable long-term savings

Additional early years support

- In addition to supporting people to lose weight once they have become overweight or obese it is important to support children and young people to participate in a healthy lifestyle from an early age. Increasing staff and parents knowledge and skills is an effective way of improving health in early years.
- One off investment in early years will enable a large proportion of early years settings to be covered in 1 year. Routine work in this setting can then be funded through funds already allocated for addressing obesity

1. Strategic context

Excess weight costs the NHS more than £5bn each year[20].|The Foresight report (2007) estimated that, in 2002, those who were overweight or obese cost the wider economy £7 billion in treatment, benefits, loss of earnings and reduced productivity and if no action was taken, the total costs to society were expected to rise to £50 billion by 2050[21]. Obesity also impacts on our ability to work. It is estimated that between £2.35bn and £2.6bn is lost in earnings each year because of obesity[22].Prior to transfer of responsibility for public health to the council weight management services had not been commissioned. New weight management services for adults and children have been available from April 2014.

Healthy people, health lives: A call to action on obesity in England[23] DH 2011 describes the basis of a 'new approach' to obesity as utilising:

- The latest evidence of underlying issues and causes, starting with the Government Office for Science's Foresight report of 2007
- The latest evidence of 'what works' – and in particular good practice from a range of initiatives at local and national level
- Extensive engagement with a wide range of delivery partners and experts over the past months

With 3 key components:

- Empowering individuals through the provision of guidance, information, encouragement and tailored support on weight management
- Giving partners the opportunity to play their full part – e.g. Responsibility deal
- Giving local government the lead role in driving health improvement and harnessing partners at a local level
- Building the evidence base on effectiveness and cost-effectiveness

To achieve:

- A sustained downward trend in the level of excess weight in children by 2020
- A downward trend in the level of excess weight averaged across all adults by 2020

1.1 Obesity in East Sussex

In East Sussex levels of obesity are similar to the England average with around one quarter of all adults estimated to be obese (with the exception of Hastings which has significantly higher rates). Although rates are similar if this trend continues the impact of obesity on the health and social care economy will be significant

The proportion of children who are obese or overweight has increased in recent years. In 2010/11, 20.5% of Reception Year and 31.4% of Year 6 pupils measured were recorded as overweight or obese across East Sussex. This compares with England where 22.6% of Reception Year and 33.4% of Year 6 pupils were overweight or obese. In East Sussex, boys in Year 6 had a significantly higher prevalence of obesity than girls in Year 6. For both year groups, there was a strong positive relationship between deprivation and obesity prevalence.

The Public Health Outcomes Framework (PHOF), *Improving outcomes and supporting transparency* (2012)[24], sets out the desired outcomes for public health and how they will be measured. The following indicators measure the impact of services and interventions which aim to reduce obesity:

Domain 1: Improving the wider determinants of health

PHOF 1.16: Utilisation of outdoor space for exercise / health reasons – the number of people reporting that they have taken a visit to the natural environment for health or exercise over the previous seven days

Domain 2: Health improvement

PHOF 2.6: Excess weight in 4-5 and 10-11 year olds – the number of primary school children in reception year (aged 4-5 years) and year 6 (aged 10-11 years) with valid height and weight recorded who are classified as overweight or obese.

[20] DH (2011). *Healthy lives, healthy people: A call to action on obesity in England*
[21] Foresight (2007) *Tackling Obesities: Future Choices.*
[22] House of Commons Health Select Committee, (2004).
[23] DH (2011). *Healthy lives, healthy people: A call to action on obesity in England*
[24] DH (2012). *Healthy lives, healthy people: Improving outcomes and supporting transparency*

PHOF 2.11: Diet – this indicator is yet to be finalised. However, it is likely to focus on an increase in consuming five-a-day and a reduction in intake of saturated fats, sugar, salt and calories

PHOF 2.12: Excess weight in adults – the proportion of adults who are classified as overweight or obese

PHOF 2.13: Proportion of physically active and inactive adults – the proportion of adults who achieve at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer recommended guidelines on physical activity

In order to address PHOF outcome indicators, an obesity care pathway has been developed for obesity reduction in East Sussex. People entering this pathway need to be signposted or referred into services which are most appropriate for their situation from Tier 1 universal community and primary care support, through to Tier 3 / 4 specialist services and surgical interventions.

In order to ensure that service users receive the most appropriate support, a range of information needs to be obtained from them, including their BMI classification and readiness to change / motivational status.

This information can be obtained in a variety of ways from face to face interventions, such as a GP appointment or health check event, to online or telephone support.

This paper explores the concept of a healthy weight triage and support website which would obtain this information as well as providing the universal support and information.

2. Objectives – what are we trying to achieve?

A reduction in the burden of disease associated with excess weight, low levels of physical activity and unhealthy eating. To address this we are proposing additional one off investment in developing the system, skills and capacity to address obesity in East Sussex.

3. Proposed Interventions

3. 1. Triage system

The development of a triage and support system which administers a number of assessments in order to triage potential service users and ensure that they receive the most appropriate support/treatment. Assessments would include:

- BMI measurement
- Healthy Foundation segmentation questionnaire
- Motivational assessment
- Eligibility assessment - geodemographics

A referral management system would make recommendations for support/treatment options to service users based on the outcome of their assessments and would include the following options:

1. Further information, including signposting details of available Tier 1 services, either on-line or as part of a resource pack which could be sent to the service user
2. Signposting information for the NHS choices weight loss plan or embedding this functionality into a local website e.g. hosted on 1space
3. A referral to an appropriate service to support weight loss service e.g. Health Trainer, Tier 2 weight management services
4. A referral to another appropriate health improvement or clinical service e.g. GP services for Health Check / specialist support Smoking Cessation services, local alcohol treatment service

A fully functional triage system would enable patients to access the most appropriate level of support for their needs, including self-care. This would ensure that scarce resources are used in the most cost-effective way and ensure that those people who can make changes with the provision of information and advice are enabled to do so, and only those people who would not be able to make changes on their own are offered intensive interventions. A range of evidence based functions can be incorporated into a system of this type e.g. the provision of periodic motivational messages and the collection of data on outcome for patients who are not accessing intensive support services.

3. 2. Additional support in Early Years Settings

Commission additional support to develop healthy settings such as increasing the health promotion offer in children's centres and other early years settings. To bring about significant change in early years and primary settings by increasing skills, knowledge, confidence of early years staff, by supporting early years and primary providers to improve their healthy lifestyle offer, and to change the acceptability of healthy options for children and their families.

4. Viable options

1. Do nothing –Providers of weight management services would accept all patients eligible for the service, waiting lists would be developed if supply exceeds demand. Primary prevention support for children and young people would be implemented at a slower rate within existing resource.

2. Commission a referral management system either as stand alone or with web component to be utilised by social care direct or similar referral management provider (ongoing costs of operating system post development to be met through the PH obesity budget)

3 As 2 but with additional investment in children's primary prevention

5. Option appraisal

Option	Pros	Cons
1. Do nothing	This option would require no investment	Lack of centralised triage and support which could leave service users without the help they need. Inappropriate referrals may occur depending on service provider Lack of joined up info and support could result in an increase in the numbers of people requiring more invasive interventions such as bariatric surgery Lack of joined up working could result in people in need of support not receiving it Increased rates of obesity Possible increase in costs associated with treatment of ill-health caused by obesity and more specialist support, including bariatric surgery.
2. Internally hosted online system only	Manage demand for services better, triage into an appropriate intervention including web based support/self care	Additional cost
3. As 2 but with additional children's primary prevention	As 2 and with enhanced primary prevention programme to reduced projected long term demand increase	Additional costs Benefits not achieved

6. Costs, benefits and funding of viable options

Option	Activity	Estimated cost
1 Do nothing	None	None
2. Online and telephone triage system	Commission the development of an online and telephone based referral and triage system	£85,00,000 (plus £15k recurrent from PH budget)
3.Option 2 plus children's primary prevention	Early Years settings interventions: extension of audit pilot to all children's centres, audit of EYS settings (nurseries and child minders), training for EYS staff in healthy offer, social marketing local amplification of change for life Portion size interventions for parents	£200,000 Total £285,000 (plus £15k recurrent from PH budget)

7. Expected outcomes and Risk

6.1 Expected outcomes - More systematic identification of the most appropriate and cost effective support option is expected to lead to an increase in cost-effectiveness of services and support to prevent and address obesity

6.2 Risk - There is a risk that demand for weight management services will outstrip supply despite a triaging system. There is a risk that early years settings may not have the capacity or are not able to prioritise health improvement interventions in their activity

6.3 Mitigation - Excess demand may happen despite triage system not because of it. Without a triage system this risk would be likely to have a greater impact

Public Health staff are working with children's services staff to identify any issues in delivering interventions in early years settings as they emerge.

8. Conclusion and recommendations

Managing utilisation of weight management service so that patients get the right level of service for their needs and behavioural and motivational preference will be essential for East Sussex given the relatively low level investment in weight management compared with some other areas. Alongside this effective primary prevention in young people to bring about change in the system to enable healthy choices to be the easiest choice will contribute to long term solutions to increasing obesity.

It is recommended that a full business case is agreed for investment in a referral management system and additional primary prevention in children and young people for 1 year as set out in Option 3. However if resource is not available for all elements of this Option the number one priority would be Option 2, a referral management system.