

# Annual Report of the Director of Public Health 2016/17



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## Social Movements for Health

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### Introduction

There is growing recognition that if we want a health and social care system that is high quality, safe and sustainable (and we do!) then carrying on as we are isn't an option. The current health and care service models are failing to address the wider determinants of health and wellbeing and it is clear that big institutions – like the NHS - are not able to tackle today's health challenges on their own.

When the NHS was conceived, the most pressing health issues were infectious diseases and most of hospitals' work was around managing short periods of acute illness. The main health issues now facing Blackburn with Darwen and the wider population are, however now very different, being predominantly long term conditions: diabetes, heart and lung disease, cancer and mental illness. Since its inception in 1948 the collective enterprise of the NHS has proven to be amongst the most successful, efficient and effective global institutions.

There is growing evidence that its operating model and service no longer fit for purpose to address the current causes and patterns of disease (Box 1), and people are asking for much deeper involvement in choices related to their health and wellbeing delivery. If the NHS is to continue to improve health and wellbeing it will need to extend and augment the ways in which it works to include supporting large scale social movements for health and increasing its focus and investment on the proactive generation of health. Indeed, Simon Stevens, Chief Executive of the NHS, states in the Five Year Forward View<sup>1</sup> that large scale social movements are now 'mission critical' for the future of the NHS.

### Our Vision:

For Blackburn with Darwen to become a place where social movements are encouraged and enabled to thrive, through close collaboration between empowered residents and responsive institutions, for the improvement of health and wellbeing

### Box 1 - A system in need of an upgrade?: Type 2 diabetes and obesity

#### Diabetes

In Blackburn with Darwen alone, diabetes diagnoses have nearly doubled in the last ten years and are continuing to increase. Nationally, over 600 children and young people have type 2 diabetes, a condition previously unheard of at this age. We cannot reverse this trend by relying on a purely service-driven model. As announced in the Five Year Forward View<sup>1</sup>, the NHS is implementing a national diabetes prevention programme of intensive intervention for people identified as already at high risk, which is important for these individuals, but does nothing to tackle the underlying causes of diabetes. Instead we need to address the risk conditions in society that have encouraged diabetes in the first place. These risk conditions create unhealthy environments allowing sugar to be hidden in children's food, advertising processed foods with high sugar content and transport policies that encourage the use of cars rather than public or active transport.

#### Obesity

to date, attempts to tackle obesity have largely taken a pathological approach, in which the cause of obesity has been assumed to be a 'problem' with the individual. We then try to 'fix' this through individually focussed behaviour change programmes and, if this doesn't work, then surgery is considered. However, as this and previous annual reports show, whole sections of the population, from children to older people, have shown increasing levels of obesity over the last twenty years, which contradicts a notion that obesity is simply an individual behavioural issue. We need to ask: if certain behaviours cause obesity, then what causes these behaviours? The answer is that, as for diabetes, there has been a change in the environment so that unhealthy choices are often the easiest, or even actively encouraged.

The risk conditions for obesity are effectively the same as those for type 2 diabetes (and many other health conditions), and addressing these wider environmental factors has the potential to make a much bigger impact on public health than focussing only on individuals and their behaviour.

*"We need to stop investing in the wrong end of the problem and think about addressing the underlying risk conditions"*

*“When we talk of social change, we talk of movements; a word that suggests vast groups of people walking together, leaving behind one way and travelling towards another”*

Rebecca Solnit

## Social Movements for Health

### What is a Social Movement?

Social movements involve collective action by individuals who voluntarily come together around a common cause. They often involve radical action and protest, which may lead to conflict with accepted norms and ways of doing things. They put pressure on society to change, respond directly to the needs of people and communities and have the potential to spread widely across populations through personal networks. In short, a social movement EMPOWERS:



(Figure from [Nesta](#)<sup>2</sup>).

Social movements can have tremendous power, leading to transformational changes in both practice and culture (as the civil rights and environmental movements have, for example). According to [Nesta](#)<sup>2</sup>:

“In their purest form movements are messy, vibrant, spontaneous and uncontrollable. They bubble up outside of formal institutions and from beyond established power structures. They challenge and disrupt. They are restless and determined. They often make society, elites and institutions deeply uncomfortable as they challenge accepted values, priorities and procedures”

Given this unpredictability and potential conflict with institutions and power structures, it is extraordinary and potentially unprecedented for the leader of the largest public institution in the country, the NHS, to call for more social movements as a way to support its ability to deliver. Yet it is social movements that can drive the adoption of new social norms that ultimately make a meaningful impact on the health of our community, and we welcome this call for action.

Social movements are integral to a healthy and thriving society. When successful they can enable disproportionately large, positive outcomes. High levels of social movement activity indicates a particular set of factors are present within a community: engaged residents; a diversity of movements; mobilisation around common causes; and significant grievance with the current state of affairs. It is these societal features that enable movements to be born and to grow, and that we need to foster. The history of Blackburn with Darwen suggests that we already have many of the raw ingredients of social movements in place (Box 2).



### Box 2 - Social movements in Blackburn with Darwen

Blackburn with Darwen has many of the precursors required to start a social movement. The first is its strong connections between politicians and the public. For a small borough, we are politically influential, having borne politicians such as Barbara Castle and Jack Straw who have helped to bring about significant change. Blackburn with Darwen also has strong community networks, political engagement and representation. Representatives from all communities play an active part in Blackburn with Darwen's local government, which helps to channel dissatisfaction into positive action.

Blackburn with Darwen also has a rich history of social movements starting here. In the 1830s, Blackburn, along with Preston, played a key role in the birth of the temperance movement in the UK, which aimed to tackle the threats of drunkenness and street drinking by addressing what we would now call social determinants. Within 50 years Blackburn had improved dramatically, with working hours reduced, education for all children and the building of a public park and library. National legislation was also passed which gave magistrates the power to close public houses by 11p.m.

When the American Civil War began in 1860s, American cotton exports ceased. This 'cotton famine' had a dire impact on Blackburn, which had only just started its cotton industry. Blackburn Council responded to this issue by employing around 1,000 people from the cotton industry to build the town's sewers. It raised the money to fund this project by subscription and without the help of national government.



### What is a Social Movements for Health?

A social movement for health specifically refers to “a persevering, people-powered effort to promote or resist change in the experience of health, or the systems that shape it”<sup>2</sup>. The HIV/AIDS movement has, for instance, transformed the way people experience their own condition and has created a cultural shift in how society responds to those with the illness and to issues of sexuality more generally; from cries of “gay plague” and HIV being considered a death sentence in the 1980s, those living with HIV now have better access to appropriate health care as well as social support and, as a result, both length and quality of life are approaching that of those without the disease.

*“Developing health as a social movement is a process of allowing and enabling a community to take action on the determinants of their own life chances”*

Another example is the disability rights movement, which has fought for equal rights and against discrimination for several decades and has achieved many notable victories, including the passing of the Disability Discrimination Act in 1995. These examples show the power of advocacy and pressure through sustained social movements to transform aspects of health.

Of course, social movements are not an answer to all of our health and care concerns. They can be messy, turbulent, and risky, leading us down somewhat untried and untested paths, without immediate benefit. Yet, they represent one approach to the system-level transformation so urgently needed in health and care and, if successful, can have significant health impacts by<sup>2</sup>:

1. Bringing about change in the experience and delivery of health care
2. Improving people’s experience of disease, disability or illness
3. Promoting healthy lifestyles
4. Addressing wider determinants of health
5. Democratising the production and dissemination of knowledge
6. Changing cultural and societal norms
7. Bringing about new health innovation and policymaking processes

The potential of social movements to actively create health, and not to focus only on preventing disease, means it makes sound economic sense to invest time, effort and resources in finding local solutions to help social movements to grow and spread.

### What is the Role of The Public Sector?

***“Political, civic and managerial leadership in public services should focus on creating the conditions in which people and communities take control, to lead flourishing lives, increase health expectancy and reduce disparities in health expectancy across the social gradient”. Fair Society Healthy Lives (The Marmot Review)<sup>3</sup>***

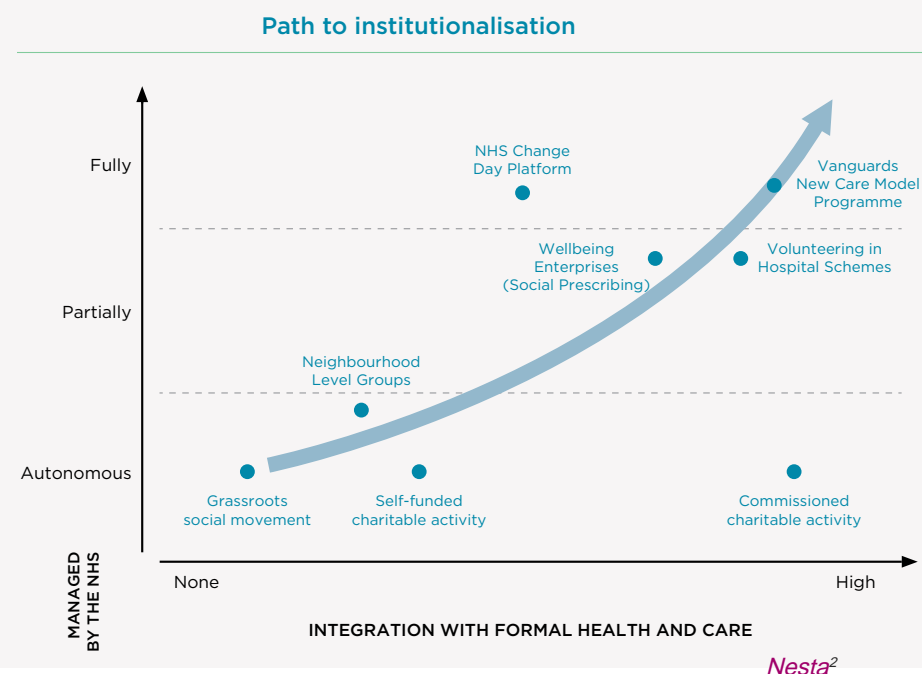
The public sector is uniquely placed to help create the conditions and make the space for social movements to flourish. Whether and how social movements achieve their aims depends in part on the ability of institutions to listen and effectively respond. To fully realise the potential of social movements, institutions need to be agile and responsive, with a commitment on both sides – community and organisations- to engage and create better ways of doing things.

Social movement theory suggests that changes are only likely to ‘catch hold’ on the ground if they are consistent with local customs, habits, aspirations and passions. Movements generally do not form from a specific call to action, but from **raw emotion**:

***“a diffuse dissatisfaction with the status quo and a broad sense that the current institutions and power structures of the society will not address the problem. This brewing discontent turns into a movement when a voice arises that provides a positive vision and a path forward that’s within the power of the crowd”<sup>4</sup>***

It is, therefore, important for public sector organisations to truly understand what drives and moves local people, to listen to their concerns and to respond. Over time, this can lead a social movement to become a sustained part of formal organisations through a process of ‘institutionalisation’. A movement institutionalises when it embeds some change (e.g. a service, solution, belief, pattern of behaviour, or cultural norm) into an organisation, social system or society at large. The figure below demonstrates a path to institutionalisation of movements within the NHS.

There are of course many differences between large organisations like the NHS and local government and society as a whole, but public sector leaders can and should learn from how social movement initiators “mobilise the masses and institutionalise new societal norms”<sup>4</sup>.





### What Needs to Change?

A lot! But this isn't about – or rather is about more than - structural reform. This is because, firstly, it is often difficult for social movements to collaborate effectively with health services without the movement either collapsing under the burden of bureaucracy or being pressured to change<sup>2</sup>. More fundamentally, and despite successive Governments persisting with the idea that major reorganisations of the health service will address many of the issues we face, structural reforms have not led to lasting improvements.

Why is this? Primarily, it is because the underlying culture, norms and expectations of organisations and the communities they serve are of far greater importance than organisational structures<sup>5</sup>. Formal organisational structures are of course necessary and useful in many ways, but even the best thought-through structures and processes can be undermined by a culture of negative behavioural norms. Meanwhile, a positive and constructive culture can deliver real impact even within the context of messy, fragmented structures (like our current health system!).

*“Culture is like the wind. It is invisible, yet its effect can be seen and felt.  
When it is blowing in your direction, it makes for smooth sailing. When it is blowing against you, everything is more difficult”<sup>4</sup>*

This is not to say that structural and organisational reform is always a bad thing; it certainly isn't. The current reforms - devolution and health and care integration – do have potential, but concentrating solely on structures without including transformation of culture and norms runs the risk of merely continuing negative norms - territorialism, hierarchical power and inertia - under a new banner, thus reducing any potential positive impact<sup>5</sup>.

To achieve the cultural changes we are hoping for, both professionals and communities need to learn how to connect, collaborate, cooperate, co-create and co-produce<sup>6</sup> in much more effective ways. New working practices and models of engagement are required that take advantage of both the efficiency and scale of institutions and the dynamism and agility of movements. For this to occur, we require two things: a willingness to change the culture and working practices within our own organisations; and better connections with empowered local communities, who are capable of demanding their voice is heard.

## Social Movements for Health

### Changemaking

We believe that embodying a ‘changemaking’ approach is the first step to driving the necessary change in the ethos and norms of the institutions and communities that create Blackburn with Darwen, rather than their formal structures.

The New Local Government Network describes their vision of a “changemaking council” for example, as one which places a much greater focus on developing a positive working culture, shared values and shared purpose by encouraging the three changemaking values of creativity, self-determination and collaboration<sup>5</sup>.

To prevent inertia and increase innovation, creativity should be valued across the whole workforce and ideas not considered merely as something that comes from senior leaders. Employees must be able to practice self-determination, a licence to act on their own initiative and to try new approaches without seeking explicit permission. Finally, effective collaboration counters fragmentation and territorialism and ensures that effort is reinforced rather than duplicated<sup>5</sup>. Social movements do not fit into the rigid structures many of us are used to working with, and to harness the agility, freedom, positivity and determination underpinning many movements we must aim to develop and share these same values in our professional lives.

It can take as few as 3% of people in an organisation to drive the conversations of 85% of other people<sup>7</sup>. If we can embed the ‘changemaking’ values of creativity, self-determination and collaboration into our own working culture, we will then be in a strong position to extend these values to our partners and ultimately to the communities we work with and for, thereby helping to create the conditions necessary for social movements to thrive.



### Recommendation 1

#### Becoming a 'changemaking' place

Improve working culture and practices by adopting and encouraging the three 'changemaking' values:

- » **Creativity** - ideas and initiative cannot be the sole reserve of a few senior individuals but must be encouraged and valued by everybody. More ideas, more insight, more impact!
- » **Self-determination** - freedom and willingness to respond quickly and creatively is crucial if we are to benefit from a social movement; employees must have license to act on their own initiative and to try new approaches without waiting for permission.
- » **Collaboration** - seek ways to work across organisational boundaries; there is no use in being an island of good practice! Effective collaboration with other departments, external partners and the public will extend changemaking values, build trust and prevent duplication of efforts.



*“The public no longer wants to be led, they want to be mobilised. They want professionals on tap, not on top”*

## Social Movements for Health

### Empowering Communities

It is well recognised that connected and empowered communities are healthier communities<sup>8</sup>. Communities that are involved in decision-making about their area and the services within it, that are well networked, supported and supportive, and where neighbours look out for each other, are known to have a positive impact on people's health and wellbeing. Social movement theory suggests that building community resilience is key to achieving large scale change and successful social movements for health<sup>9</sup>.

To do this, we need to be more open and responsive to communities and work together to create change. Fundamental to this change are interpersonal relationships, including both how professionals go about their work and how we engage with communities. Therefore, we will follow the advice of Nesta and advance our own transformation “with humility and in partnership with the people who the NHS has served for over half a century” whilst developing “solutions that are created through deep engagement and collaboration”<sup>2</sup>. We aim to mobilise communities at scale for health and wellbeing by:

- » **Recognising people as assets, with knowledge and skills as well as needs**
- » **Developing approaches that are community-led and better at connecting people to their communities**
- » **Creating healthy places that build social capital**
- » **Commissioning in a way that reflects the concerns of local communities and values co-production**

We need to acknowledge that public sector organisations are more than statutory regulators and service providers by recognising and encouraging their wider role of supporting communities and enabling people to act for themselves<sup>6</sup>. To create an environment conducive to social movement development and growth, we must empower communities so that local people's creativity is fostered, their responsibility and desire to look after themselves and each other is encouraged and supported, and collaboration and coproduction become routine.

Communities and residents themselves must also be willing to speak up, to demand more and to engage. For our part, we may need to convince our residents that their voices really will be heard, and then actively encourage them to speak out in order to generate a climate of public opinion and political conviction that change is necessary. There has been a recent culture shift that supports this in that we are increasingly seeing patients and residents demanding a say in their own health circumstances. There are several examples across Blackburn with Darwen where people have identified an issue in their communities, for instance social isolation or physical activity, and are doing something about it. Although their work is on a small scale, they are the passionate enthusiasts who can help social movements gain traction (Box 3).

Movements need local activists who will influence their peers and so form a critical mass of support for sustained change. In doing so, informal ‘communities of interest’ can form, in which groups of people who may not usually work together come together to act and learn in order to achieve a common goal. They provide a space where individual identity becomes collective identity, a powerful catalyst for change. These networks can be cultivated and are recognised to be one of the most important mobilisation mechanisms for social movements. These informal groups need to be considered as crucial partners and we should do what we can to support their growth.



### Box 3 – Blackburn with Darwen's 'Passionate Enthusiasts'

**Circle of Friends** - Beth Gregory has been involved in community groups in one guise or another since she became a North East Lancashire Road Safety League officer when she was twelve. Around 8 years ago Beth, along with five others, started her latest community group – the Circle of Friends – which runs social events for the elderly in her local village, Guide. Eight people initially joined but news of the group soon spread by word of mouth. Within a matter of months there were over 34 members from all over the area.

The Friends receive talks from a variety of speakers, play bingo, exercise, laugh and catch up. As the group are mainly in their eighties or nineties, Beth thinks it is important that they all meet and socialise in this way so that they stay connected. She believes that without this group, most of the members would “sit at home in front of the television and ‘vegetate’”!

Beth acknowledges that there are difficulties – running costs and transport needs have made it increasingly difficult to run the group – but is pleased to see similar groups being set up across Blackburn with Darwen, and hopes that these too will reach out to other elderly people who might also be lonely and feel isolated.

**Young Weavers** - Kevin Riddehough has been cycling for as long as he can remember. About ten years ago Kevin came across the 'Let's Ride' website set up by British Cycling, which allows anyone to join organised cycle rides and/or create their own cycling group.

Kevin was inspired to set up his own group within the Blackburn area and initially organised rides during the week around his work commitments. In December 2012, Kevin, along with his wife, Vicky, then started Bus Stop Bikers, before establishing the Young Weavers in 2014 to encourage more families, rather than just adults, to take part.

Young Weavers has been up and running for nearly three years now. The activities take place on the weekend and alternate, so that on one week there is a bike ride and then the next is a walking/family activity. There are also sporadic family events, such as craft events or trips to Stonyhurst College. Young Weavers has a committee, Facebook group and dedicated website.

Kevin will keep on cycling and inspire others to become active. The reason he does this is because he loves seeing someone, who started by cycling at the back of the group, going to the head of the group and chatting on every ride. For Kevin, success is not about how many members he has, it is about reaching a variety of people and encouraging those who do not exercise to get on a bike and ride.

### Recommendation 2

‘Work with communities to support the growth of social movements for health’

- » Develop strong and sustained networks: recognise the importance of and support shared learning through communities of interest and other networks beyond time-limited programmes of work.
- » Identify and support organisational and community social movement ‘champions’ to promote social movements for health within their formal and informal networks.
- » Create learning and development opportunities in support of - and in the spirit of - social movements for health.
- » Deliver a rolling programme of celebration and learning to include an annual Festival of Strengths



## Social Movements for Health

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### Embedding Social Movement Approaches In Practice

We are beginning to put the thinking behind social movements into practice. Boxes 4 and 5 highlight how we are attempting to harness the power of social movements to address Adverse Childhood Experiences (ACEs) and substance misuse, respectively. We recognise, though, that the potential scope of social movements for health is much broader and that almost every aspect of health and wellbeing could be influenced for the better by a demand for change led by our residents, including housing, transport and education alongside traditional health systems.

#### Box 4 – Adverse Childhood Experiences (ACEs)

The Adverse Childhood Experiences (ACEs) movement began in response to a 1998 U.S. study which identified ten stressful or traumatic experiences that children can be exposed to whilst growing up, ranging from those that directly harm a child (such as physical, verbal or sexual abuse, and physical or emotional neglect) to those that affect the environment in which they grow up (including parental separation, domestic violence, mental illness, alcohol abuse, drug use or incarceration). There is a strong relationship between ACEs and both chronic illness (diabetes, heart disease, etc.) and health-harming behaviours (smoking, alcoholism, violence, incarceration, etc.) in adulthood. However, it is possible to both prevent ACEs and to reduce the consequences of ACEs in those that have already experienced them.

So far, the ACEs movement has primarily been led by professionals, both locally and internationally, with no deep rooted culture change yet making ACEs a policy priority. There is then both a need and an opportunity for a health social movement around ACEs and their effects.

We believe that only a citizen-led social movement has the potential to change norms around ACEs and to create environments that nurture healthy children and families. We are committed to encouraging and fostering a social movement around ACEs and tailoring our own local programs and policies to help create safe, stable and nurturing communities.

We are working to: raise awareness and understanding of ACEs; create environments for people to share and support each other in working through their experience of ACEs; create an ACE-informed workforce across sectors (including education, health and social care, criminal justice, and voluntary, community and faith groups); engage local community members in developing effective and novel solutions; and explore the adoption of evidence-based ACEs interventions that have been successfully implemented elsewhere.

While we see ourselves as well placed to provide the initial spark for a local movement, the long-term success of ACEs prevention will rely on local people and communities taking ownership of the movement from the very beginning, in order to drive the changes that they want. We are ready to listen, to adapt and to support. Importantly, we're also prepared to 'let go' and allow the movement to take its own course, however unpredictable that may prove to be!

### Box 5 – Substance misuse

There is strong local evidence that recovery from drugs and substance misuse is best supported by peers, allies and community action. We recognise this and have actively encouraged the growth of a social movement in relation to our substance misuse services.

When the Council tendered for a substance misuse service provider in 2014, we required bidders to adopt a Recovery Orientated Integrated System (ROIS) model, in which those with lived experience were involved in raising awareness, reducing stigma and promoting prevention. Key to this were coproduction and the development of community-based assets, including: working collaboratively with local people and wider stakeholders to ensure that services truly meet the needs of people and their families; building on individual strengths; assisting people to achieve their life goals; and promoting overall improved wellbeing for all.

The drug and alcohol third sector organisation CGL (Change, Grow, Live) was appointed and has provided substance misuse services across BwD since 2015, including education and prevention, training, treatment and recovery support through easy access support to both young people and adults. The effectiveness of the system has been enhanced by new and improved relationships between professionals, citizens and volunteers with each other and with schools and colleges, local businesses and employers, and other voluntary, community and faith sector organisations.

There have been many positives from using this model. Many service users are engaged and connected through regular sports and social activities including football, boxing, fishing, walking, choirs and family craft sessions. There is now a regular community sports day, participation in the nationwide 'Recovery Walk' and health and nutrition classes that provide cooking and lifestyle skills. In addition, residents are given the opportunity to learn a skill or gain further qualifications and help is provided to get users into apprenticeships and employment. All of these activities help those affected by substance misuse by encouraging them to stay clean, be more confident and sociable, stay connected and understand that they are not alone with their situation.

A key part of the model's success has been enabling and empowering residents to take action for themselves, with some now regularly leading projects or getting involved in mentoring others. For example, some service users are involved in a furniture restoration project, whilst others lead art and craft sessions. The Step Up Buddy system also utilises peer mentors to ensure a wealth of experience and support for those leaving treatment.

As a commissioner we have not dictated what needs to be done, but instead allowed and encouraged charities and the community to mobilise and organise specific services and broader wellbeing projects which are most relevant and beneficial to them. This is a prime example of how powers can successfully be relocated away from statutory organisations and towards citizens, to empower them to take ownership of their own recovery and to tackle substance misuse more widely.



### How Will We Know If We Are Successful?

In order to continuously improve our practice we will work with organisations and communities to develop ways of continuously evaluating progress, by asking:

- Did we accomplish the goal we were trying to accomplish?
- Did our community grow stronger (through creating capacity or gaining power they didn't have before)?
- Did individuals involved in the whole effort learn, grow and develop their capacity to organise with others?

### Recommendation 3

Embed social movements in practice

- Identify and develop exemplar social movements, in order to create real-world examples of communities mobilised for health and care.
- Understand and demonstrate 'what works' through continuous engagement and evaluation.
- Support and encourage spread of movements, by developing approaches that could be scaled, adapted and adopted in other communities



## Social Movements for Health

### Summary of Recommendations:

#### Recommendation 1 – Becoming a ‘Changemaking’ Place

Improve working culture and practices by adopting and encouraging the three ‘changemaking’ values:

- Creativity –ideas and initiative cannot be the sole reserve of a few senior individuals but must be encouraged and valued by everybody. More ideas, more insight, more impact!
- Self-determination –freedom and willingness to respond quickly and creatively is crucial if we are to benefit from a social movement; employees must have license to act on their own initiative and to try new approaches without waiting for permission.
- Collaboration – seek ways to work across organisational boundaries; there is no use in being an island of good practice! Effective collaboration with other departments, external partners and the public will extend changemaking values, build trust and prevent duplication of efforts.

#### Recommendation 2 - Work With Communities To Support The Growth Of Social Movements For Health

- Develop strong and sustained networks: recognise the importance of and support shared learning through communities of interest and other networks beyond time-limited programmes of work
- Identify and support organisational and community social movement ‘champions’ to promote social movements for health within their formal and informal networks
- Create learning and development opportunities in support of - and in the spirit of - social movements for health
- Deliver a rolling programme of celebration and learning to include an annual Festival of Strengths

#### Recommendation 3: Embed Social Movements In Practice

- Identify and develop exemplar social movements, in order to create real-world examples of communities mobilised for health and care
- Understand and demonstrate ‘what works’ through continuous engagement and evaluation.
- Support and encourage spread of movements, by developing approaches that could be scaled, adapted and adopted in other communities.



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## Integrated Needs Assessment Summary Review

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### Introduction

Department of Health guidance describes the central importance in the modernised health and care system of an enhanced Joint Strategic Needs Assessment (JSNA), which should consider all the current and future health and social care needs of the area. The local authority and CCG should be guided by the JSNA when developing their Joint Health and Wellbeing Strategy.

The following 41 pages present many of the key messages from Blackburn with Darwen's JSNA, which is known as the Integrated Strategic Needs Assessment (ISNA). It begins with a profile of the borough's population and local economy ('Setting the Scene'), and is then arranged under the same three themes as the Joint Health and Wellbeing Strategy itself: 'Start Well', 'Live Well' and 'Age Well'.

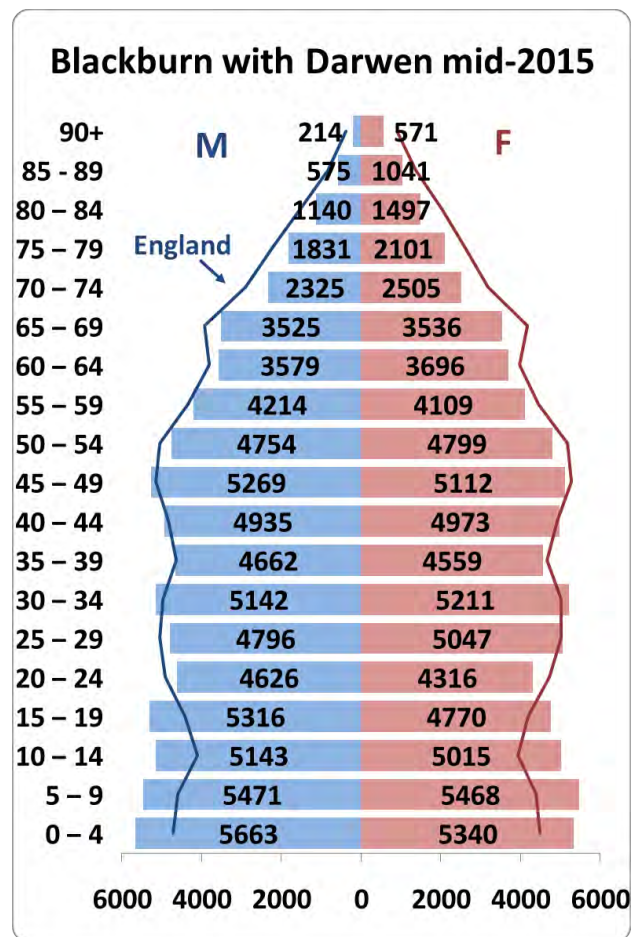
The ISNA Summary Review documents the social and environmental context of Blackburn with Darwen as a place and its impact on the health behaviours, physical and mental wellbeing of the population collectively, and residents as individuals. It also demonstrates the scale of our challenge – doing more of what we have always done will not be sufficient to secure the improvements in health and wellbeing that people aspire to and are demanding. We need, therefore, to fully embrace the power of social movements.



## SETTING THE SCENE

## POPULATION

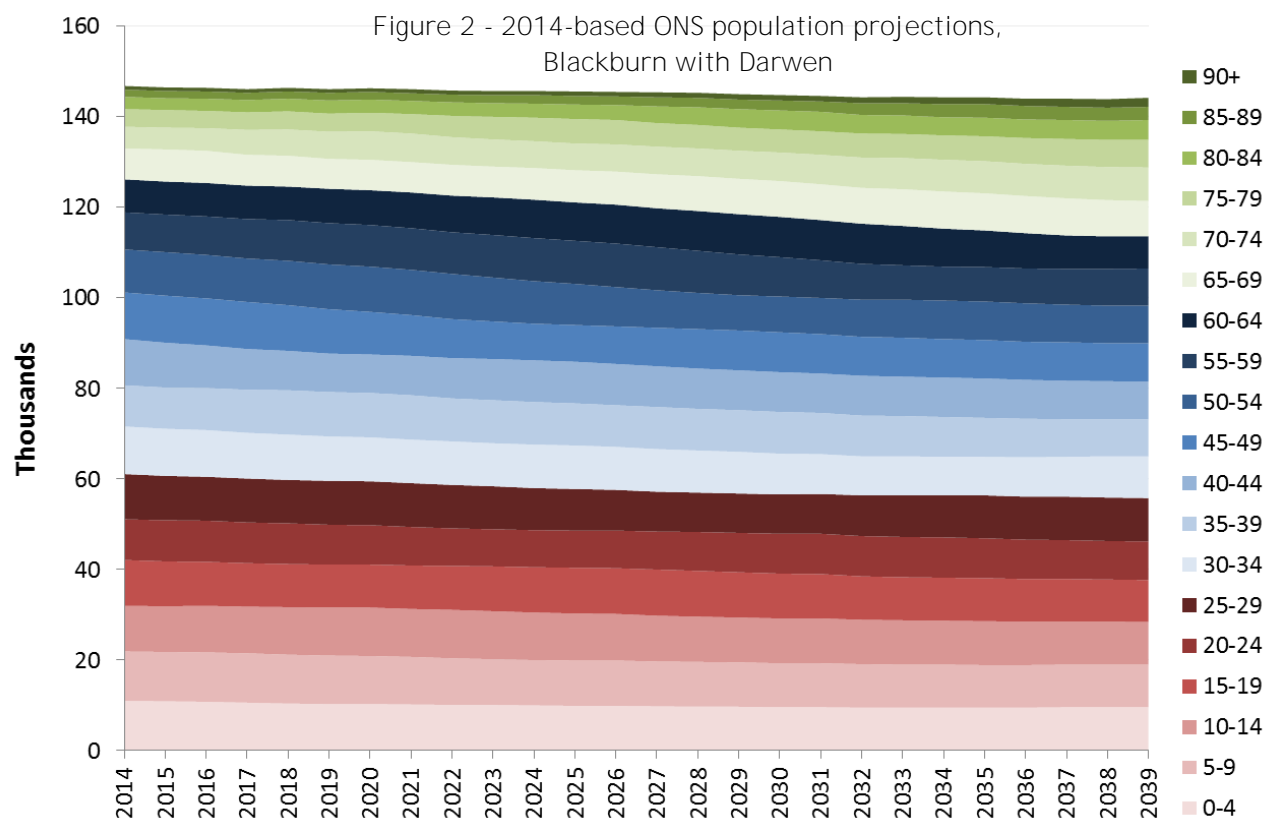
Figure 1 - ONS mid-2015 population estimate for Blackburn with Darwen (with England profile for comparison)



## POPULATION ESTIMATES AND PROJECTIONS

Mid-2015 estimate<sup>2</sup>

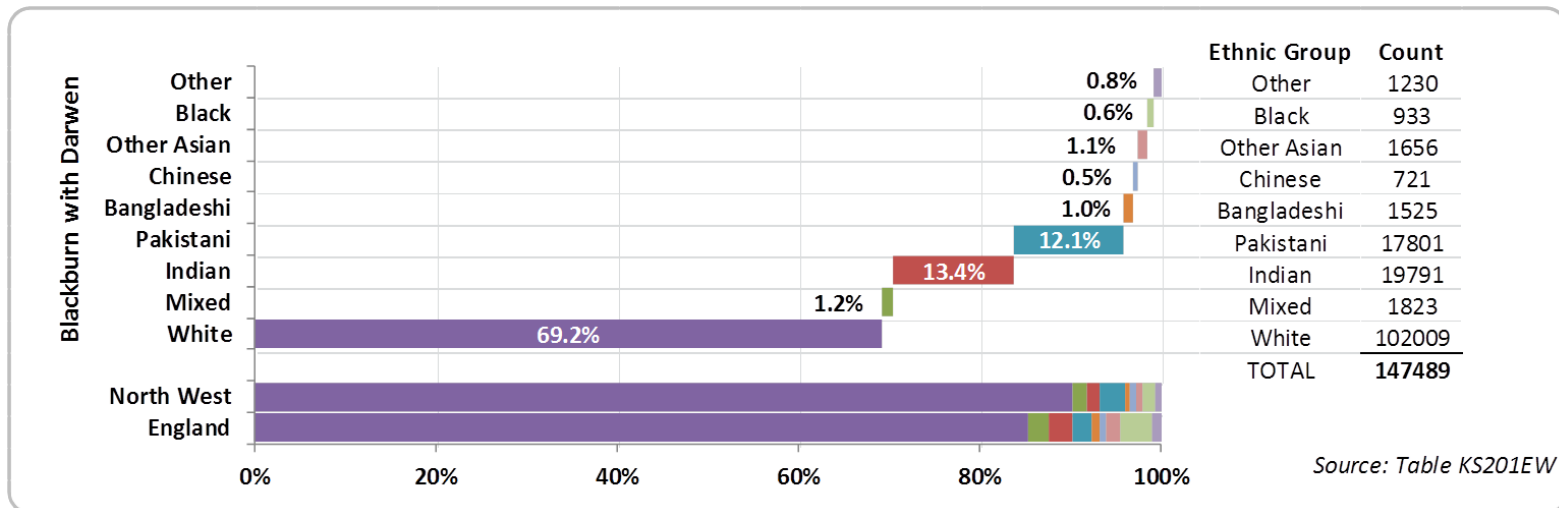
The latest ONS mid-year population estimates for Blackburn with Darwen are for 2015, and indicate a total population of 146,846. This represents an increase of 103 people since mid-2014. The England age structure is superimposed for comparison, from which it can be seen that Blackburn with Darwen has a much younger age profile than average. 28.7% of its population is aged under 20, which is the fifth highest proportion in England.

Population projections<sup>3</sup>

The latest population projections from ONS are based on the 2014 population estimate, and look ahead to 2039. For Blackburn with Darwen overall, a slow almost imperceptible fall is now predicted (Figure 2). However, the 65 age-group is expected to rise by approximately 10,000 over the period (ie. by almost 50%).

## 2011 CENSUS DATA

## Ethnicity



The Census is still our best source of data on the ethnic breakdown of the borough's population, and the relationship between ethnic group and other social characteristics. The proportion of residents who are Indian or Pakistani are the 11<sup>th</sup> highest and the 6<sup>th</sup> highest respectively of any local authority in England.

Figure 3 - Ethnicity: Blackburn with Darwen v. NW and England, 2011 (showing counts for Blackburn with Darwen)

The main ethnic groups have markedly different age profiles from each other (Figure 4), and are represented in varying concentrations across the borough (Figure 5).

Figure 4 - Age profiles by ethnic group, Blackburn with Darwen, 2011

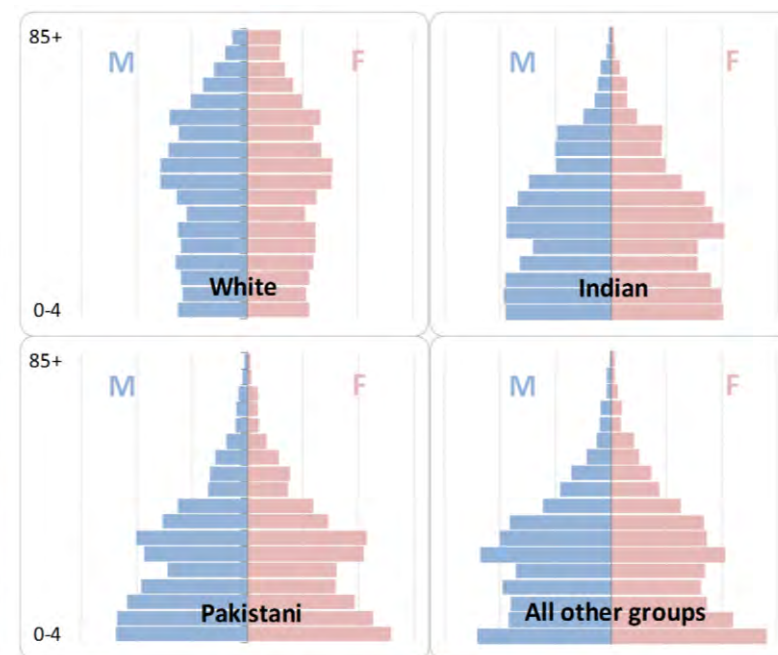
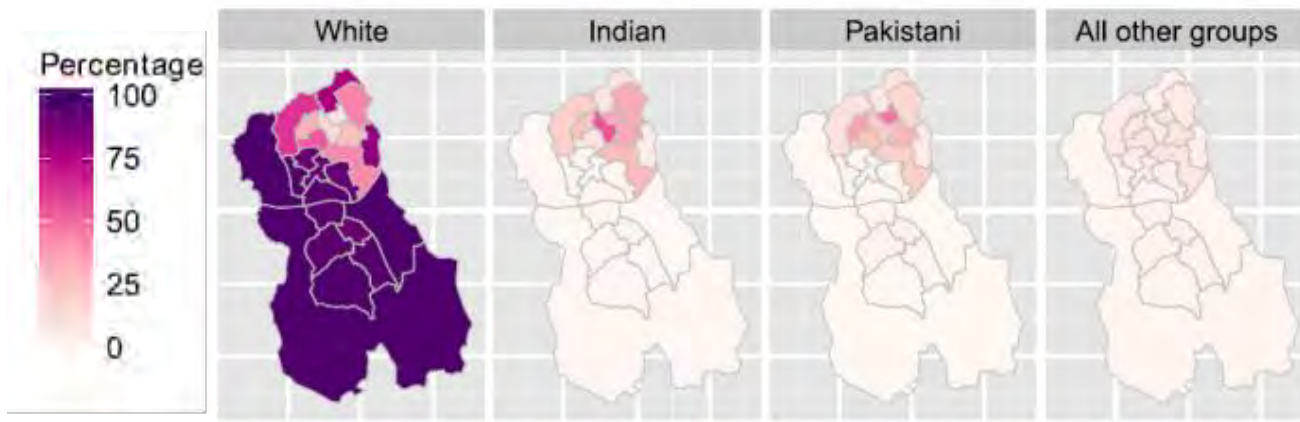


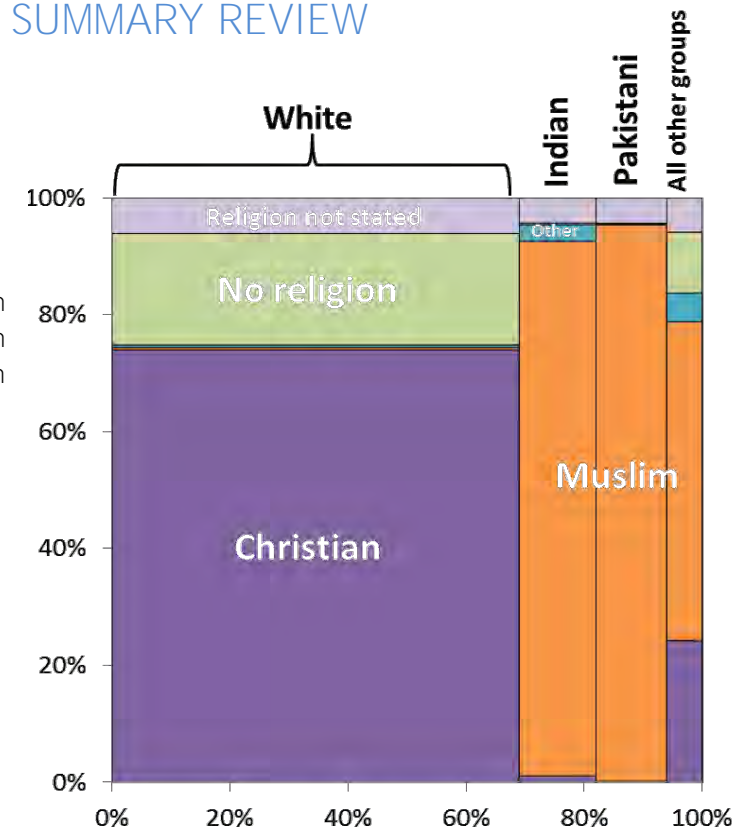
Figure 5 - Blackburn with Darwen - ethnicity by ward



## Religion

According to the Census, 77,599 Blackburn with Darwen residents (52.6%) identify themselves as Christian, and 39,817 (27.0%) as Muslim. 13.8% have no religion, and 5.6% did not answer the question. Religion and ethnicity are closely interlinked, with the vast majority of Christians in the borough being White, and almost all Muslims being Indian, Pakistani or members of other minority ethnic groups (Figure 6).

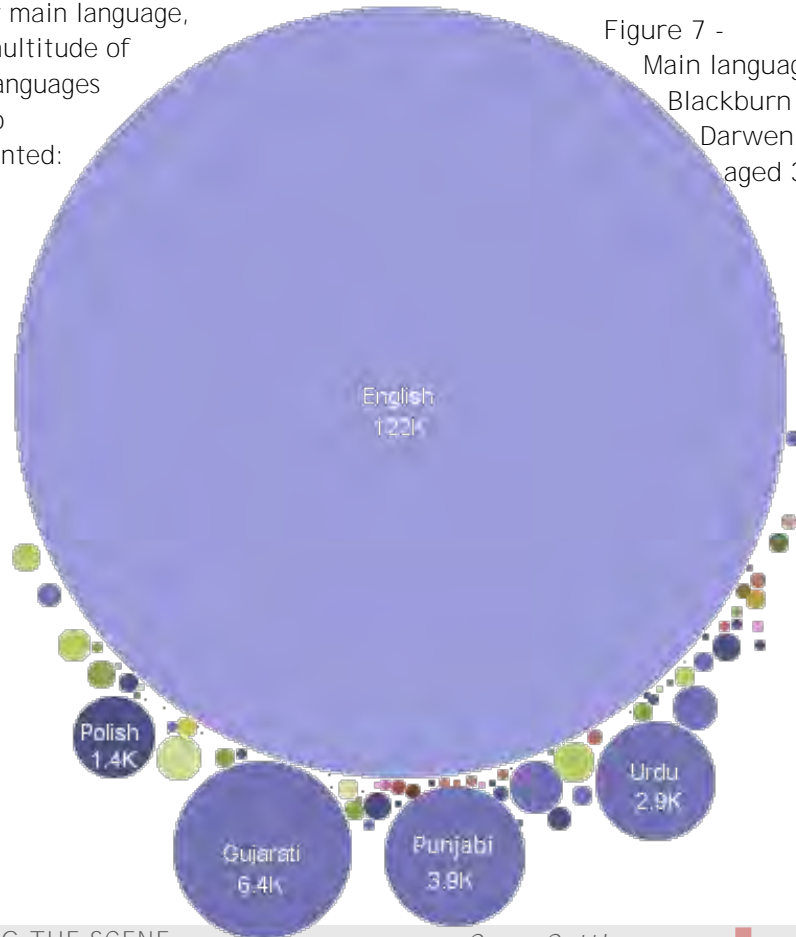
Figure 6 - relationship between ethnicity and religion in Blackburn with Darwen



## Language

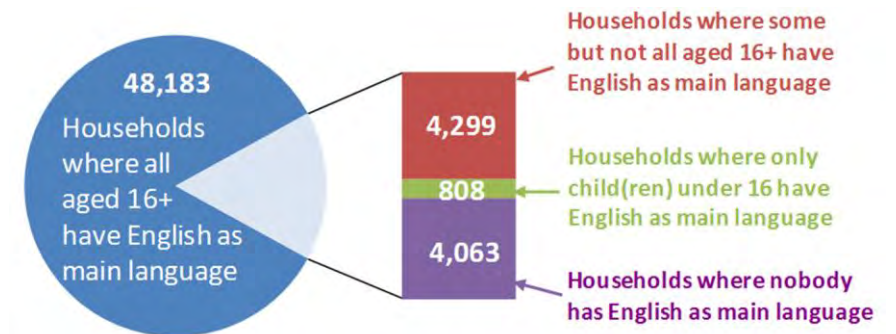
For the first time, the Census asked about the 'main language' of everybody aged 3 or above. Over 86% of Blackburn with Darwen residents had English as their main language, but a multitude of other languages are also represented:

Figure 7 - Main language of Blackburn with Darwen residents aged 3+



Out of 57,353 households in Blackburn with Darwen, there are just over 4,000 where *nobody* has English as their main language, and just over 800 more where only children have English as their main language.

Figure 8 - Main language by household



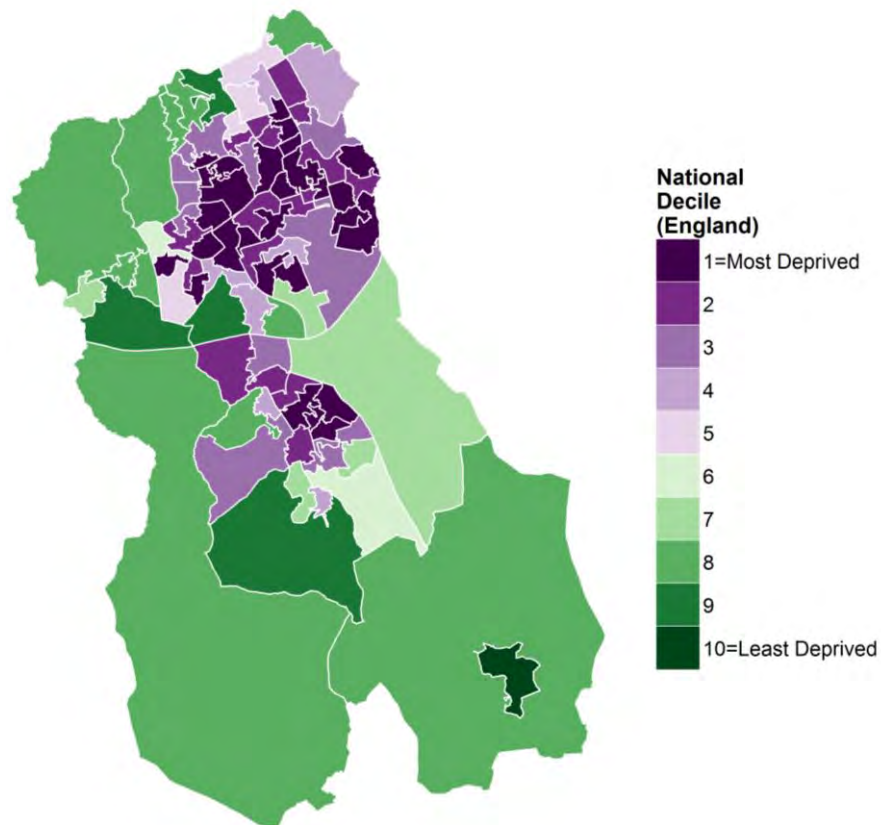
However, it is important to appreciate that many of those with a main language other than English nevertheless speak English 'well' or 'very well'. Only 973 people in the borough could not speak it at all.



## DEPRIVATION

The long-awaited Indices of Deprivation 2015 came out in October 2015, replacing the 2010 version. They are based on 37 indicators, mostly dating from around 2012/13.

Figure 9 - Index of Multiple Deprivation (IMD) 2015



### Deprivation at the Lower Super Output Area (LSOA) level

The best-known output is the Index of Multiple Deprivation (IMD), which incorporates all the indicators, and is calculated for small neighbourhoods known as Lower Super Output Areas (LSOAs).

Figure 9 shows IMD 2015 mapped for **Blackburn with Darwen's 91 LSOAs**.

Nearly half (45 out of 91, or 49%) of the Borough's LSOAs are in the worst two national deciles. By definition, each national decile accounts for 10% of all the LSOAs in England, so Blackburn with Darwen has well over its 'fair share' of deprived LSOAs.

### CHANGE SINCE 2010

It is natural to wonder how things have changed since 2010, but IMD scores from different years are not directly comparable. What we can do is analyse *relative* change - i.e. how many LSOAs have moved up or down in the rankings (Figure 10). 64 out of 91 LSOAs in Blackburn with Darwen stayed in the same decile, and only two of them moved by more than one decile. However, even staying still **does not necessarily mean 'no change'**, as the whole country could have got more or less deprived since 2010.

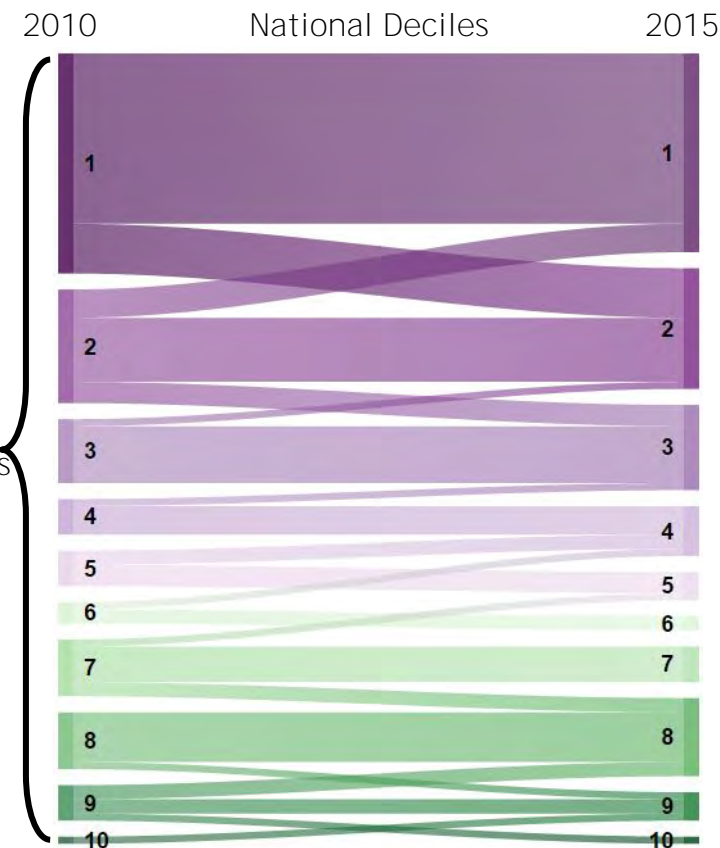


Figure 10 - IMD 2010 and IMD 2015 - movement of Blackburn with Darwen's 91 LSOAs between National Deciles

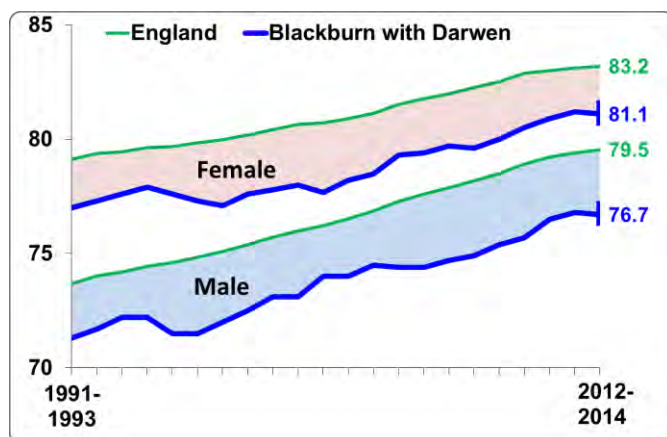
### Deprivation at the Borough level

There are various ways of summarising the Indices of Deprivation at the borough level. In the past, we have tended to focus on the 'Rank of Average Score' method, which ranks authorities according to the average IMD score of their LSOAs. On that basis, Blackburn with Darwen was 17<sup>th</sup> most deprived out of 326 authorities in 2010, and now ranks as 15<sup>th</sup> most deprived in 2015.

However, the summary indicator which is now most widely quoted is the proportion of LSOAs in the Borough falling within the 10% most deprived in England (i.e. in National Decile 1). In Blackburn with Darwen, that proportion fell from 34% in 2010 to 31% in 2015, moving the Borough from 11<sup>th</sup> most deprived to 12<sup>th</sup> most deprived in the rankings.



Figure 11 - Life expectancy in England and Blackburn with Darwen, 1991-93 to 2012-14

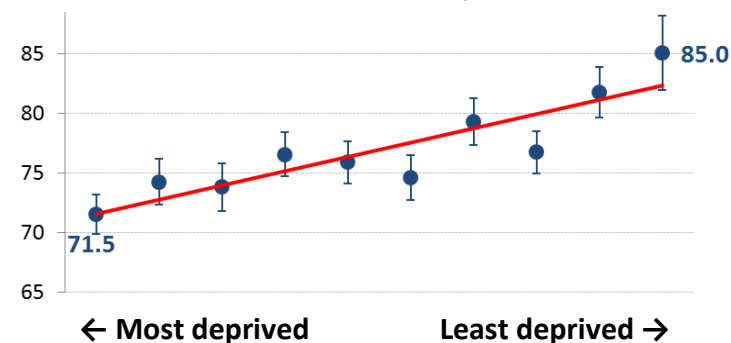


### LIFE EXPECTANCY

Life expectancy in Blackburn with Darwen has risen over the years, but the gap with England has not closed (Figure 11). There is also striking inequality in life expectancy *within* Blackburn with Darwen. To illustrate this, Public Health England has ranked **the borough's** LSOAs by IMD score, divided **them into ten equal groups ('deciles')** of deprivation, and calculated the life expectancy for each (Figure 12).<sup>4</sup>

In 2012-14, the difference in female life expectancy between the most and least deprived deciles was 8.8 years, and for males it was 13.5 years (Figure 12). Public Health England prefers to quote the 'Slope Index', which is based on the slope of the fitted (red) line. This comes to 8.3 years for females and 11.9 years for males.

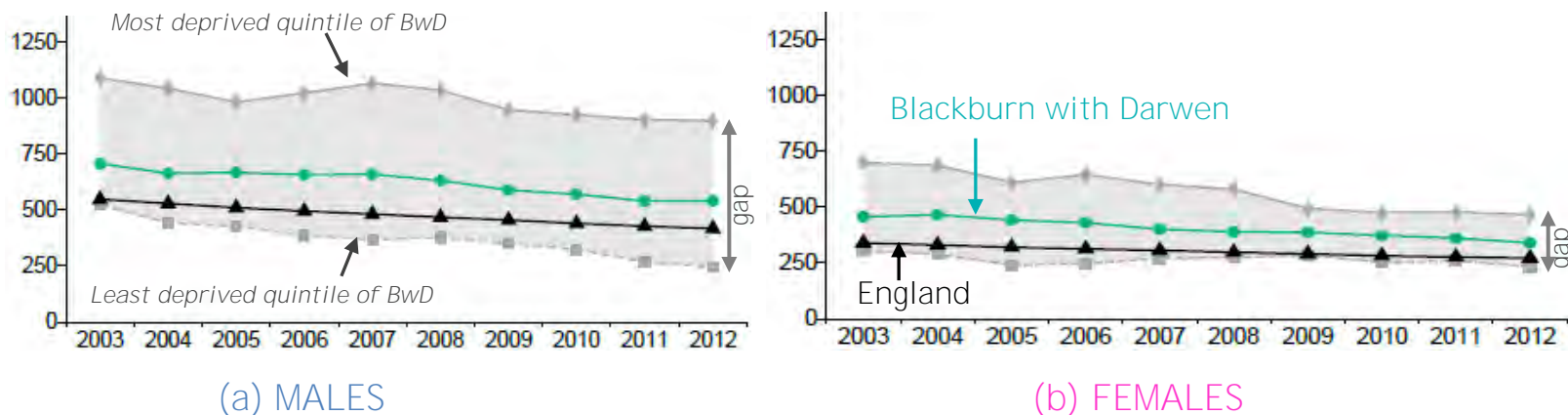
Figure 12 - Male life expectancy by deprivation decile Blackburn with Darwen, 2012-14



### PREMATURE MORTALITY

The inequalities between more and less deprived parts of the borough are also illustrated in the 2015 Health Profile for Blackburn with Darwen.<sup>5</sup> The gap in premature death rates is particularly stark for men, and if anything appears to be growing.

Figure 13 - Premature mortality (under 75) for Blackburn with Darwen, England, & most/least deprived quintiles of Blackburn with Darwen for (a) males and (b) females



[Directly Age Standardised Rate per 100,000. Rates are for three years pooled - e.g. '2012' is actually '2011-13']

## LOCAL ECONOMY

Any analysis of health and social care needs would be incomplete without a quick introduction to the local economy, not only because it helps to set the context, but also because so many of the wider determinants of health and wellbeing are economic in nature.

### SKILLS

In 2015, there were estimated to be 13,500 people aged 16-64 in Blackburn with Darwen with no qualifications, or 14.9% of the working-age population. This is the 11th highest rate of any upper tier authority in England, and significantly higher than the North West (10.0%) or England (8.5%) averages. Data from the Centre for Cities provides a graphic illustration of the relationship between lack of qualifications and the employment rate in the UK's 63 'Primary Urban Areas' (Figure 14).<sup>6</sup>

Only 18.4% of people aged 16-64 in Blackburn with Darwen had a degree or equivalent and above in 2015, which is the 24<sup>th</sup> lowest rate (England 28.8%).<sup>7</sup> However, this suggests a slight improvement on previous years. There is also an encouraging trend in the proportion of **the borough's** 19-year-olds qualified to Level 3 (i.e. two A-levels or equivalent) (Figure 15)<sup>8</sup>. Blackburn with Darwen overtook England several years ago, and currently stands 2.4 percentage points ahead (Blackburn with Darwen 59.8%, England 57.4%).

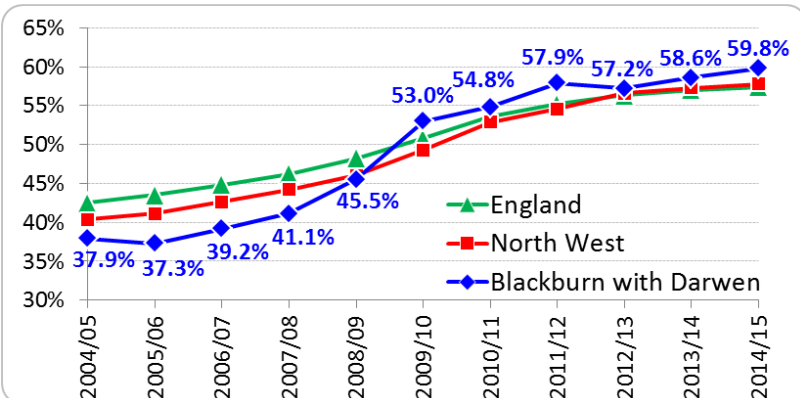


Figure 15 - Level 3 qualification at age 19<sup>8</sup>

## ECONOMIC ACTIVITY

As seen in Figure 16, an estimated 64.8% of **the borough's** residents aged 16-64 are employed. This is the 12<sup>th</sup> lowest rate out of 150 upper tier local authorities (not including the City of London and Scilly Isles).

Together with those who are officially unemployed (i.e. actively seeking work and available to start), it means that only 70.1% are **'economic active'**, which is the 7<sup>th</sup> lowest rate in England. The other 29.9% of residents are economically inactive, either through choice or circumstance.

Figure 14 - Relationship between employment rate and lack of qualifications

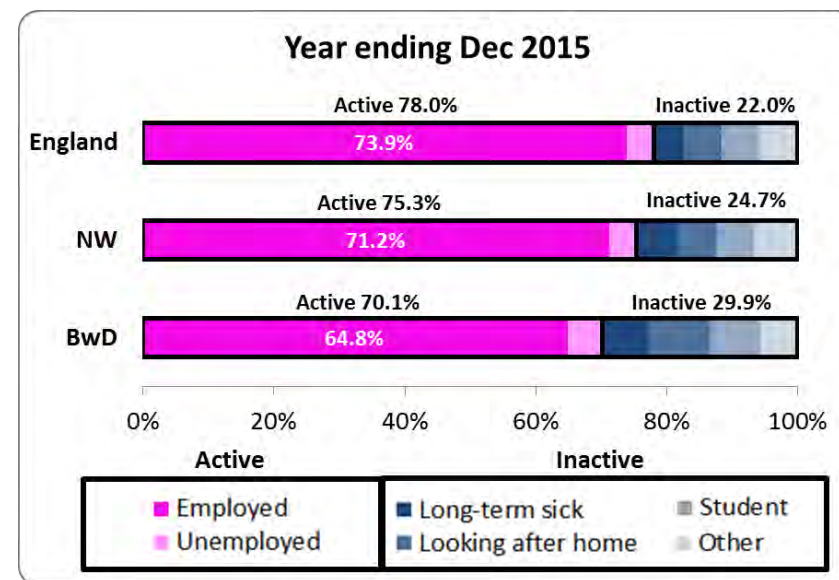
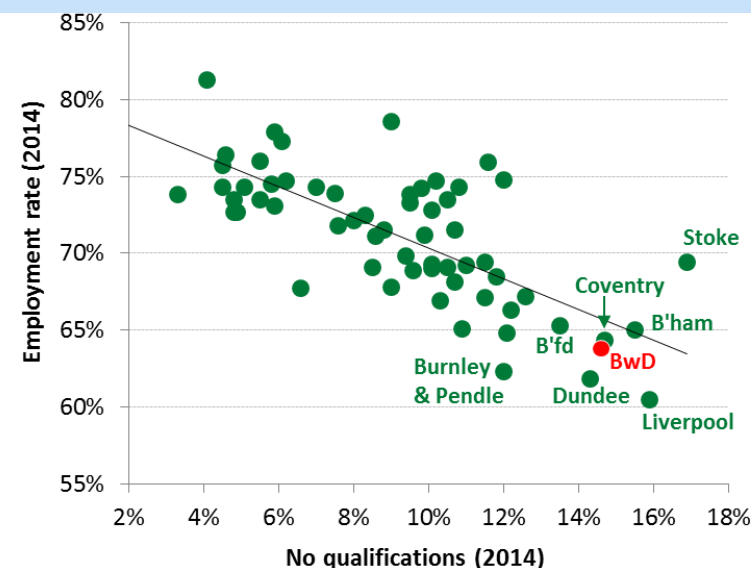
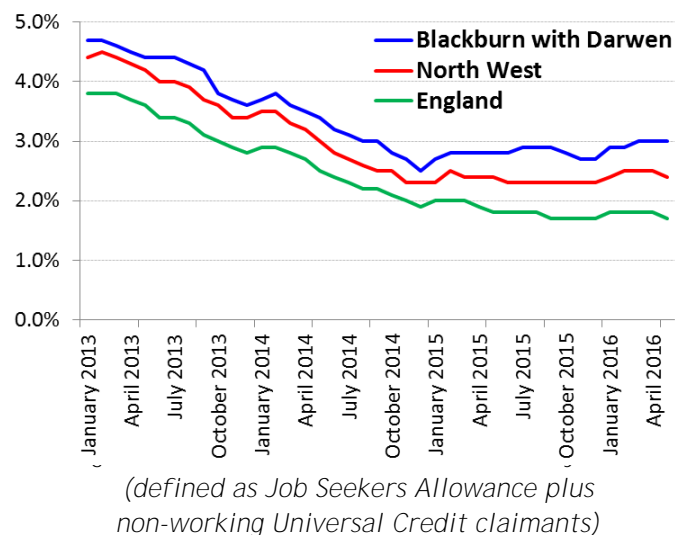


Figure 16 - Economic activity and inactivity & employment rate (age 16-64, year ending December 2015)

## WORKLESSNESS



### Claimant Count

Not everybody who is unemployed will claim benefits, but the Claimant Count is a useful indicator of those that do. The term now includes non-working claimants of Universal Credit as well as Job Seekers Allowance claimants, and figures are available on this basis going back to January 2013 (Figure 17).

In May 2016, **Blackburn with Darwen's Claimant Count** was 2745, or 3.0% of the working-age population (England 1.7%). Rates have been fairly steady since the beginning of 2015, although the gap with England appears to have widened slightly.

At the ward level, the Claimant Count rate in May 2016 ranged from 0.5% in North Turton with Tockholes, to 5.5% in Wensley Fold (Figure 18).

[Click to download the latest ward-level Claimant Count and Rate](#)

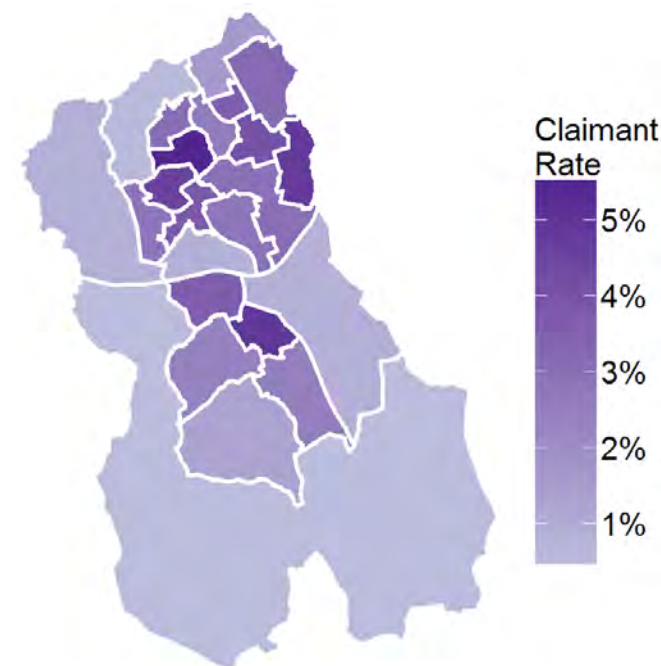


Figure 18 - Claimant rate May 2016 (Wards)  
(defined as Job Seekers Allowance plus non-working Universal Credit claimants)

### Key out-of-work benefits

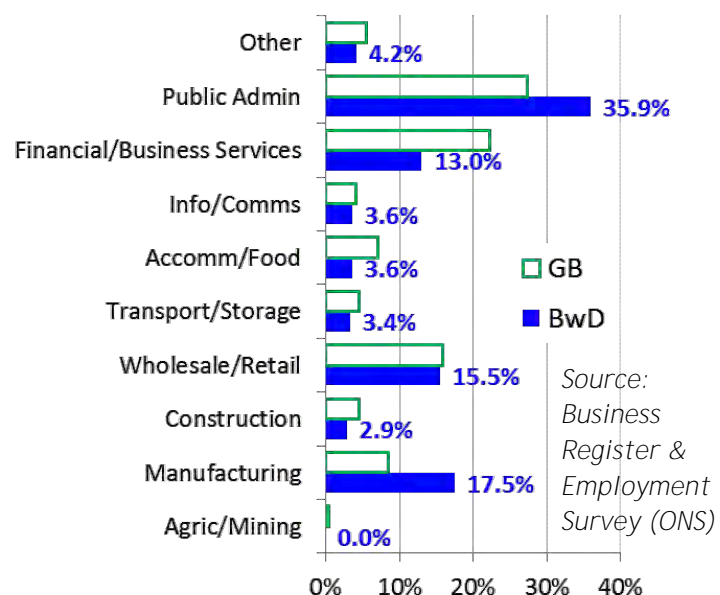
**'Key out-of-work benefits'** is usually presented in the Summary Review as a convenient measure of all those who qualify for benefits because they cannot be in full-time work. It has basically consisted of those claiming Job-Seekers Allowance, incapacity benefits, or Income Support for lone parents. However, an increasing number of those who would formerly have claimed JSA now receive Universal Credit instead. Unfortunately, this has yet to be incorporated in the **official calculation of 'out-of-work benefits'**.

If we remove the JSA claimants, and add on the new **'Claimant Count'** instead (which combines JSA claimants and non-working claimants of Universal Credit), then the total number of people on **'Key out-of-work benefits'** in Blackburn with Darwen as at November 2015 becomes approximately 13,110, or roughly **14.2%** of the 16-64 age-group. This compares with 8.9% in England and 11.7% in the North West. However, it must be stressed that this is a very rough-and-ready improvisation. If the adjustment were really this easy, it would surely have been done for us already on websites such as Nomis.<sup>9</sup>

### Working-age Incapacity

The largest single category of out-of-work benefits claimants are those receiving Employment Support Allowance, or some other sort of incapacity benefit. This group is considered in more detail in the **'Live Well'** section (page 34).

Figure 19 - Employees by sector - Blackburn with Darwen compared with Great Britain (2014)



### EMPLOYMENT BY SECTOR

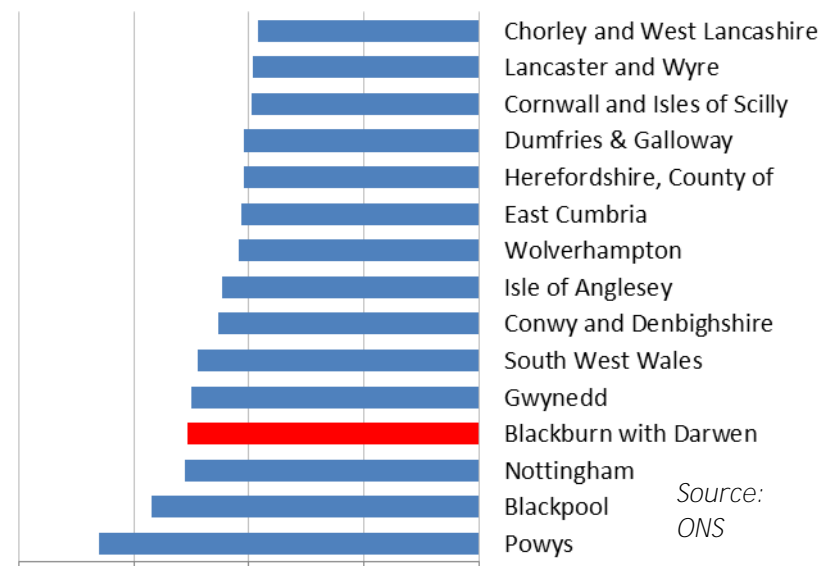
Public Administration, which includes Education and Health, accounts for more than a third of employees in Blackburn with Darwen. Figure 19 shows how the percentage of Blackburn with Darwen employees in each sector compares with the Great Britain average.

### PRODUCTIVITY

Productivity describes the ability to produce outputs from a given amount of inputs such as labour. Economic output can only be increased by raising the amount of inputs (e.g. employees) or by raising their productivity, so productivity is vital to improving standards of living.<sup>10</sup>

The preferred sub-regional measure of productivity is Gross Value Added (GVA) per hour worked. On this basis, Blackburn with Darwen has the 4th lowest productivity out of 173 'NUTS 3' areas in the UK (Figure 20), at less than 75% of the UK average.<sup>10</sup>

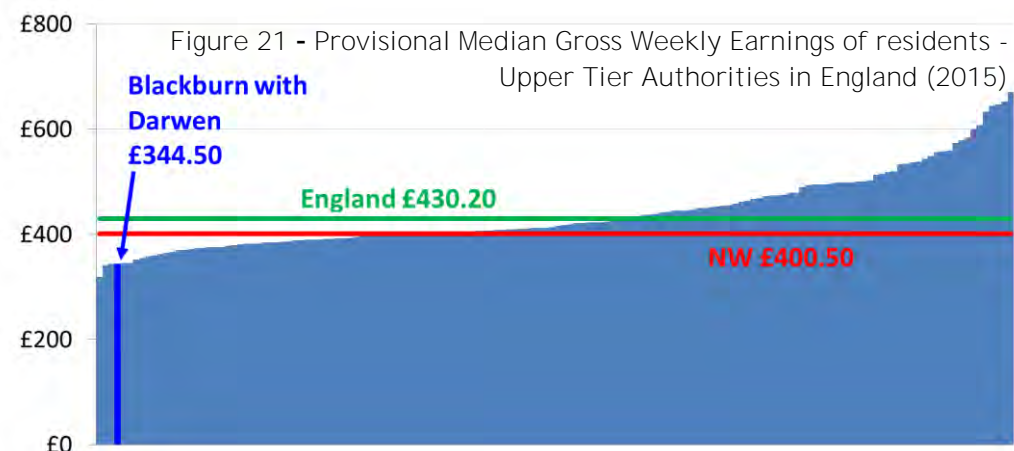
Figure 20 - Productivity (GVA per hour worked) - lowest ranking NUTS3 areas, relative to UK (2014)



### EARNINGS<sup>11</sup>

Provisional median gross weekly earnings for Blackburn with Darwen residents in 2015 were £344.50. Although this looks like a reduction compared with last year's Summary Review, the figure quoted there was later revised downwards. The new provisional figure puts Blackburn with Darwen in fourth lowest position out of 150 upper-tier authorities (Figure 21).

Analysis by the Resolution Foundation<sup>12</sup> shows that 25% of employees in Blackburn with Darwen stand to benefit from the introduction of the National Living Wage in April 2016, rising to 32% by 2020. Both proportions are just within the top quintile nationally.





# INTEGRATED STRATEGIC NEEDS ASSESSMENT - SUMMARY REVIEW

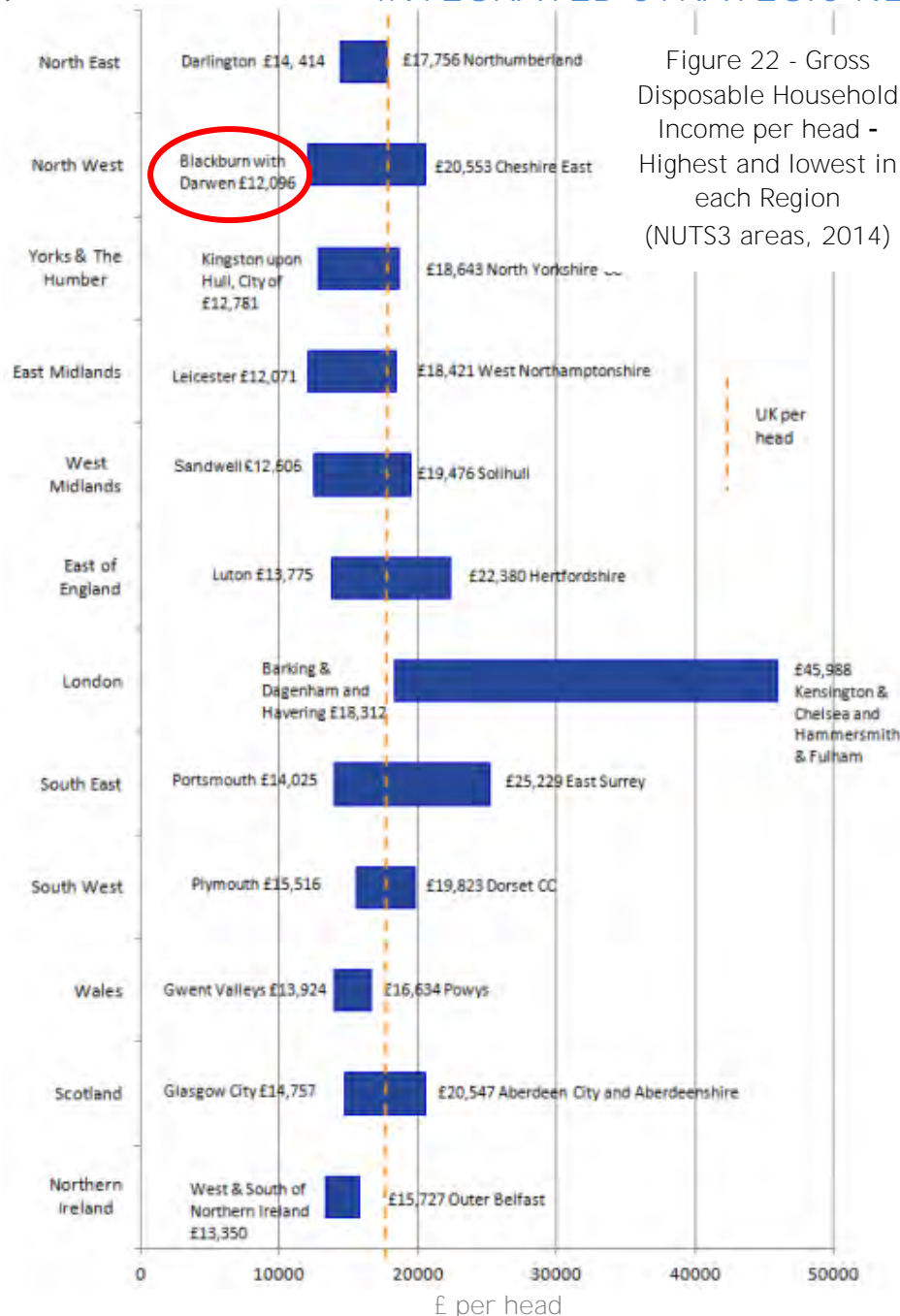


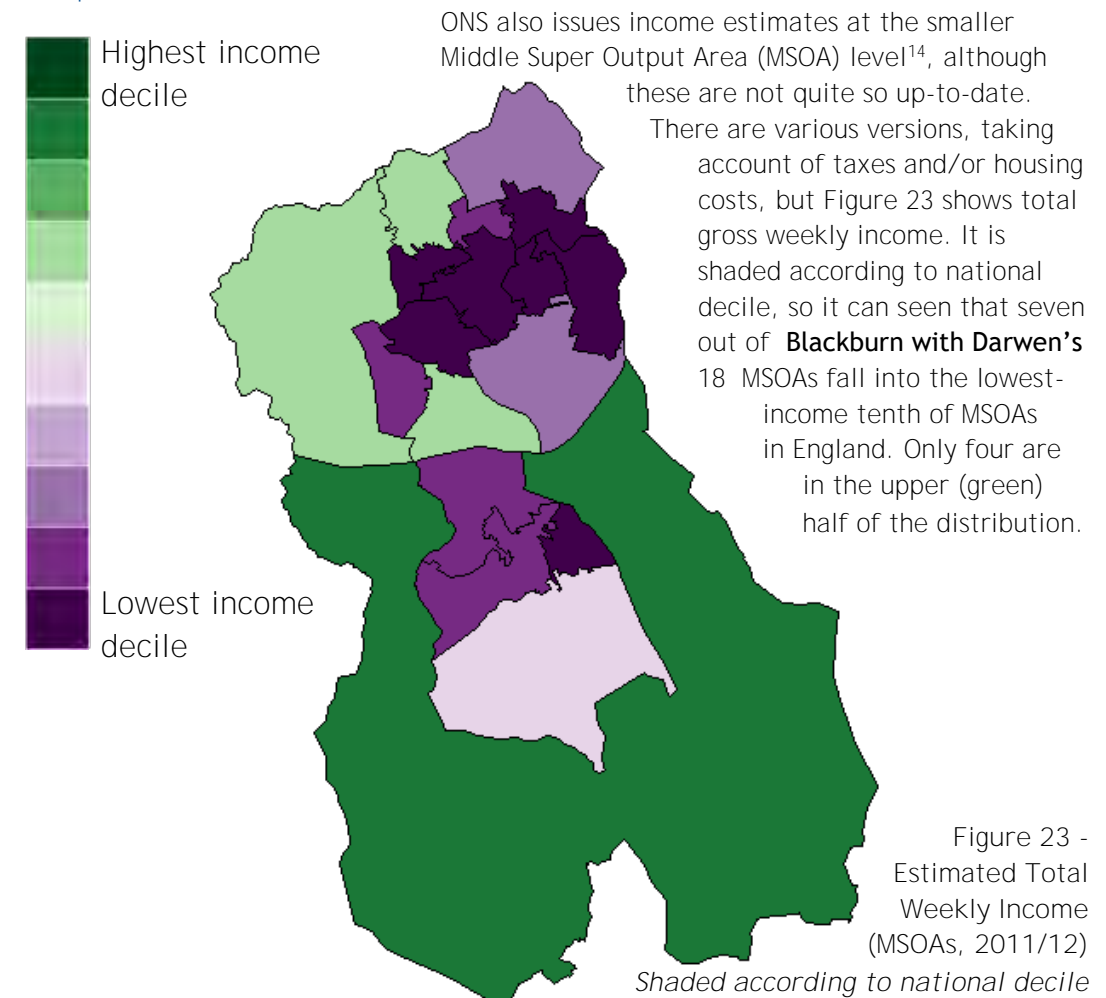
Chart taken from ONS Statistical Bulletin<sup>13</sup>

## HOUSEHOLD INCOME

### Blackburn with Darwen as a whole

A recent ONS report<sup>13</sup> shows that in 2014, Blackburn with Darwen had the second lowest Gross Disposable Household Income per head in the UK, after Leicester and followed by Sandwell. This means it is the lowest NUTS3 area in the North West. Figure 22 shows the lowest and highest average incomes found in each region.

### Inequalities within Blackburn with Darwen



## WELFARE REFORMS

Figure 24 - Impact of Welfare Reforms pre-2015\* and post-2015†

(Blackburn with Darwen compared with GB)<sup>15</sup>

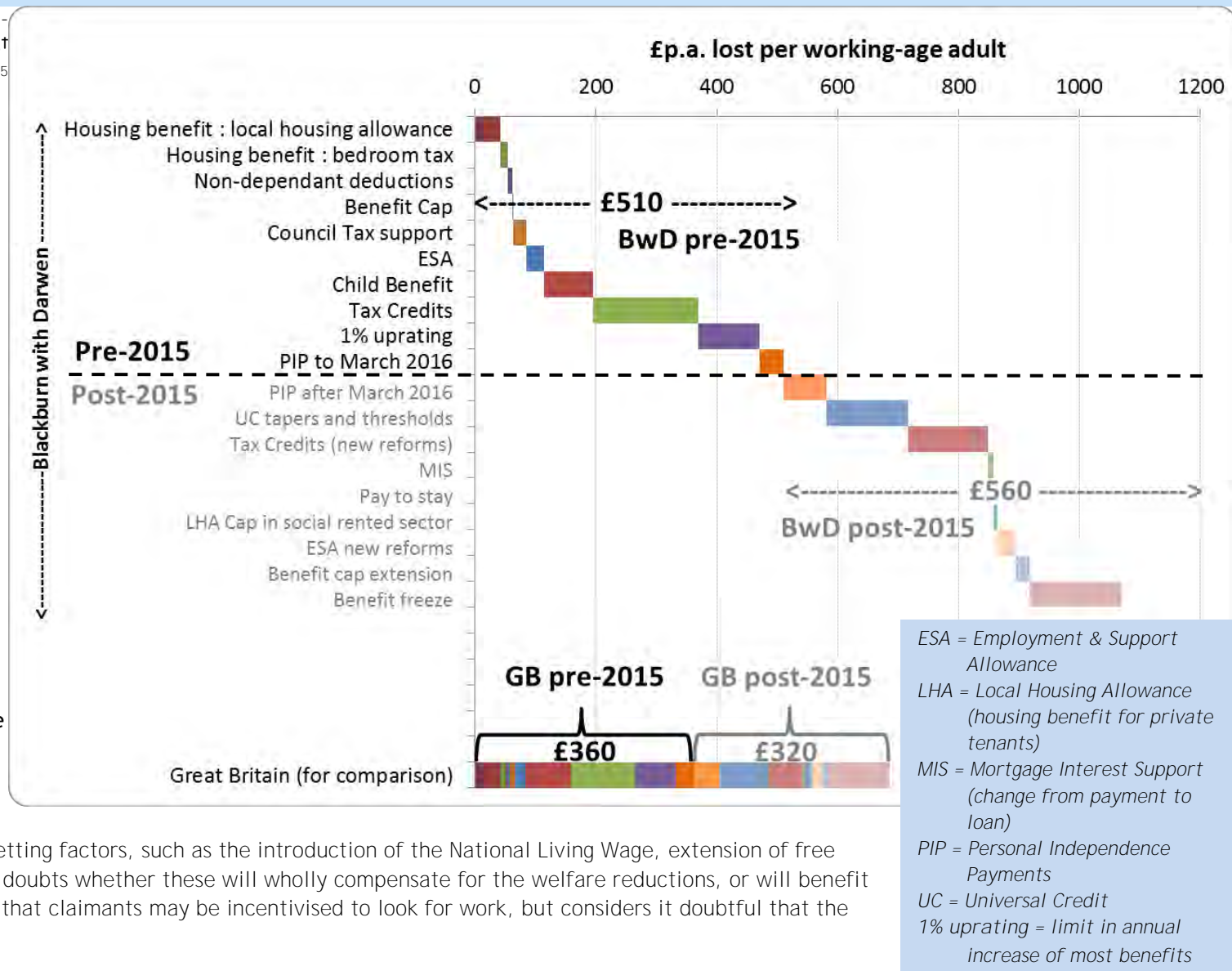
A new report from Sheffield Hallam University summarises the impact of the welfare reforms introduced since 2010, and the likely impact of the further reforms announced since 2015. It finds that generally speaking, they fall most heavily upon the most deprived authorities.<sup>15</sup>

The report estimates that the pre-2015 reforms have already lost Blackburn with Darwen £510 p.a. per working-age adult. Just before the 2015 Budget, the Guardian reported widespread concern in Blackburn with Darwen about the prospect of further cuts:<sup>16</sup>

**'There's never any money left': threat of welfare cuts alarms Blackburn families**

The Sheffield Hallam report now predicts that by 2020-21, the further reforms announced in 2015 will have resulted in an additional loss of £560 per head in Blackburn with Darwen. Along with Blackpool, this is the highest equal predicted impact out of 378 local authorities. Blackburn with Darwen's **low wages and large families** make it particularly vulnerable to the planned reductions in Tax Credits, and the new Universal Credit tapers and thresholds.

The report does acknowledge that there are offsetting factors, such as the introduction of the National Living Wage, extension of free childcare, and rent and tax reforms. However, it doubts whether these will wholly compensate for the welfare reductions, or will benefit the same people. It also considers the possibility that claimants may be incentivised to look for work, but considers it doubtful that the demand for labour will expand to match.



\* i.e. impact by March 2016 of reforms introduced by the Coalition Government following 2010 General Election

† i.e. predicted impact by 2020-21 of reforms introduced following the 2015 General Election (plus the post-2016 increases in PIP already announced before 2015).

## SAFE AND HEALTHY HOMES AND NEIGHBOURHOODS

HOUSINGCondition of housing stock

Blackburn with Darwen's housing stock is dominated by older terraced housing, much of it in poor condition, with 27,000 houses in the borough estimated to be 'non-decent'. Approximately 12,300 homes contain a 'Category 1 hazard', which by definition means it poses a risk to health and safety. The greatest concentrations of such houses are found in Bank Top, Mill Hill and central Darwen.<sup>17</sup> Poor management and maintenance in the growing private rented sector is a particular concern, and the Council has presented evidence to a House of Commons Select Committee arguing for tighter regulation to avert social problems and the destabilisation of communities.<sup>18</sup>

Houses in multiple occupation (HMOs)

Some of the most acute social problems are concentrated in multi-tenanted 'Houses in multiple occupation' (HMOs), which themselves are concentrated in particular areas of the borough. The locations of the biggest private-sector HMOs in Blackburn with Darwen (those with 5 or more bedspaces) are shown in Figure 25. These alone have more than 500 bedspaces between them.<sup>19</sup>

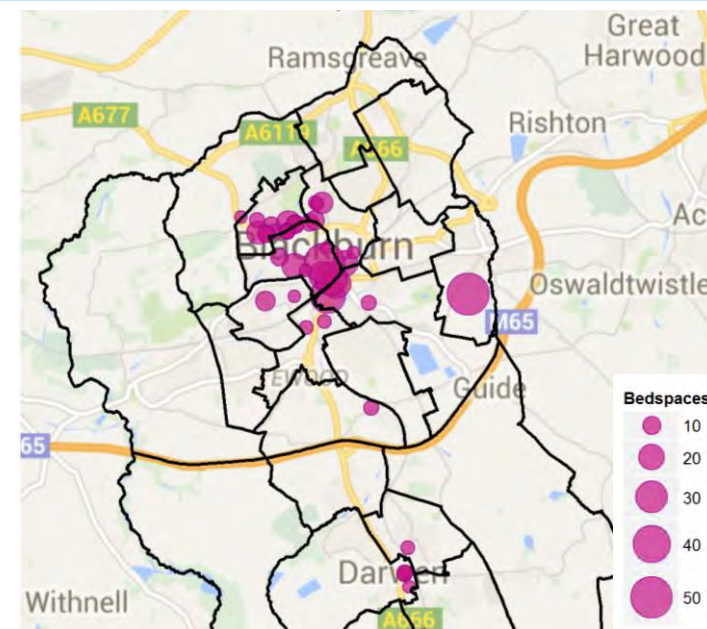


Figure 25 - Houses in Multiple Occupation (HMOs) with 5+ bedspaces as at December 2011 (overlaid with Wards)

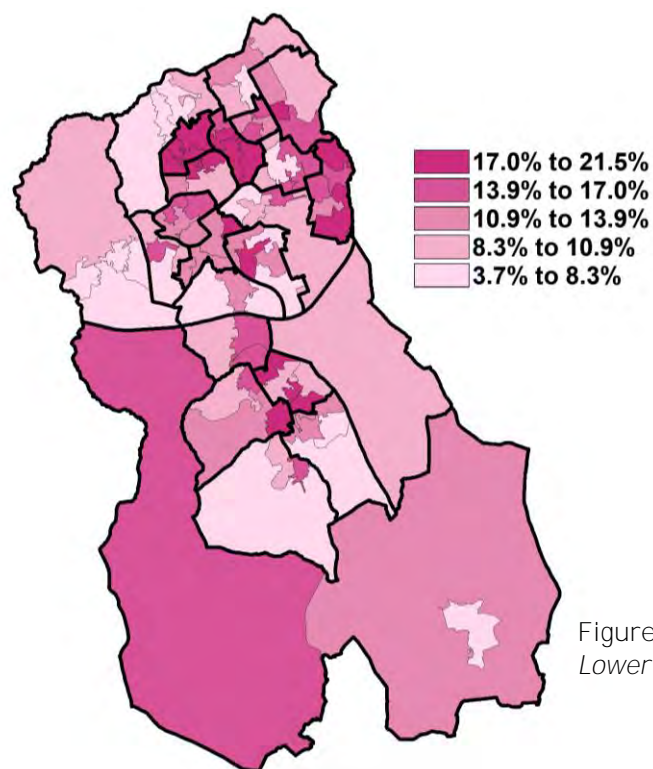


Figure 26 - % Households in Fuel Poverty, 2014 (modelled estimates)  
Lower Super Output Areas overlaid with Wards

Cold housing and fuel poverty

A common reason for housing being classified as non-decent or hazardous is low energy standards and excess cold. As well as being a major contributor to excess winter deaths, cold housing adds to the burden of circulatory and respiratory disease, colds and flu, exacerbates chronic conditions such as rheumatism and arthritis, and has a negative effect upon mental health across all age-groups.<sup>20</sup>

A household is defined as being in fuel poverty only if its required fuel costs are above average, *and* spending that amount on fuel would leave it below the poverty line\*. An estimated 7232 households in Blackburn with Darwen were in fuel poverty in 2014. This equates to 12.4% of all households in the borough, and compares with an England average of 10.6%.<sup>21,22</sup> Out of more than 300 local authorities, Blackburn with Darwen now ranks just outside the highest 50 for fuel poverty, which suggests a relative improvement in recent years.

\* The Department of Energy & Climate Change no longer issues fuel poverty figures according to the old definition (the need to spend more than 10% of income on maintaining a satisfactory level of heating).



## CRIME AND VIOLENCE

### Crime and antisocial behaviour

Crime and fear of crime affects not only the health of individual victims, but the wellbeing of whole communities, and public engagement has shown it to be a high priority in Blackburn with Darwen.<sup>23</sup>

Data about the type and whereabouts of every recorded incident of crime or antisocial behaviour is available from <http://data.police.uk/>. In Figure 27, the darkest shading denotes the areas with the greatest density of incidents in the year to December 2015.

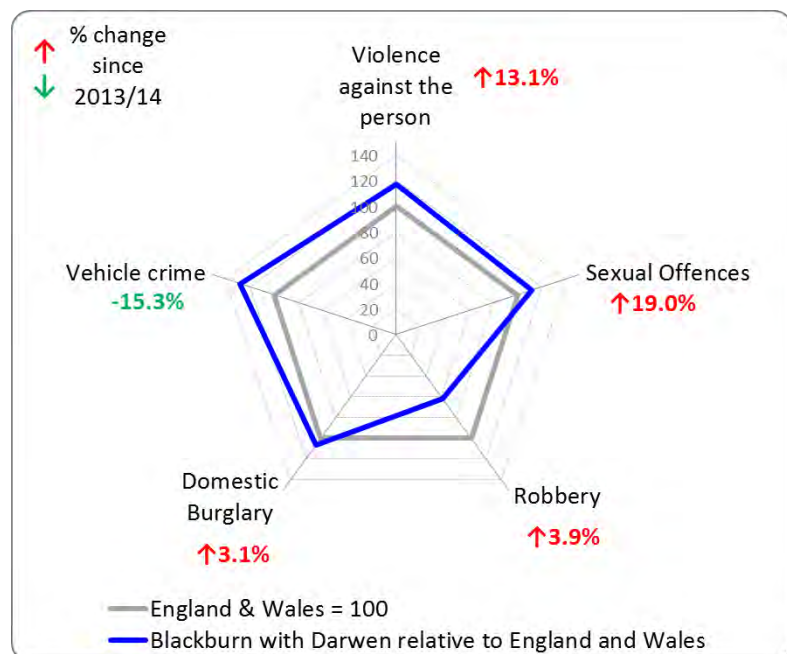
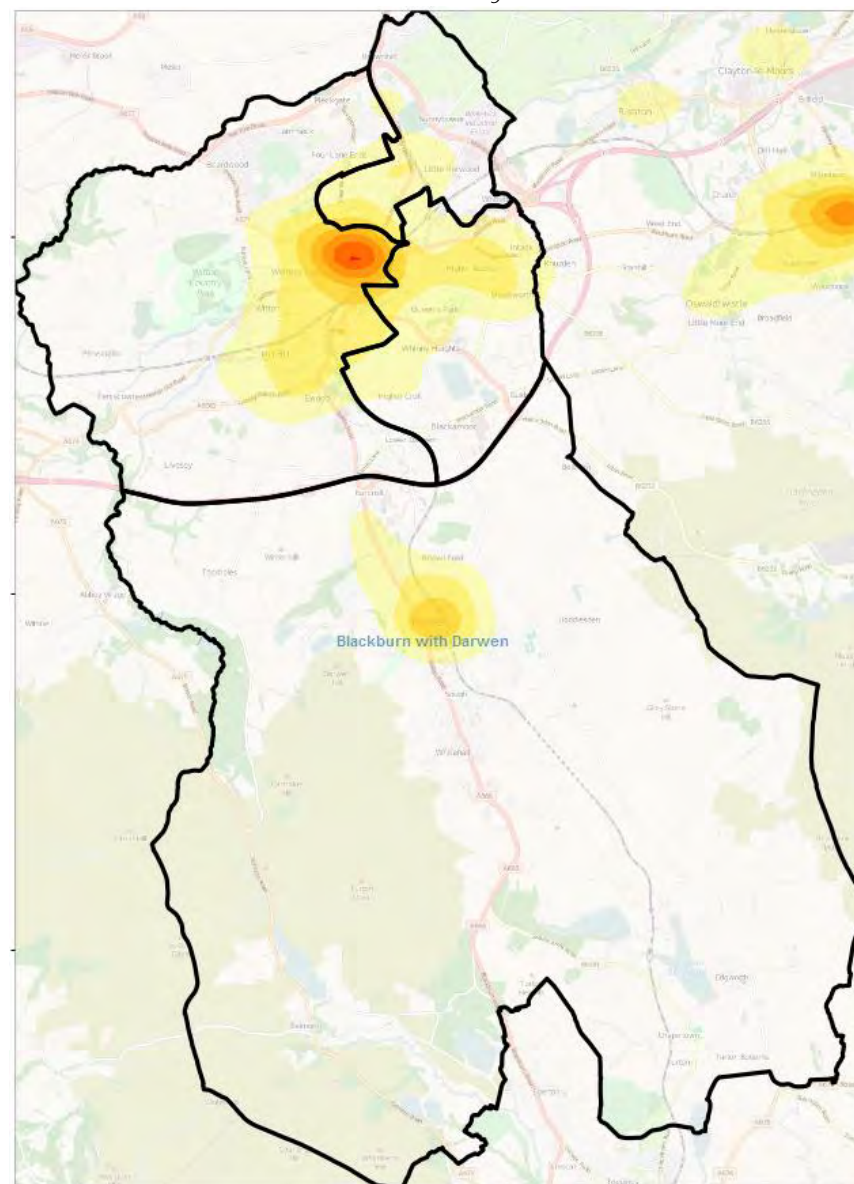


Figure 28 - Recorded crime per 1000 population 2014/15 - Blackburn with Darwen compared with England & Wales (=100). Also showing percentage change since 2013/14.

Health Outcomes Framework.<sup>26</sup> Blackburn with Darwen had 2337 recorded offences of violence against the person during 2014/15, which as a rate is almost 18% higher than the national average, and puts it in the second highest quintile. The borough is also in the second highest quintile in 2014/15 for the rate of sexual offences per 1000 population. Rates of emergency hospital admissions for violence are high across most of the urban north of England, although most places are on a downward trend. Blackburn with Darwen's rate for the period 2012-13 thru 2014-15 is down on the year before, but stands at roughly twice the England average, and ranks 6<sup>th</sup> highest in the country.

Figure 27 - Hotspots of recorded Crime and Antisocial Behaviour (January-December 2015)  
Overlaid with Locality boundaries



### Key offences

Figure 28 compares five key crime rates in Blackburn with Darwen in 2014/15 against the England & Wales average (which is scaled to equal 100 for every crime type). All except the robbery rate are higher than the national average. Violence against the person and Sexual Offences have both risen since 2013/14, but not as fast as the national average. All recorded crime figures have to be treated with caution, as they do not currently meet the standards required for National Statistics status.<sup>24,25</sup>

### Violence

The relationship with health is particularly direct in the case of violent crime, which is the subject of three indicators in the Public



## SOCIAL MOBILITY

THE SOCIAL MOBILITY INDEX

A new index from the Social Mobility and Child Poverty Commission attempts to measure the chances that poorer children in each local authority have of doing well later in life. Data was collected reflecting their educational attainment before, during and after their school years, and also the outcomes achieved by adults in the same area (in terms of income, job status and home ownership). From these sixteen indicators was derived the overall Social Mobility Index, as well as a separate summary measure for each of the four life-stages.

Overall Index

On the overall Social Mobility Index, Blackburn with Darwen ranks 154<sup>th</sup> out of 324 lower-tier local authorities in England (where 1<sup>st</sup> is best) - i.e. it sits just above mid-table. **The prime ‘hotspots’ of Social Mobility** (red shades in Figure 29) are predominantly in London, though Ribbles Valley and Rossendale are also in the best quintile. At the opposite end of the spectrum, the worst ‘coldspots’ (blue shades) are West Somerset, Norwich and Wychavon, with Blackpool ranking 9<sup>th</sup> from bottom. Although there is a tendency for social mobility to be better in more affluent areas, this is by no means always the case.

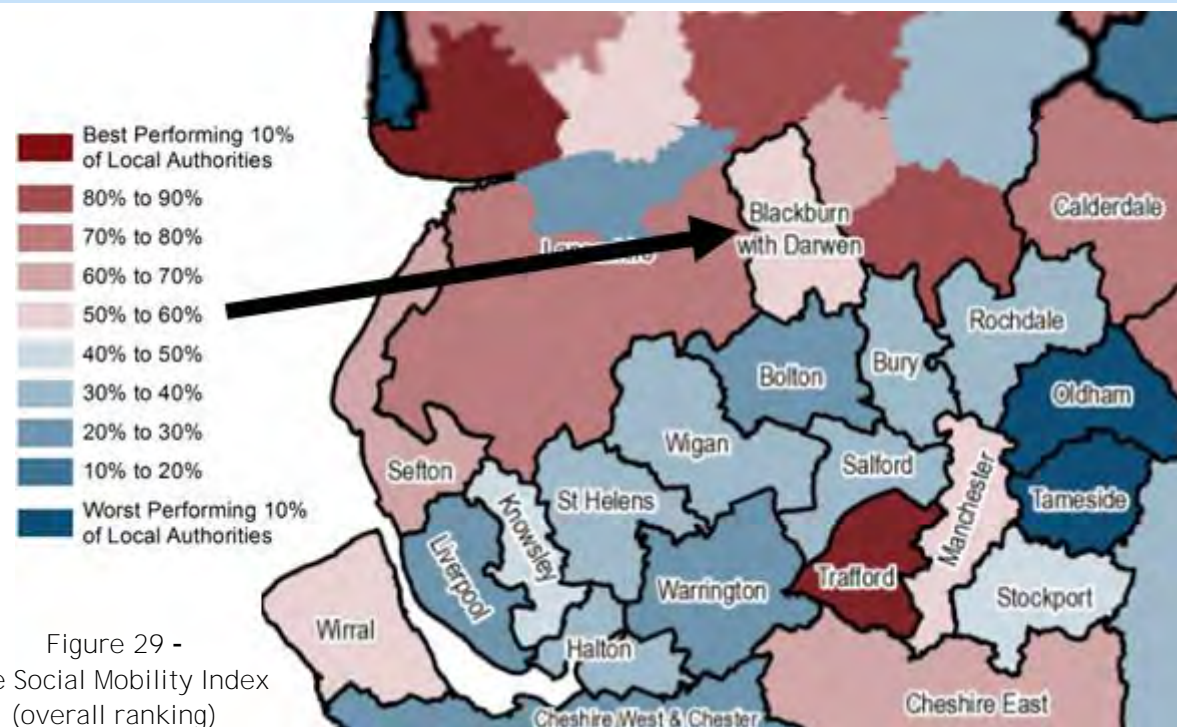


Figure 29 -  
The Social Mobility Index  
(overall ranking)

Life Stage Indices

**Blackburn with Darwen’s overall Social Mobility Index masks considerable variation** in how the borough performs at each of the four life stages:

Early Years	School	Youth	Adulthood
Blackburn with Darwen ranks 312 <sup>th</sup> (13 <sup>th</sup> worst) on the Early Years indicators. This is mainly due to the low percentage of children eligible for Free School Meals who achieve a ‘good level of development’ at the end of Early Years Foundation Stage.	<b>Blackburn with Darwen’s poorer children</b> make up substantial ground during their school years, particularly when it comes to GCSE performance. For the four school-age indicators combined, Blackburn with Darwen ranks 86 <sup>th</sup> best, putting it in the top 30%.	The youth indicators look at how young people eligible for free school meals perform at A-level, and their success at entering higher education and <b>avoiding ‘NEET’ status</b> . Blackburn with Darwen ranks 28 <sup>th</sup> best in the country, making it one of the top 10% of authorities.	<b>Blackburn with Darwen’s ranking slips</b> again to 235 <sup>th</sup> (90 <sup>th</sup> worst) on the adult indicators. It scores well for affordable housing, but this is offset by low pay and the low proportion who are in managerial and professional occupations.

The results show that Blackburn with Darwen’s more disadvantaged young people make remarkable progress on their journey from ‘Early Years’ to the ‘Youth’ life-stage. Although the borough is still a relative ‘coldspot’ on the ‘Adulthood’ indicators, there is reason to hope that this will change as the new better-equipped generation of young people enters the workforce.

## SETTING THE SCENE

Cross-Cutting  
Themes:

Identification, prevention  
& early intervention

Positive mental health  
& wellbeing

Poverty & financial  
inclusion (fairness)

## START WELL

## DETERMINANTS OF HEALTH FOR CHILDREN/YOUNG PEOPLE

## CHILD POVERTY

The Child Poverty Act of 2010 pledges that by 2020, no more than 10% of children should be living in families whose income is less than 60% of median household income (before housing costs). In both 2012/13 and 2013/14, 17% of children in the UK were in poverty by this definition<sup>27</sup>, and the 2020 target is widely expected to be missed. The Government intends to replace the child poverty measure and legislation before then, but it remains in force at present.<sup>28</sup>

It is not possible to monitor local child poverty on exactly the same basis, but the HMRC provides a proxy measure based on administrative data. This has been known by several names over the years, but is currently referred to as the Children in Low-Income Families Local Measure. It counts the number of children living in families which are *either* receiving Income Support (IS) or means-tested Job Seekers Allowance (JSA), *or else* are in receipt of tax credits with an income less than 60% of the median.<sup>29</sup> The two sub-categories give a rough out-of-work/in-work split.<sup>30</sup> At the UK

level in 2013, the Children in Low Income Families Local Measure works out to be 1.2 percentage points higher than the official measure, so it is only a rough equivalent.

On the local measure, 9105 children in Blackburn with Darwen, or 22.5% of the total, were 'in poverty' in 2013 (the latest year available), which is the same percentage as in 2012, and down from 26.0% in 2011. There was wide variation around the borough, as seen in both Figure 30 and Figure 31.

A relatively high 41.3% of Blackburn with Darwen's children in poverty are in couple families (see green shading in Figure 30) - the sixth highest proportion in England. This is particularly evident in wards with a high Asian population. The pale colours in Figure 30 indicate that the borough has a substantial problem of child poverty even among working families (i.e. those not receiving IS or JSA).

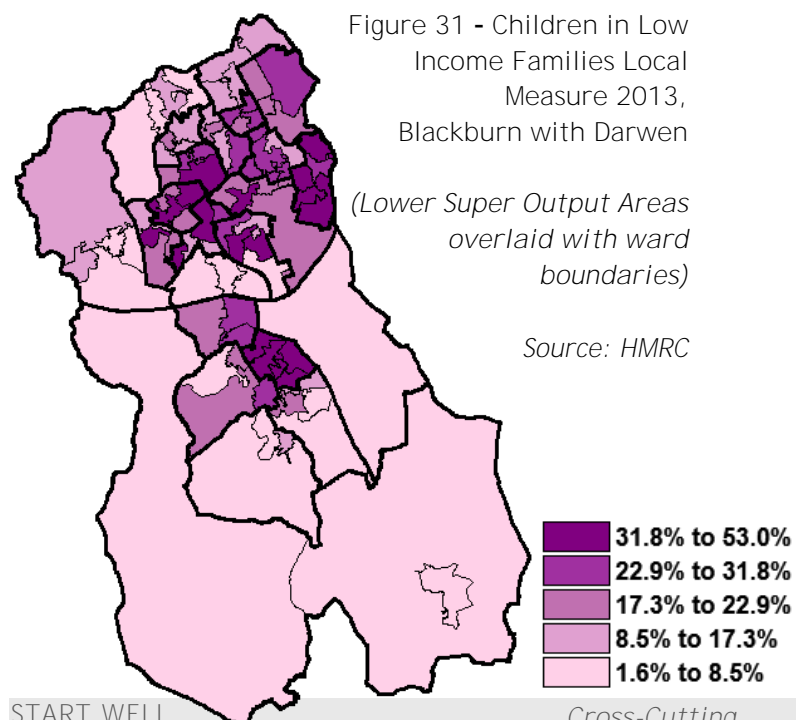
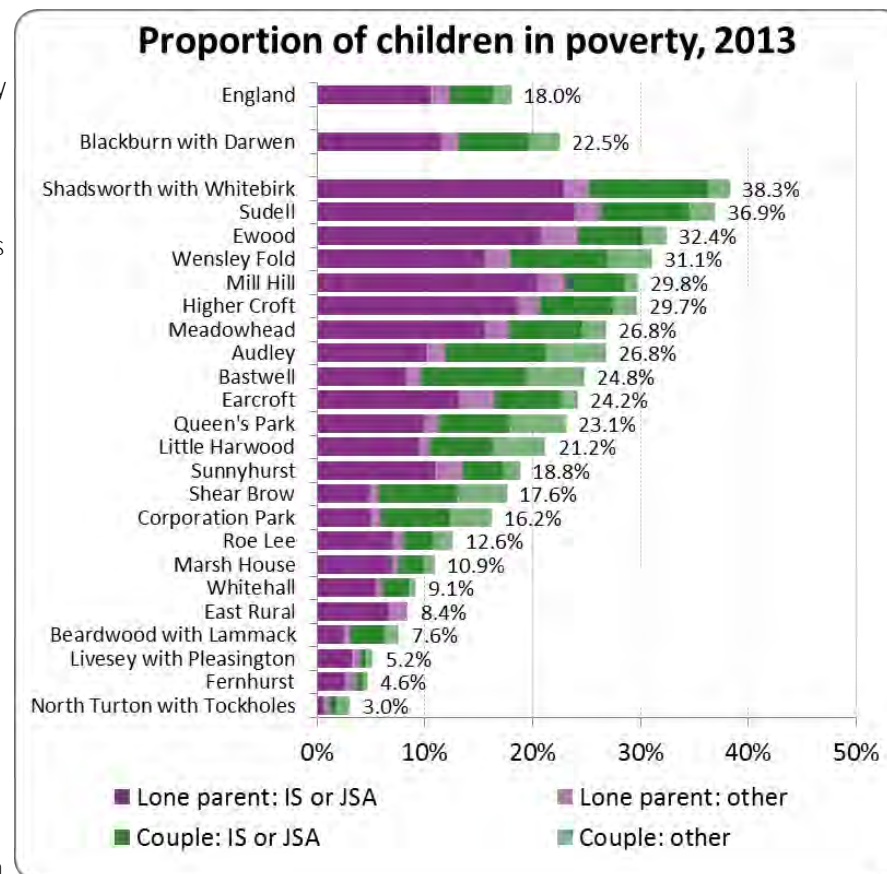


Figure 30 - Revised local child poverty measure, BwD wards, by lone parent or couple family and approx. out-of-work/in-work split



## EDUCATION

### Early Years Foundation Stage

The Early Years Foundation Stage profile measures children's development at the end of the school year in which they turn 5. Figure 32 shows that in 2015, 56% of Blackburn with Darwen children were deemed to have a 'good' level of development. This is an improvement on 47% in 2014, but it is the third lowest proportion in England, after Leicester and Halton.

In contrast to the Summary Review of even two years ago, the inequalities within Blackburn with Darwen by ethnic group or by first language are now relatively small.<sup>31</sup> However, there is a 20 percentage point gap between those who qualify for Free School Meals (FSM) and those who do not. Only 40% of **Blackburn with Darwen's FSM** pupils have a 'good' level of development, which is the third equal lowest proportion in England.

### Primary education - Key Stage 2

At the end of primary education, 81% of Blackburn with Darwen pupils in 2015 achieved the expected level - Level 4 or above - in reading, writing and mathematics (England 80%).<sup>32</sup> By this age there is very little difference, either locally or nationally, in the performance of White and Asian pupils, or those with or without English as their first language (Figure 33). Children entitled to Free School Meals (FSM) still do less well, but Blackburn with Darwen's results for this group are the 19<sup>th</sup> highest in England. Outside of London, only Rutland has better FSM attainment at Key Stage 2.

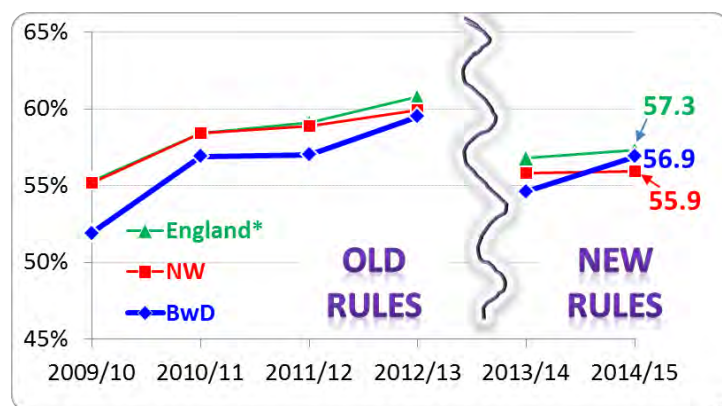


Figure 32 - Foundation Stage: percentage of children achieving a good level of development, 2015 (overall, and broken down by ethnicity, first language, and Free School Meals status)

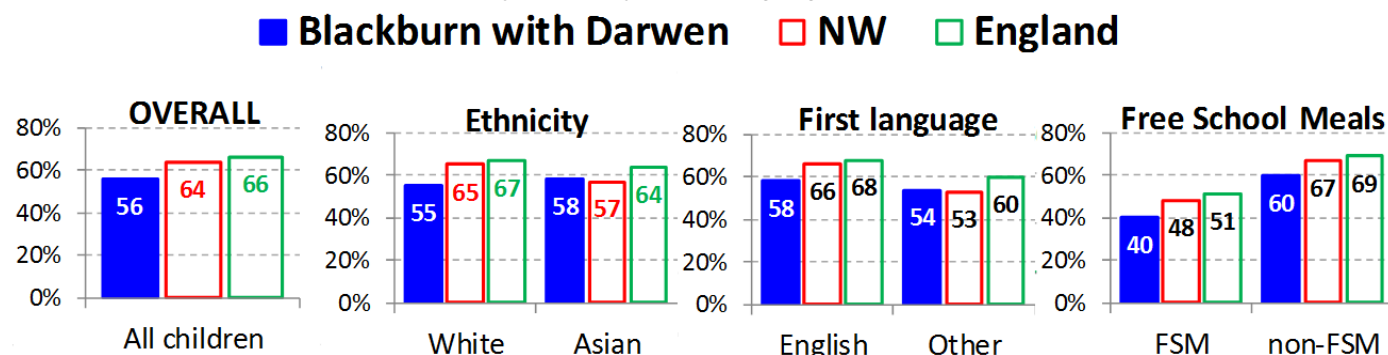
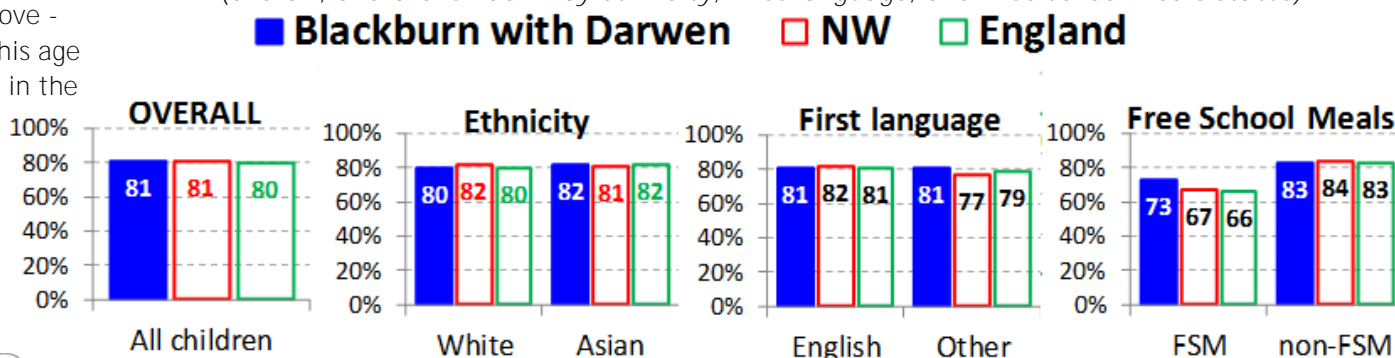


Figure 33 - Key Stage 2: % achieving Level 4+ in reading, writing and mathematics, 2015 (overall, and broken down by ethnicity, first language, and Free School Meals status)



### GCSE attainment

GCSE attainment has been measured in a new way since 2013/14 which is not comparable with earlier results. However, during both periods, Blackburn with Darwen has been improving at a faster rate than average (Figure 34). On the key '5+ GCSEs at Grade A\*-C including English and Maths' measure, the gap with England is now only 0.4 percentage points (56.9% versus 57.3%).<sup>33</sup>

Asian pupils in Blackburn with Darwen are now out-performing White pupils on the '5+ A\*-C inc English & Maths' measure by 60.6% to 55.7%, and pupils without English as their first language are obtaining better results than those with (59.4% v. 55.8%). There is still a large gap, however, between pupils eligible for Free School Meals (with 37.8% achieving the standard) and all other pupils (60.7% achievement). A similar gap is seen both regionally and nationally.



## VULNERABLE GROUPS

NEETS

Young people who are *Not in Education, Employment or Training* (NEET) have been described by the Deputy Prime Minister and by Sir Michael Marmot as a ‘time bomb’ for the economy, society, and public health.<sup>34,35</sup> In 2014, Blackburn with Darwen was estimated to have 336 NEETs aged 16-18, down from 369 in 2013 and 460 in 2012. This equates to 5.8% of the age-group, compared with an England average of 4.7%, and places the borough in the second highest quintile of upper-tier authorities.<sup>36</sup>

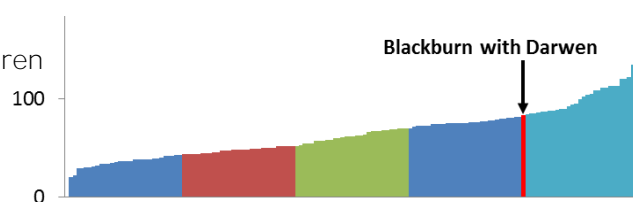
FAMILIES WITH MULTIPLE PROBLEMS

The government estimated in 2011 that there were approximately 120,000 ‘troubled families’ in the country, each costing local and central government an estimated £75,000 per year.<sup>37</sup> In addition to their other difficulties, an estimated 71% of these families had poor health, with 46% having an adult who suffers from a mental health problem.<sup>38</sup> Local authorities were funded to assist such families by giving them one dedicated worker rather than a “string of well-meaning, disconnected officials”.<sup>39</sup>

**Blackburn with Darwen was assumed to have 465 troubled families, and by May 2015, like a lot of other authorities, it had ‘turned around’ all of them.**<sup>40</sup> The scheme is now being extended to work with 400,000 more families nationally, who are experiencing a wider range of problems.<sup>41</sup>

Figure 35 -

Looked-after children  
per 10,000  
aged 0-17,  
March 2015

LOOKED AFTER CHILDREN

As at 31<sup>st</sup> March 2015, 315 children in Blackburn with Darwen were being looked after by the local authority.<sup>42</sup> This gives a rate of 83 per 10,000 children under the age of 18, down from 89 per 10,000 a year ago. However it is still higher than the England average of 60 per 10,000, and places Blackburn with Darwen on the border between the highest and 2nd-highest quintiles (Figure 35).

CHILDREN IN NEED

**Looked after children are one category of ‘Children in Need’ - the DfE’s term for all those referred to the local authority and assessed to be in need of services.** Blackburn with Darwen had 1617 Children in Need at the end of March 2015, up from 1515 a year earlier. This gives a rate of 423 per 10,000, compared with averages of 368 in the NW and 337 for England.<sup>43</sup> Figure 36 shows the primary reason why these children were assessed as being in need. The number attributed to abuse or neglect has risen from 802 to 928 in one year.

YOUNG CARERS

According to the 2011 Census, Blackburn with Darwen has approximately 1543 ‘young carers’ aged under 25, or 3.1% of the age-group (NW 3.0%, England 2.6%). However, it is suspected that these are serious underestimates, and may be anything may be anything up to four times too low.<sup>44</sup>

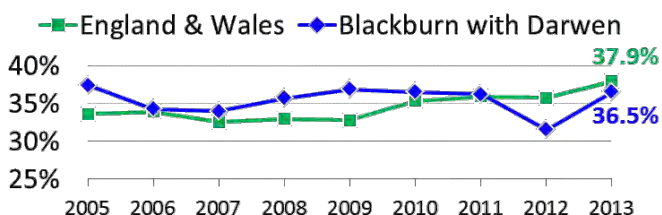
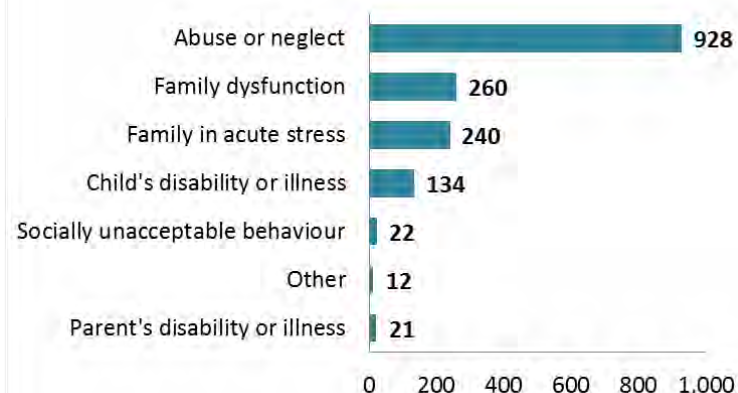


Figure 37 - % young offenders reoffending within 1 year

Figure 36 - Children in Need in Blackburn with Darwen, by primary need at initial assessment (March 2015)

YOUNG OFFENDERS

Young offenders tend to have worse than average health for their age, particularly in terms of mental health problems.<sup>45</sup> The number of juvenile offenders has fallen steeply in recent years, with less than a fifth as many in Blackburn with Darwen in 2013 as in 2005. The proportion who reoffend within a year **is one of the government’s Social Justice Outcome Framework indicators.** This rate has crept up nationally, but inevitably there is more fluctuation in Blackburn with Darwen (Figure 37).<sup>46</sup>



## LIFESTYLE FACTORS AND THEIR CONSEQUENCES

## ALCOHOL

## National trends

The drinking habits of 11-15 year-old secondary school pupils in England are monitored by means of an annual HSCIC survey. In 2014, 38% of pupils responded that they had drunk alcohol at least once, and 8% had done so in the last week. The equivalent figures in 2003, however, were 61% and 25%, so there is a clear downward trend.<sup>47</sup> An expert panel set up by the Cabinet Office and Department of Health has also been looking at young people's risk behaviours.<sup>48</sup> It acknowledges the decline in drinking rates, but cautions that there is a minority who frequently drink to excess, leading to poor outcomes for themselves and heavy demands on hospital and other public services.

## “What about YOUTH?” survey

A major new survey carried out for the first time in 2014<sup>49</sup> provides an insight into the health behaviours of 15 year-olds in every upper-tier local authority. Public Health England have produced an interactive tool for exploring the results at <http://fingertips.phe.org.uk/profile/what-about-youth>.

The three questions about alcohol were: whether the pupil had ever had an alcoholic drink; whether they were regular drinkers (i.e. usually drinking at least once a week); and whether they had been drunk in the preceding four weeks. Blackburn with Darwen emerged significantly better (i.e. lower) than average on all these questions, ranking 30<sup>th</sup> lowest in England on all three. It was also among the bottom three in the NW on all three questions - and lowest of all on the one about drunkenness. These results are likely to be assisted by the high proportion of Muslim pupils in the borough, many of whom may not drink at all.

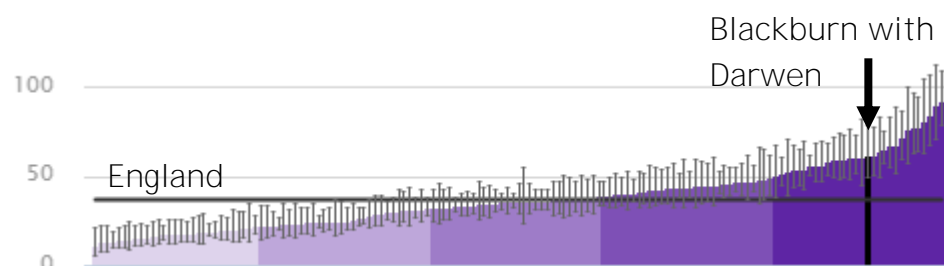
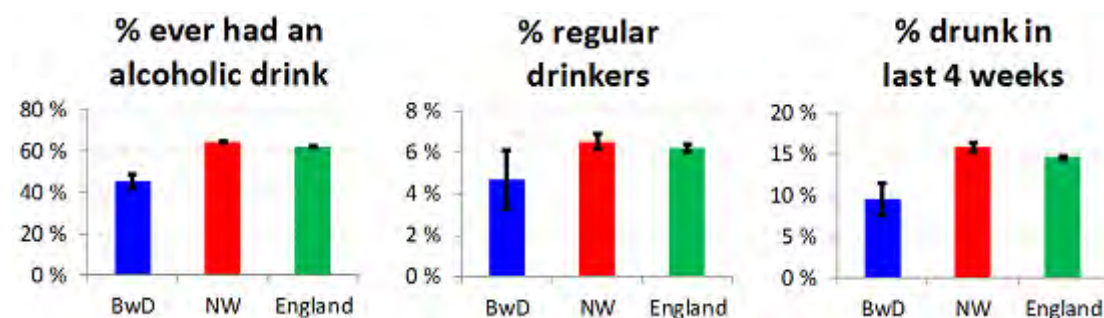


Figure 38 - Drinking Behaviours among 15 year-olds in Blackburn with Darwen, NW and England  
Source: What About YOUTH survey (2014)



## Hospital admissions

Alcohol-specific conditions are those which are invariably due to alcohol. The most recent figures for hospital admissions in under-18s for alcohol-specific conditions are for 2012/13-2014/15 (Figure 39<sup>50</sup>). **Blackburn with Darwen's admission rate is** the sixth highest in the NW, significantly higher than England, and in the highest quintile of local authority districts overall.

Figure 39 - Alcohol-specific admissions, under-18s, crude rate per 100,000 (2012/13-2014/15)

Source: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles>

## SUBSTANCE MISUSE

The 'What about YOUth' survey (<http://fingertips.phe.org.uk/profile/what-about-youth>)<sup>49</sup> also asked three questions in 2014 about drug-taking: whether the pupil had ever tried cannabis; whether they had taken cannabis in the last month; and whether they had taken any other drugs in the last month. On all these questions, Blackburn with Darwen was not significantly different from the England average.

Again, however, it seems that those who do indulge in Blackburn with Darwen have a high propensity to need hospital treatment. Between April 2012 and March 2015, an average of 43 young people aged 15-24 from Blackburn with Darwen were admitted to hospital each year for substance misuse, giving a rate of 227.1 per 100,000 per annum. This is the second highest rate in England (average 88.8), and appears to be on a rising trend:

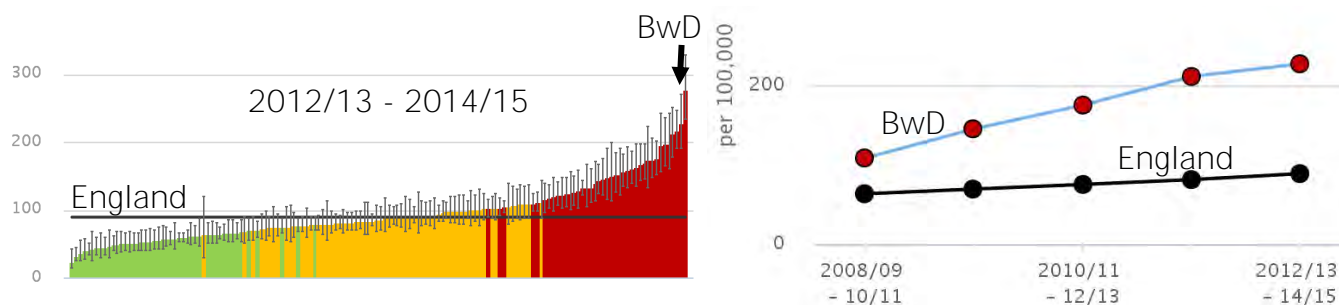


Figure 40 - Hospital admissions due to substance abuse  
(directly standardised rate per 100,000 aged 15-24 years) Source: ChiMat<sup>69</sup>

## SMOKING

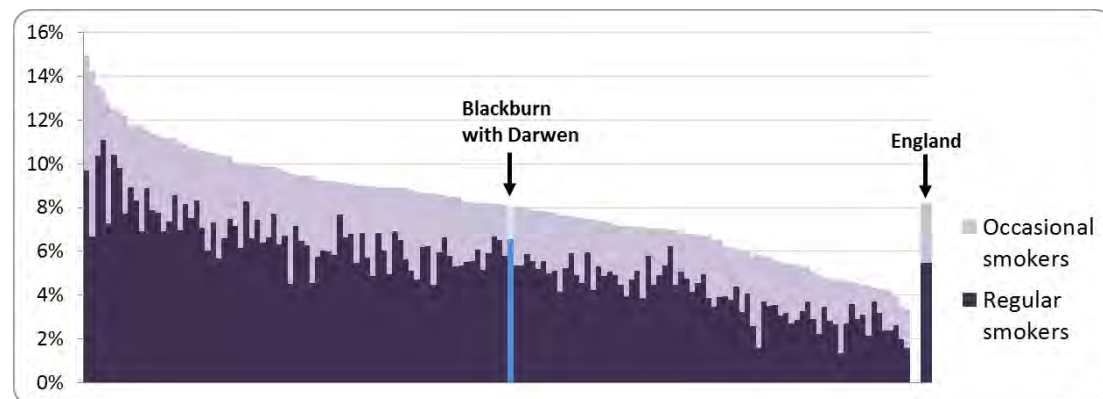


Figure 41 - Proportion of 15 year-olds smoking 'Regularly' or 'Occasionally'

### Cigarettes

The 2014 'What about YOUth' survey<sup>49</sup> classifies pupils according to whether they smoke cigarettes at all ('current smoker'), and if so whether that is at least once a week ('regular smoker') or less frequently ('occasional smoker'). Blackburn with Darwen had 8.0% 'current' smokers (England average 8.2%). This total is made up of 6.6% regular smokers and 1.5% occasional smokers (Figure 41). The tool at <http://fingertips.phe.org.uk/profile/what-about-youth> portrays the low proportion of occasional smokers as a 'good' thing - but that rather depends on the alternative. Obviously we would prefer pupils not to smoke at all, but if they do, then 'occasional' is arguably preferable to 'regular'.

### Other tobacco products

The survey also asked whether pupils had tried any other tobacco products (such as shisha), to which 16.5% of Blackburn with Darwen pupils answered 'yes'. This is the second highest proportion in the North West (average 11.3%), but not significantly different from the England average of 15.2%.

### Electronic cigarettes

32.2% of 15-year-old pupils surveyed in Blackburn with Darwen had tried e-cigarettes, which is the second highest proportion in the country (after Blackpool). There is a pronounced north-south divide (Figure 42), with the borough sitting amid a huge swathe of authorities which are all significantly higher than the England average of 18.4%.

Figure 42 - Proportion of 15-year olds who have tried e-cigarettes  
(Significantly higher than England,  
Significantly lower than England,  
No significant difference)



## TEENAGE PREGNANCY

The number of under-18 conceptions in Blackburn with Darwen fell to a new low of 61 in 2014. When the government launched its Teenage Pregnancy Strategy in 1998, the number was 169.<sup>51</sup> Expressed as a rate, this puts Blackburn with Darwen below the England average, though not by a significant amount. In terms of percentage reduction since the start of the Teenage Pregnancy Strategy, the borough is now the 11<sup>th</sup> most improved upper-tier local authority since 1998 (Figure 44).

Figure 43 - Under-18 conception rate (per 1000 females aged 15-17)

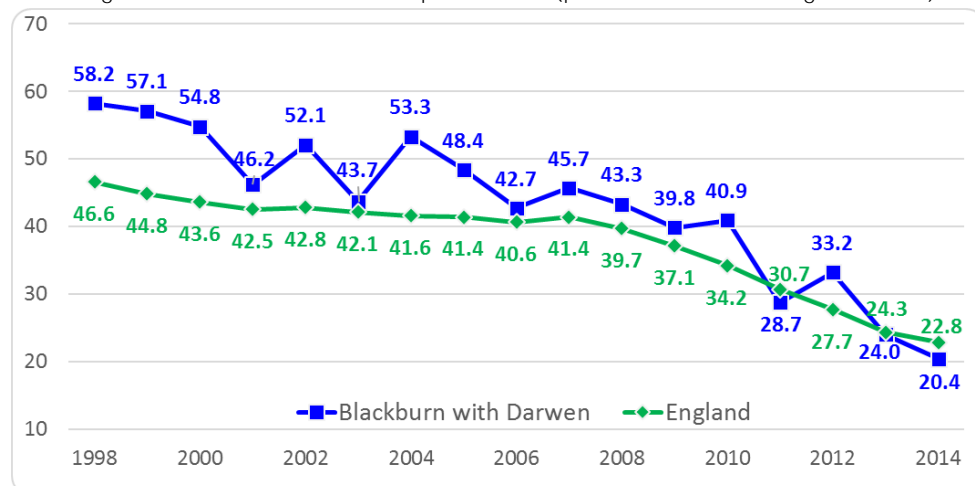
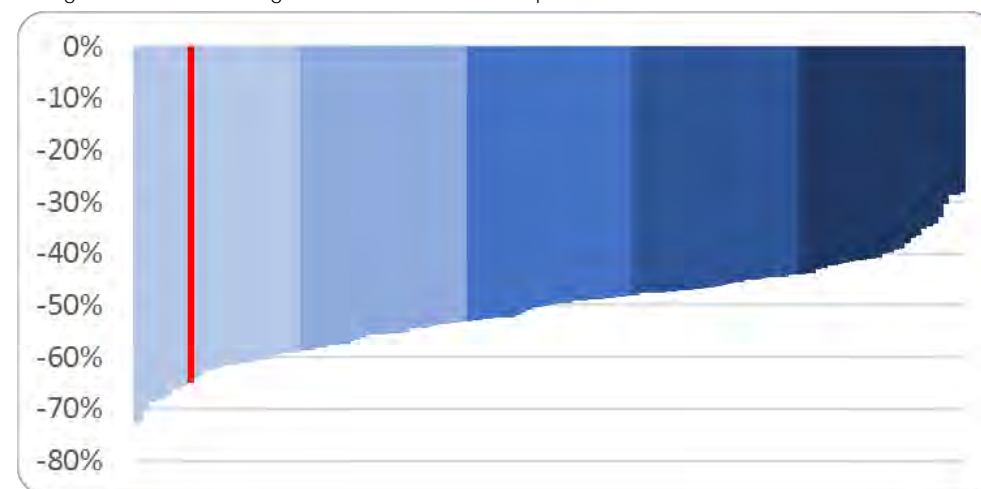


Figure 44 - % change in under-18 conception rate between 1998 and 2014



Under-16 conceptions involve even smaller numbers, and thus fluctuate a lot from year to year. With 13 such conceptions in 2014, Blackburn with Darwen had a rate of 4.5 per 1000, which is very close to the England average (4.4 per 1000) and not significantly different from it.<sup>26</sup>

## CHLAMYDIA SCREENING<sup>52</sup>

Chlamydia is a largely hidden condition, so cases are most often discovered through opportunistic screening. The National Chlamydia Screening Programme aims to diagnose and treat as many cases as possible in young people, and local authorities are encouraged to aim for a 'Chlamydia Detection Rate' of at least 2300 per 100,000 15-24 year-olds.

Latest figures for 2014 show that this target was only achieved in 29% of upper tier local authorities. Blackburn with Darwen's detection rate was a below-average 1854 per 100,000 (Figure 45). The proportion of tests proving positive in the borough was unexceptional, but the percentage of the population tested was the third lowest in the NW. Public Health England's map shows Blackburn with Darwen surrounded by authorities with a higher detection rate (Figure 46).

Figure 45 - Chlamydia diagnostic rate per 100,000 15-24 year-olds (Upper-Tier LAs, 2014)<sup>52</sup>

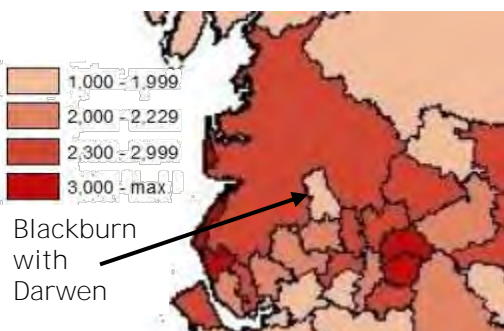
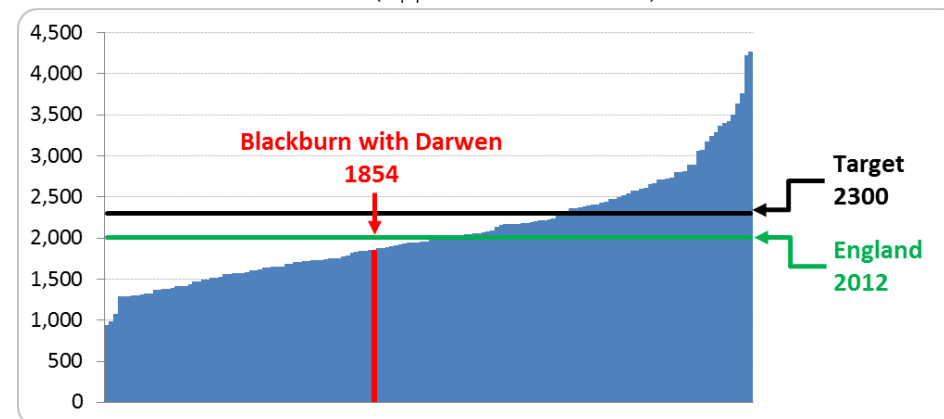


Figure 46- Chlamydia Detection Rates in NW (2014)

## CHILD OBESITY AND UNDERWEIGHT

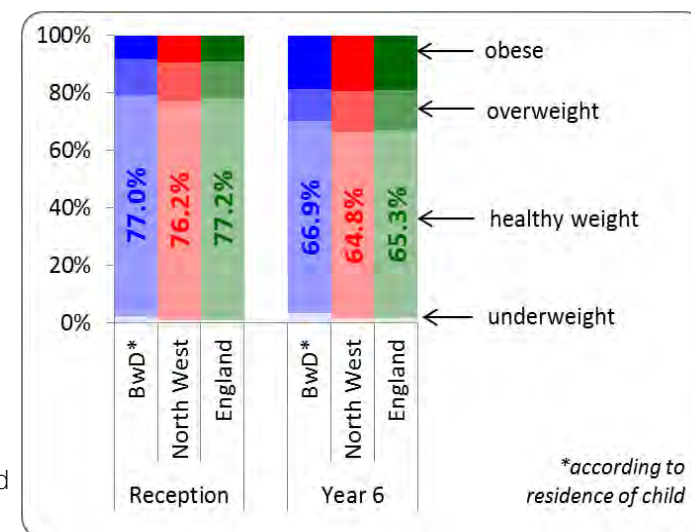
The National Child Measurement Programme (NCMP) undertakes an audit of the height and weight of children in Reception and Year 6 of primary school each year, and the results for 2014/15 are shown in Figure 47.\* The percentage of children of healthy weight in Blackburn with Darwen is similar to the NW and England averages.<sup>53</sup>

However, just over 100 children in Blackburn with Darwen were underweight, which is a significantly higher proportion than average. The Reception rate of 2.1% underweight is the 8th highest out of 144 upper-tier local authorities in England, and the Year 6 rate of 3.1% is the highest of all. It should be noted that a high proportion of Blackburn with Darwen pupils are of Asian ethnicity. Nationally, children in this group were more than twice as likely as average to be underweight.<sup>54</sup>

Blackburn with Darwen does not compare badly on any of the measures of overweight or obesity. The proportion of Year 6 children who are above a healthy weight (i.e. overweight or obese) is significantly *better* than average (29.9% compared with an England average of 33.2%), and just outside the lowest quintile nationally.

Work is ongoing in Blackburn with Darwen to explore the potential causes of both overweight and underweight, and develop an evidence-based action plan to address the underlying issues at both ends of the spectrum.

Figure 47 -  
National Child  
Measurement  
Programme  
2014-15



## CHILDREN'S ORAL HEALTH

### Dental health of 5-year olds

The latest 2015 survey of 5-year old children<sup>55</sup> found that approximately 56% of children in Blackburn with Darwen had one or more decayed, missing or filled teeth.<sup>†</sup> This was the highest proportion in England, and compares with a national average of just under 25%. The average child in the borough had 2.4 decayed, missing or filled teeth, which was the second highest in England.

### Hospital admissions for tooth extraction

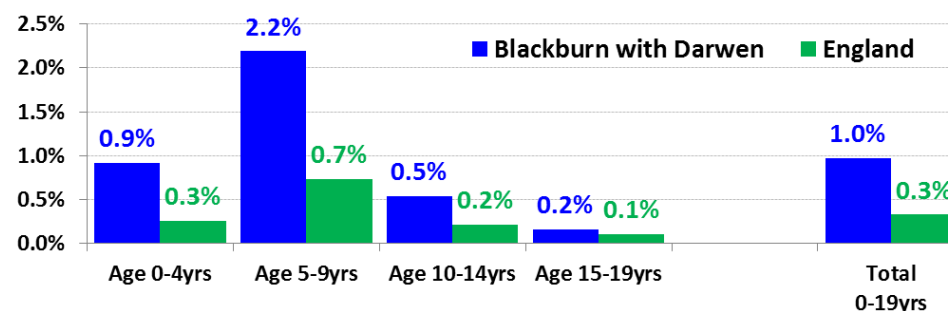
One consequence of a high level of decay is a high rate of hospital admission for tooth extraction. In 2014/15, there were 409 admissions of Blackburn with Darwen children to have teeth out because of dental caries. This translates to a higher than average proportion of the population in every age-group, and particularly among 5-9 year-olds (Figure 48).<sup>56</sup>

Hospital admissions are only part of the story, as in 2014/15, over 179,000 teeth were extracted in primary care from 0-9 year-old children in England. However, these figures are not available at the local authority level.<sup>57</sup>

### Tackling tooth decay

Interventions and health programmes aimed at addressing the problem of child tooth decay in Blackburn with Darwen include the identification of vulnerable children **through nurseries and children's centres, providing free toothpaste**, and educating communities about which products have high sugar content.<sup>58</sup>

Figure 48 - Hospital admissions for tooth extraction 2014/15  
(with caries as primary diagnosis, as % of age-group)



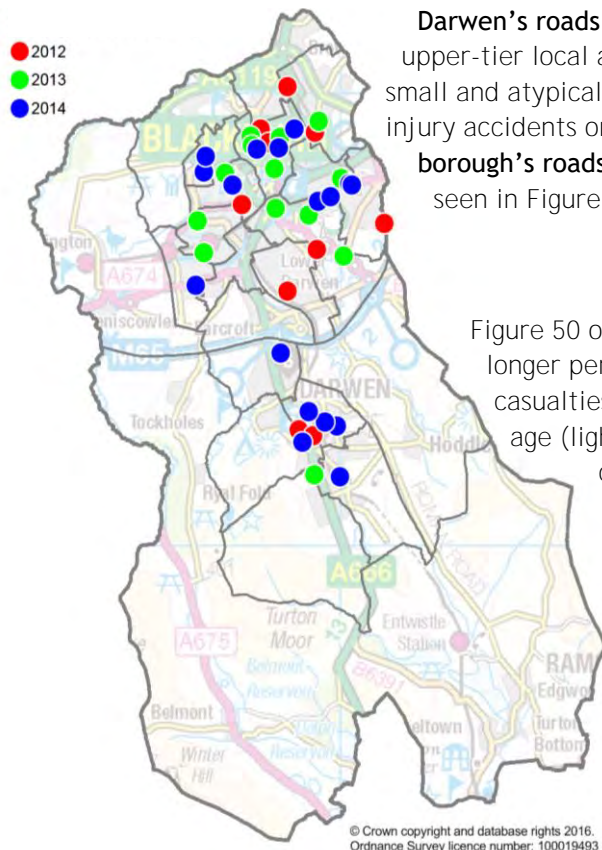
\* Figure 47 is based on pupils *living* in Blackburn with Darwen, as this is now the main measure reported by Public Health England.

† Public Health England has switched to quoting this as "43.9% of Blackburn with Darwen children with *no obvious decay*".



## ACCIDENTS

Figure 49 - Children (0-15)  
Killed or Seriously Injured (KSI)  
in Blackburn with Darwen 2012-14  
(showing ward boundaries)

ROAD ACCIDENTSKilled or seriously injured (KSI)

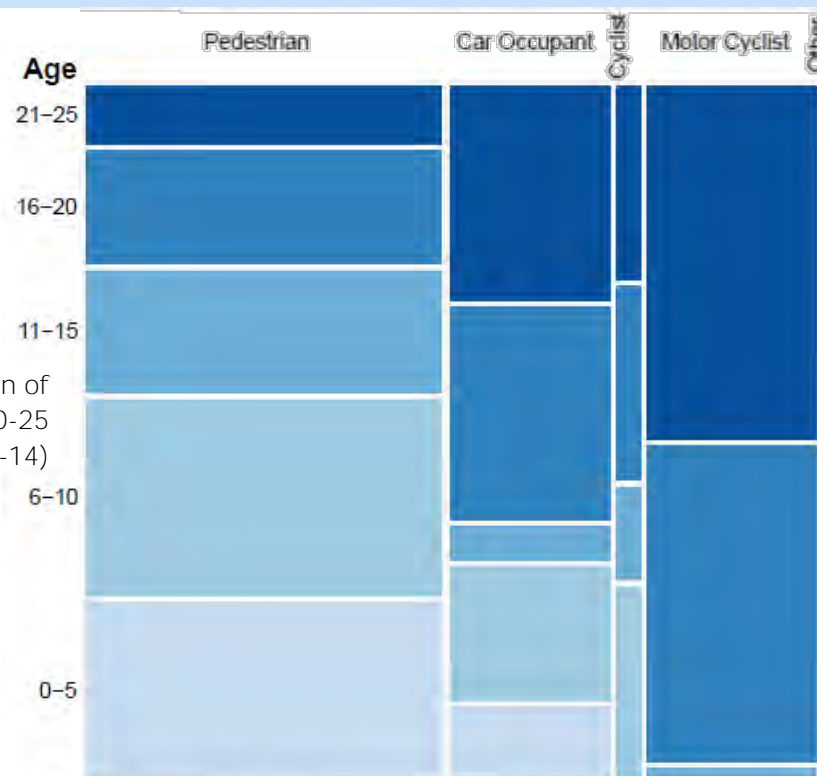
Over the three year period 2012-14, 42 children aged 0-15 were killed or seriously injured (KSI) on Blackburn with Darwen's roads.<sup>59</sup> This equates to the third highest crude rate of any upper-tier local authority in England - or the second highest if the very small and atypical City of London is excluded. However, it consists of injury accidents only, as there has not been a single child fatality on the borough's roads since 2006. The locations of these accidents can be seen in Figure 49 on the left.

Figure 50 on the right looks at a broader age-range (0-25), over a longer period (2010-14), which allows us to break the KSI casualties down by the type of road user (columns) as well as by age (light to dark shading). There was one fatality, to a motorcyclist in the 21-25 ageband, and all the other casualties were serious injuries. Out of 157 in total, very nearly half of KSI casualties were pedestrians, most of whom (42 out of 76) were aged under 11.<sup>60</sup>

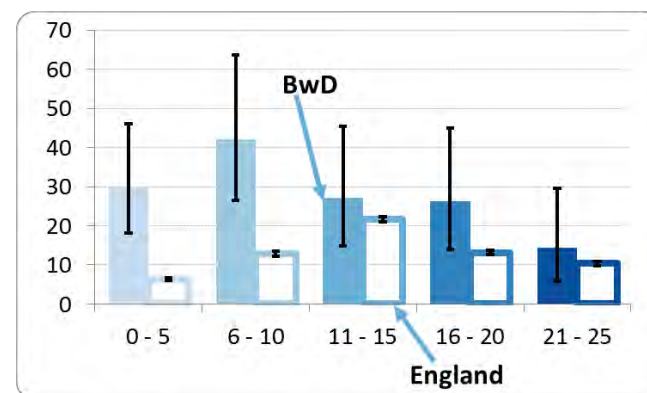
PEDESTRIAN CHILD KSI

The borough's rate of pedestrian child KSI casualties (Figure 51) is well above the national average, particularly at the youngest ages.<sup>60</sup> For the 0-15 age-group as a whole, its pedestrian KSI rate is second only to the anomalous City of London.<sup>61</sup>

Figure 51 - Child pedestrian KSI rate  
per 100,000 (2010-2014)  
showing 95% confidence intervals<sup>60</sup>

All child road casualties

If we broaden our scope to include *all* recorded child casualties on the road, whether serious or not, Blackburn with Darwen still compares badly. A new report from the RAC places it 3rd highest out of 378 authorities in Great Britain, for the years 2010-14 combined. The other authorities featuring in the top four are Blackpool, Hyndburn and Burnley.<sup>62</sup>



## EMOTIONAL WELLBEING OF CHILDREN AND YOUNG PEOPLE

### Lack of data

**Hard facts about the prevalence of children and young people's mental health problems continue to be** scarce and out of date, as the last national survey was in 2004. Plans are now well advanced to conduct a survey across England and Scotland during 2016<sup>63</sup>, but the final results are not expected to be published until 2018.<sup>64</sup> In the meantime, the House of Commons Health Select Committee has acknowledged that those trying to plan and run services are **'operating in a fog'**.<sup>65</sup> In Blackburn with Darwen, the best available insight into children and young people's emotional health and wellbeing continues to be the specialised Integrated Strategic Needs Assessment carried out in 2014.<sup>66</sup>

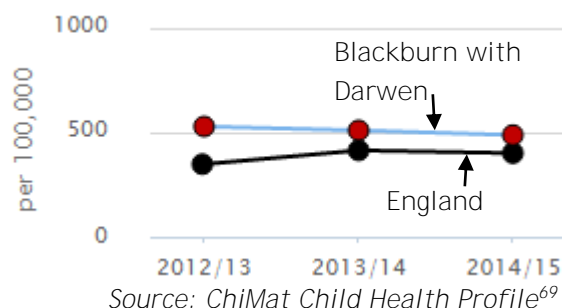
### National policy

In 2014, the Government set up a Children and Young People's Mental Health and Wellbeing Taskforce, to consider how children and young people's mental health services can be better organised, commissioned and provided and made easier to access. The Taskforce has called for improvements in the following areas by 2020:<sup>67</sup>

- tackling stigma and improving attitudes to mental illness
- introducing more access and waiting time standards for services
- establishing 'one stop shop' support services in the community
- improving access for children & young people who are particularly vulnerable

### Emotional wellbeing of school pupils

A high proportion of Blackburn with Darwen children start school without having reached a **'good'** level of development (see page 16). However, out of the entire school population, the proportion in 2015 who had a statement of special educational needs (SEN) because of social, emotional and mental health was close to the national average. The 2013/14 rates of exclusion due to persistent disruptive behaviour, and for drugs/alcohol use, are the lowest in the North West and among the lowest in England.<sup>68</sup>



### Self-harm

One possible consequence of emotional ill-health, particularly in children and young people, is self-harm. The scale of the problem is reflected in the rate of hospital admissions for self-harm, although this only represents a fraction of total incidents.

The 2014/15 rate of self-harm admissions in the 10-24 age-group in Blackburn with Darwen was significantly higher than the England average, but unexceptional for the NW, which has many of the highest rates in England. It is encouraging to note that the number of admissions in Blackburn with Darwen has declined from 156 in 2012/13 to 137 in 2014/15.

Figure 52 - Emergency admissions for self-harm (10-24 years), directly standardised rate per 100,000 (Blackburn with Darwen v. England)

## CHILD & INFANT MORTALITY

### INFANT MORTALITY

Unfortunately the number of infant deaths (under age 1) registered in 2014 in Blackburn with Darwen rose to 19, after having been at levels of 10-12 for several years. This meant that the rate per 1000 for 2012-14 has reverted to being significantly higher than average, and is the eighth highest out of 150 upper-tier authorities in England.<sup>69</sup>

### CHILD MORTALITY

The ChiMat Child Health Profile also includes a mortality rate for children aged 1-17 (i.e. explicitly excluding infants).<sup>69</sup> This is also measured over three years, but there are very few deaths in this age-group (approximately 6 per year in the case of Blackburn with Darwen), so very few local authorities differ significantly from average. In 2012-14, Blackburn with Darwen was just outside the highest quintile, with a rate of 14.8 per 100,000, but this is not significantly different from the England rate of 12.0 per 100,000.

## LIVE WELL

## LIFESTYLE FACTORS

ADULT OBESITY

In 2012-14, an estimated 66.5% of Blackburn with Darwen adults were overweight or obese.<sup>26</sup> This is not significantly different from the England average of 64.6%, but that itself is of course far from ideal. New research predicts that by 2035, this proportion will have risen to 72% across the UK. By then, the annual direct health cost arising from overweight and obesity is predicted to reach over £2.5bn nationally.<sup>70</sup>

ALCOHOL (ADULTS)The Alcohol Harm Paradox

It has been known for some time that although alcohol consumption is, if anything, higher among more affluent groups, the *harms* from alcohol consumption fall disproportionately upon deprived populations.<sup>71</sup>

A major national survey has now shed new light on this so-called 'Alcohol Harm Paradox'. It found that in deprived, as opposed to non-deprived, communities, **heavy ('increased risk') drinking was ten times more likely to be accompanied by a combination of smoking, excess weight, and inadequate diet and exercise.** The researchers suggest that the ill effects of these factors may be multiplicative, rather than additive.

They recommend sending out a public health message that any given level of alcohol consumption is likely to be more harmful to those who also smoke, are overweight or have an unhealthy lifestyle. Deprivation was also associated with a greater tendency to binge-drink, which may carry higher risks of injury and heart disease than spreading the same amount of consumption over several days.<sup>72</sup>

Alcohol-related admissions and mortality

A headline indicator of the health consequences of drinking is the rate of alcohol-related hospital admissions. This has shown little change in the last year (Figure 54), and Blackburn with Darwen is still significantly above average, ranking 24<sup>th</sup> highest out of 152 upper-tier authorities.<sup>26</sup>

Blackburn with Darwen had the 19<sup>th</sup> highest rate of alcohol-related deaths in 2014, out of 152 upper-tier local authorities. It also had the 13<sup>th</sup> highest rate of mortality from chronic liver disease in 2012-14.<sup>73</sup>

Alcohol-related incapacity

In 2015, Blackburn with Darwen had 320 claimants of incapacity benefits (nearly all of which will be Employment & Support Allowance), whose main disabling condition was Alcohol Misuse. This equates to 355.5 per 100,000 people of working age, which is the second highest rate out of 152 upper-tier authorities, and far exceeds the England average of 136.8 per 100,000.<sup>73</sup>

Figure 53 - Adult excess weight 2012-14 (Blackburn with Darwen, NW and England)

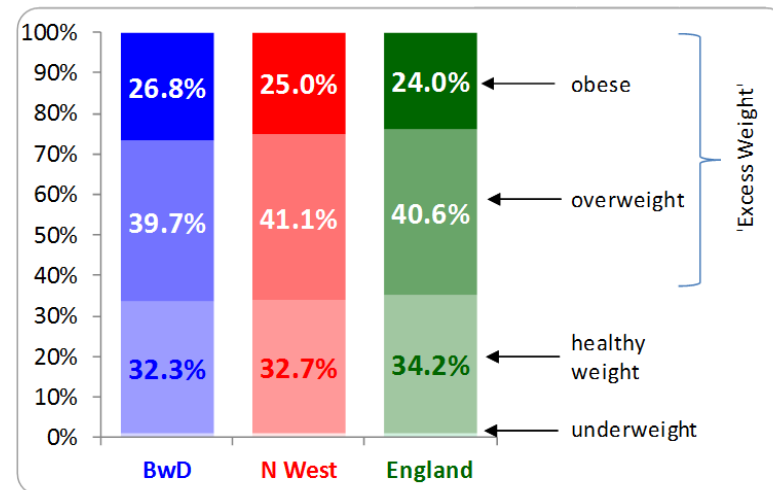
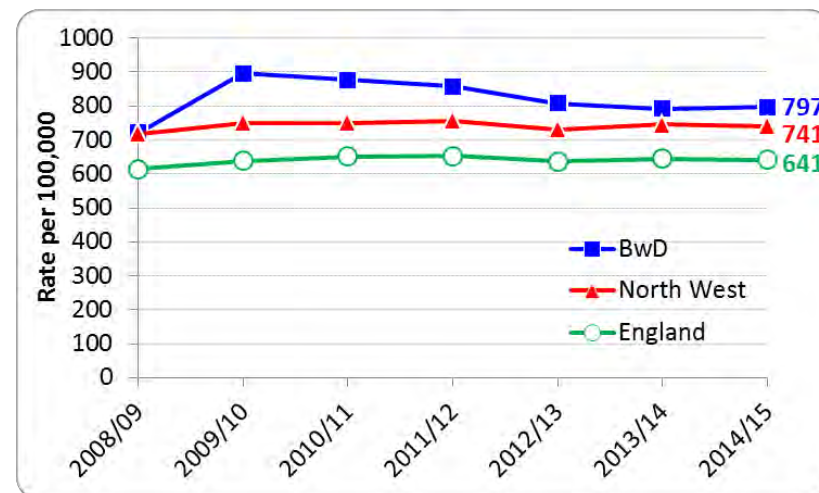


Figure 54 - Rate of alcohol-related admission episodes per 100,000 population - 'narrow' measure (PHOF indicator 2.18)





## SMOKING (ADULTS)

### Prevalence

The primary source of smoking prevalence data in **Public Health England's Tobacco Control Profiles** is the Integrated Household Survey (IHS), which estimates that 23.6% of adults in the borough were current smokers in 2014.<sup>74</sup> This is the 6<sup>th</sup> highest rate in England, and significantly higher than the national average of 18.0%. Smoking **rates are generally higher in the 'Routine & Manual' (R&M) group** (light bars in Figure 55), and Blackburn with Darwen has the 10<sup>th</sup> highest rate for this group, at 35.2%.

The IHS is being discontinued, so the Tobacco Control Profiles already contain prevalence data from two other sources - the Quality Outcomes Framework, and the GP Patient Survey. Whichever source is used, smoking prevalence in Blackburn with Darwen is consistently in the worst or second-worst decile nationally.<sup>75</sup>

### Outcomes

The borough still compares poorly on many smoking-related health outcomes, including having the third highest rate of smoking attributable deaths from heart disease in 2012-14, and the fourth highest rate of emergency hospital admissions for COPD in 2014/15.

### Costs

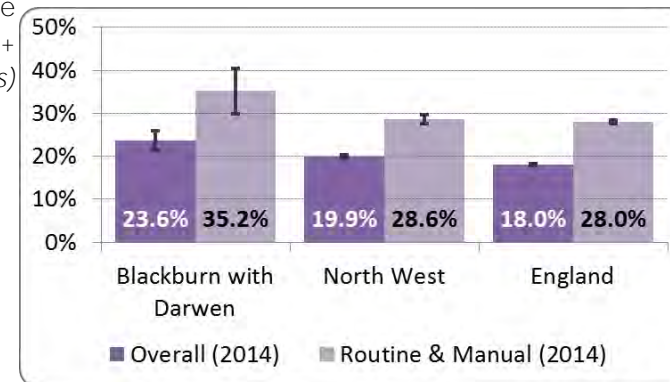
Updated estimates from ASH now put the cost to society of smoking in Blackburn with Darwen at approximately £42.8m p.a.. This includes lost productivity due to smoking breaks (£19m), early deaths (£10m) and sick days (£3m). It also includes the £6.2m cost to the NHS of smoking-related disease, plus the cost of smoking-related social care, fires and waste disposal.<sup>76</sup> Public Health England estimates that every £1 spent on smoking cessation saves £10 in future health care costs and health gains.<sup>77</sup>

### Stop Smoking services



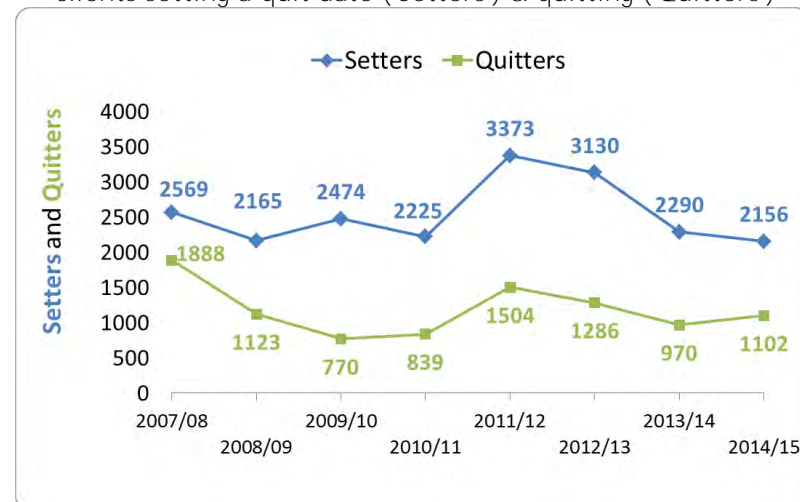
Figure 57 - Launch of the smokefree homes programme

Figure 55 - Estimated smoking prevalence for adults aged 18+  
(Source: IHS via Tobacco Control Profiles)



Results for 2014/15<sup>78</sup> show a further slight fall in the number of Blackburn with Darwen clients setting a quit date ('setters'), but a slight rise in those who have quit at four-week follow-up ('quitters') [Figure 56]. Relative to the number of smokers, both these results are significantly better than the England average.<sup>79</sup> Nationally, the number of setters and quitters have both continued to decline, with speculation that this may be due to the growing popularity of e-cigarettes

Figure 56 - Blackburn with Darwen Stop Smoking Service - clients setting a quit date ('Setters') & quitting ('Quitters')<sup>78</sup>



### SMOKEFREE HOMES PROGRAMME

Blackburn with Darwen's new 'smokefree homes programme' gathers pledges from the public to keep their homes smoke-free, in order to minimise harm to children, young people and non-smokers.



## SEXUAL HEALTH

### Sexually Transmitted Infections (STIs)

#### INCIDENCE OF STIS

Interpretation of the overall rate of STI diagnoses is complicated by the fact that local authorities are encouraged to detect as many cases as possible of Chlamydia in young people under 25 (see page 20). An indicator has therefore been introduced which specifically *excludes* diagnoses of Chlamydia in the under-25s. On this basis, 547 new STIs were diagnosed in Blackburn with Darwen in 2014, giving it a rate of 576 per 100,000, which is significantly lower (i.e. better) than the England average of 829 per 100,000.<sup>80</sup>

The rate of gonorrhoea diagnoses is a useful marker for high levels of risky sexual activity. In Blackburn with Darwen (Figure 59), it is consistently lower (i.e. better) than the England average. The 2014 rate was 26.5 per 100,000, significantly below the national average of 63.3 per 100,000.

#### STI DIAGNOSES BY ETHNIC GROUP AND COUNTRY OF BIRTH

Out of all the new STI diagnoses made in GUM clinics on Blackburn with Darwen

**residents in 2014, 83.0% had ethnic group specified as 'White' and 11.6% as 'Asian or Asian British'. Only around 1% did not** have ethnicity recorded. Where recorded, 6.4% of new STIs diagnosed in Blackburn with Darwen were in people born overseas.<sup>81</sup>

## HIV

An estimated 103,700 people were living with HIV in the UK in 2014.<sup>82</sup> The groups most affected are men who have sex with men (MSM), and men and women of black African ethnicity.<sup>82</sup> The numbers infected through non-sexual routes (e.g. injecting drug use, or mother-to-child transmission) remain low.

#### HIV TESTING

Testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of transmission.

#### Uptake

In 2014, an HIV test was offered at 88.9% of eligible attendances at GUM clinics among residents of Blackburn with Darwen, and 69.4% of offers were accepted. In England, it was offered at 80.1% of eligible attendances, and 77.5% of offers were accepted.<sup>81</sup> Logically, this equates to much the same performance locally and nationally. However, attention tends to focus on the uptake - the percentage of offers accepted. On this basis, Blackburn with Darwen on 69.4% is significantly worse than England on 77.5%.<sup>80</sup>

The uptake of HIV testing among MSM in Blackburn with Darwen is of particular concern, as it is the lowest in the country. There has been a sudden deterioration from 91.6% of test offers to MSM attendees being accepted in 2013, to only 81.6% in 2014 (Figure 60). This compares with a national average of 94.5%.

#### Coverage

The proportion of eligible GUM attendees who received at least *one* HIV test in the course of the year (perhaps across multiple attendances) is known as the testing coverage. Blackburn with Darwen's **overall coverage of 67.3%** in 2014 is not significantly different from England (68.9%), and is significantly better than the North West average of **55.4%. However, the borough's testing coverage for MSM is actually lower** than the overall figure, at 65.1% (England 87.2%). This again puts Blackburn with Darwen bottom of the league table nationally where MSM are concerned.

Figure 58 - All new STI diagnoses (exc. Chlamydia aged < 25) per 100,000 (2014)

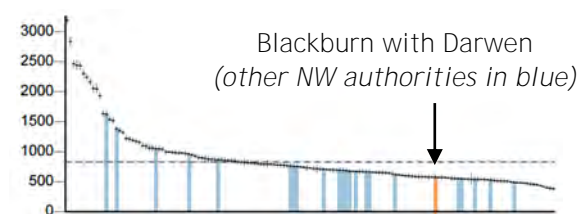


Figure 59 - Gonorrhoea diagnoses per 100,000 (2014)

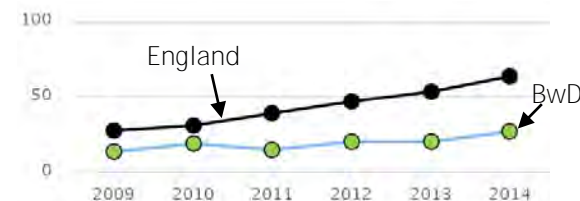
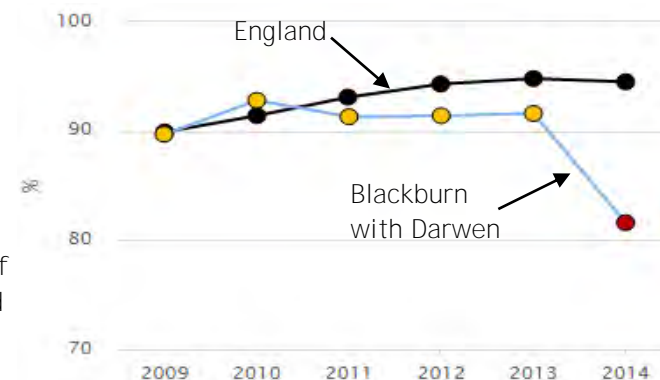


Figure 60 - Uptake of HIV test among MSM attending GUM clinics (i.e. % of test offers accepted)



### PEOPLE LIVING WITH HIV

In 2014, there were 89 people living in Blackburn with Darwen who received NHS care for HIV.<sup>80</sup> This equates to a crude rate of 1.02 per 1000 people aged 15-59, compared with an England average of 2.22 per 1000. Areas with a prevalence of more than 2 per 1000 are advised to consider routine HIV testing for all hospital admissions as well as new registrants in primary care, but Blackburn with Darwen is well below this level.

### HIV DIAGNOSES

There were only 3 new diagnoses in Blackburn with Darwen in 2014, giving a rate of 2.6 per 100,000 (Figure 61). This is in the lowest quintile nationally, significantly below the NW and England averages, and on an apparently downward trend (although numbers as small as this are subject to random fluctuation).

People diagnosed with HIV late (having a CD4 count of <350 cells/mm<sup>3</sup> within 3 months of their diagnosis) are ten times more likely to die in the following year than those diagnosed promptly.<sup>83</sup> Between 2012 and 2014, Blackburn with Darwen had 6 late diagnoses of HIV, representing 46.2% of all diagnoses (England average 42.2%).<sup>80</sup>

Figure 61 - New HIV diagnoses per 100,000 population (2014)

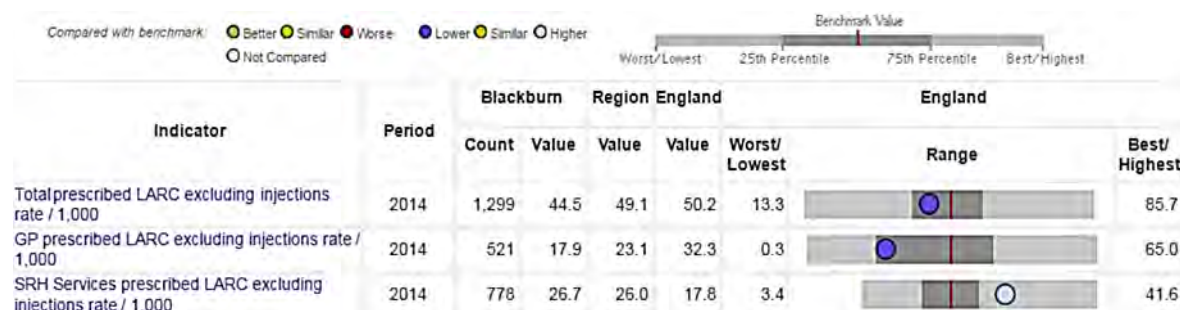
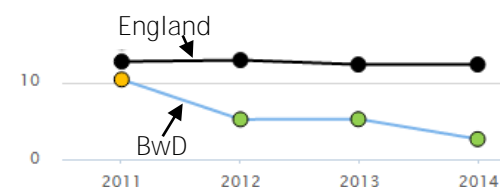


Figure 62 - Prescribing rates for LARC (excluding injections)

Source: PHE Sexual and Reproductive Health Profiles<sup>80</sup>

England.<sup>80</sup> The rate of LARCs prescribed in sexual and reproductive health (SRH) services (excluding injections) per 1,000 women aged 15 to 44 years was 26.7 for Blackburn with Darwen, 26.0 for North West and 17.8 for England. Therefore the total rate of LARCs prescribed (excluding injections) for BwD was 44.5 per 1,000 women which was lower than the national rate of 50.2 per 1,000 women. The indicators exclude injections because:

- Injections rely on repeat visits/administration within the year and have a higher failure rate than the other LARC methods
- Injections are easily given and thus do not require the resources and training that other LARC methods require
- Injections are outside local authority commissioning contracts

### ABORTIONS

The rate of abortion in Blackburn with Darwen in 2015 was 18 per 1000 women (aged 15-44), which is significantly above the England rate of 16.2 per 1000.<sup>85</sup> 35% were repeat abortions, compared with 38% in England. **The Department of Health's policy states that women who request an abortion should have early access to services if legally entitled to one.**<sup>84</sup> 78% of abortions in Blackburn with Darwen **took place before 10 weeks' gestation, compared with an England average of 80.4%.**<sup>85</sup>

Only 11% of abortions in Blackburn with Darwen in 2015 were surgical, and 89% medical.<sup>85</sup> This is one of the lowest proportions of surgical abortions in the North West, and compares with an England average of 45.8%. Early medical abortion is less invasive than a surgical procedure and carries less risk as it does not involve instrumentation or the use of anaesthetic. However, women may prefer a surgical abortion for a variety of reasons such as wishing to avoid the experience of going through an induced pregnancy loss, or preferring to make only one visit to the provider site (medical abortions typically require two). PHE states that a very high percentage of medical abortions compared to other areas could be an issue for concern, so we cannot unequivocally state if these proportions are good or bad.<sup>80</sup>

## DRUG MISUSE (ADULTS)

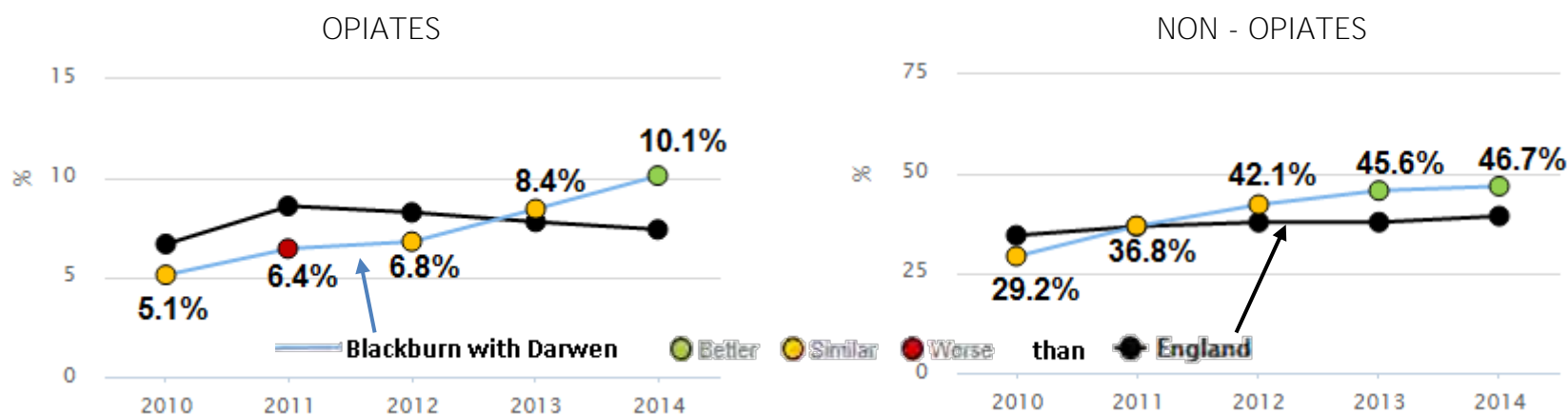
### Prevalence

There have been no new estimates of the prevalence of opiate and/or crack cocaine use since 2011/12, when Blackburn with Darwen was estimated to have 1417 users. When expressed as a rate, this was almost 75% higher than the England average.<sup>86</sup>

### Treatment

The treatment of opiate users and non-opiate users involves very different numbers and outcomes. In Blackburn with Darwen, the percentage of those in treatment who complete it successfully (without re-presenting within 6 months) has continued to improve, and is now significantly better than average for both types of user:

Figure 63 - Successful completion of drug treatment (Blackburn with Darwen v. England)<sup>26</sup>



### DRUG USERS IN TREATMENT WHO LIVE WITH CHILDREN

According to the latest JSNA Support Pack from Public Health England, 40% of users in treatment in Blackburn with Darwen have a child living with them. This is down from 46% the year before, but still well above the national average of 30%.<sup>88</sup>

### Value for money

Public Health England has published a presentation which highlights how investment in drug treatment and recovery services not only benefits individuals, but strengthens families and makes communities safer. It estimates that every £1 spent on drug treatment saves £2.50 in costs to society.<sup>77</sup>

Even higher returns can be obtained from motivational interviewing and the development of supportive networks for people with drug addiction. Each £1 spent in these ways is estimated to return £5 to the public sector in reduced health care, social care and criminal justice costs.<sup>89</sup>



Figure 64 - Extract from 'Why Invest?' presentation

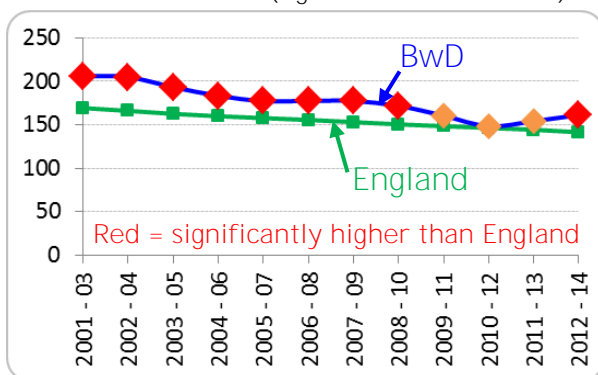
## HEALTH OUTCOMES

## CANCER

## Incidence

The number of new cases of cancer diagnosed each year has been rising nationally, by almost a third in the past 20 years. Possible reasons include the growing and ageing population, their smoking, drinking and eating habits, and better detection of cancer.<sup>90</sup> The incidence rate in Blackburn with Darwen fluctuates from year to year, but is not significantly different from the England average (Figure 65).<sup>91</sup>

Figure 66 - Premature (age < 75) mortality from all cancers (Age Standardised Rate)



## Mortality and Survival

Even though cancer incidence has been increasing, improved survival means that premature mortality from the disease has been gradually declining. Premature mortality in Blackburn with Darwen has followed the general downward trend, but the latest rate is once again significantly higher than the England average (Figure 66).<sup>26</sup> The same applies to the portion of this mortality considered 'preventable'.<sup>26</sup>

When all patients aged 15-99 diagnosed with cancer in 2013 were followed up for a year, Blackburn with Darwen had a 1-year 'survival index' of 67.7%, compared with an England average of 70.2%. This puts it near the bottom of the league table, which is also true if we look at bowel or lung cancer individually.<sup>92,93</sup>

## Prevalence

Cancer prevalence is here taken to mean a count of the persons alive who have ever been diagnosed with cancer (also known as 'cancer survivors'). By 2010 (the most recent year available), there were 3525 cancer survivors in Blackburn with Darwen who had been diagnosed since 1991 (Figure 67).<sup>94</sup> Some of these survivors will experience emotional, practical, medical and financial problems which continue long after treatment has finished.<sup>95</sup> Assuming cancer incidence continues to rise and survival continues to improve, Public Health England and Macmillan estimate that the number of survivors in Blackburn with Darwen could grow to 6,800 by 2030.<sup>96</sup>

Figure 68 shows the number of survivors in Blackburn with Darwen from each of the 'Big 4' cancers, broken down by time since diagnosis.\*

\*NB - Individuals with more than one type of cancer may be double-counted in Figure 68, but not in Figure 67. Both charts include diagnoses since 1991 only.

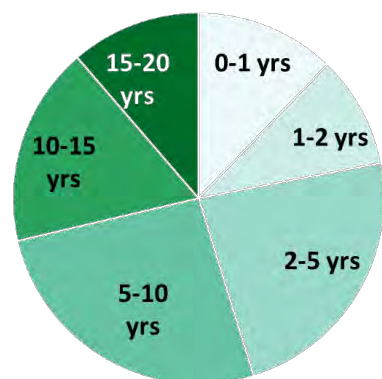


Figure 67 - Cancer survivors in Blackburn with Darwen in 2010 (all cancers, total = 3525) showing length of survival

Figure 65 - Age-Standardised Incidence Rate (All Cancers, M+F)

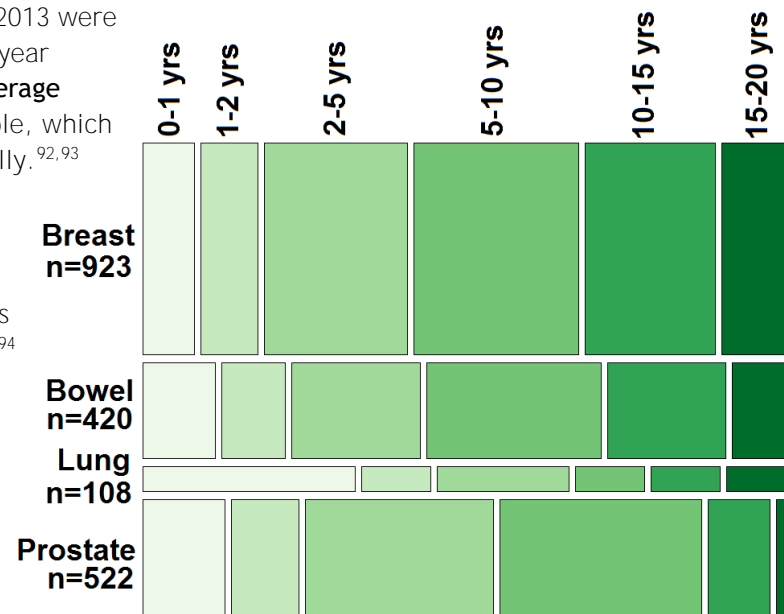
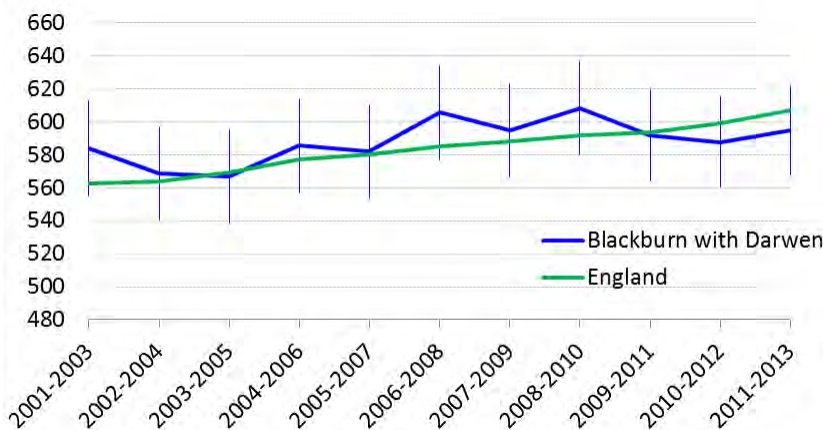


Figure 68 - BwD survivors of 'Big 4' cancers as at 2010 showing length of survival



## CARDIOVASCULAR DISEASE

Cardiovascular disease, or CVD, is an umbrella term for conditions of the circulatory system, such as coronary heart disease (CHD), stroke, heart failure and rhythmic heart disorders. Together these accounted for 27.2% of all deaths in England & Wales in 2014<sup>97</sup>, and 28.6% in Blackburn with Darwen.

### CVD mortality

In 2012-14, the Borough had the second highest all-age mortality rate for CVD out of 152 upper-tier authorities in England.<sup>98</sup>

### PREMATURE MORTALITY (BELOW AGE 75)

**Blackburn with Darwen's** death rate from CVD in the under-75 age-group is consistently higher than average (Figure 69), and was the 6<sup>th</sup> highest out of 152 upper-tier authorities in 2012-14. Two-thirds of these deaths were from types of CVD from which premature death is considered to be largely preventable, either via behaviour change or through public health measures. This gives Blackburn with Darwen the 7<sup>th</sup> highest premature death rate from 'preventable' types of CVD.<sup>26</sup>

### Coronary Heart Disease (CHD)

In 2014/15, there were 6641 people in Blackburn with Darwen who had been diagnosed with CHD, and modelled estimates suggested that approximately another 1660 residents were likely to have it too without knowing.<sup>99</sup> Out of all the upper-tier local authorities in England, Blackburn with Darwen had the 5<sup>th</sup> highest

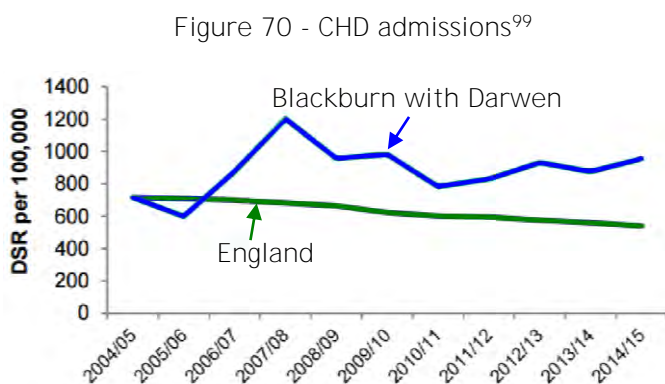
premature mortality rate for CHD in 2012-14.<sup>98</sup>

There were 1096 hospital admissions for CHD in 2014/15, which gives a rate significantly above the England average (Figure 70).<sup>99</sup>

### Stroke

In 2014/15 there were 2980 people in Blackburn with Darwen who had ever been diagnosed with a stroke.<sup>99</sup> There were also 225 new admissions because of stroke, which is significantly above the England rate, although the gap is much less striking than for CHD.

The premature mortality rate from stroke in Blackburn with Darwen in 2012-14 was 20.9 per 100,000, which ranks ninth highest among upper-tier local authorities. The mortality rate among those aged 75 and above was also significantly higher than the England average.<sup>98, 99</sup>

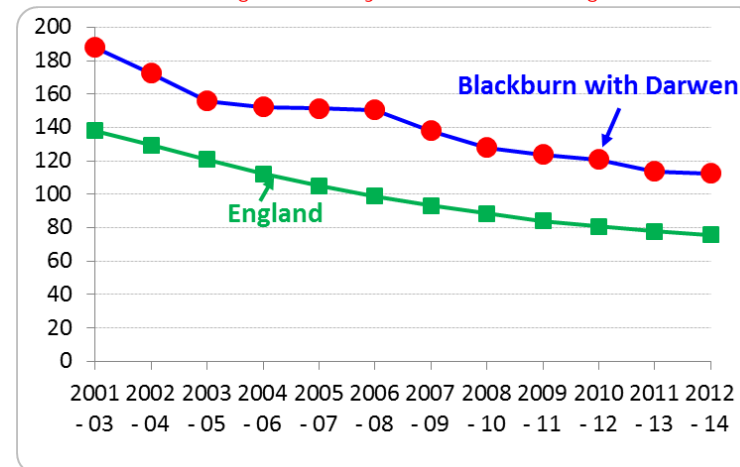


### CVD risk factors

**High blood pressure is one of the leading risk factors for CVD.** Public Health England's Hypertension Profile shows that Blackburn with Darwen has approximately 22,000 patients diagnosed with hypertension, but is suspected of having around a further 17,300 undiagnosed cases.<sup>100</sup> **The borough is in the second highest quintile on a 'lifestyle risk factors' index combining estimated levels of obesity, lack of exercise and excess alcohol.** In 2014/15, only 10.8% of eligible residents aged 40-74 were offered an NHS Health Check, and 7.0% received one, both of which proportions are well below the national average.<sup>99</sup>

Figure 69 - CVD mortality under age 75 (directly standardised rate per 100,000 persons)

● Red = significantly worse than England



## Diabetes

Figure 71 - Summary of Blackburn with Darwen performance on Diabetes care pathway  
Data from <http://www.phoutcomes.info/>  
& associated tools (unless otherwise stated)

### Background

Diabetes affects around 4m people in the UK, predicted to rise to 5m by 2025, and consumes around 10% of NHS spending.<sup>103</sup> Blackburn with Darwen's prevalence of 8.1% (Figure 71) is the highest in the NW, and 10<sup>th</sup> highest out of 209 CCGs nationally. This may be partly for reasons amenable to preventative action (e.g. low physical activity), but also because of the inherently high risk in Asian populations.

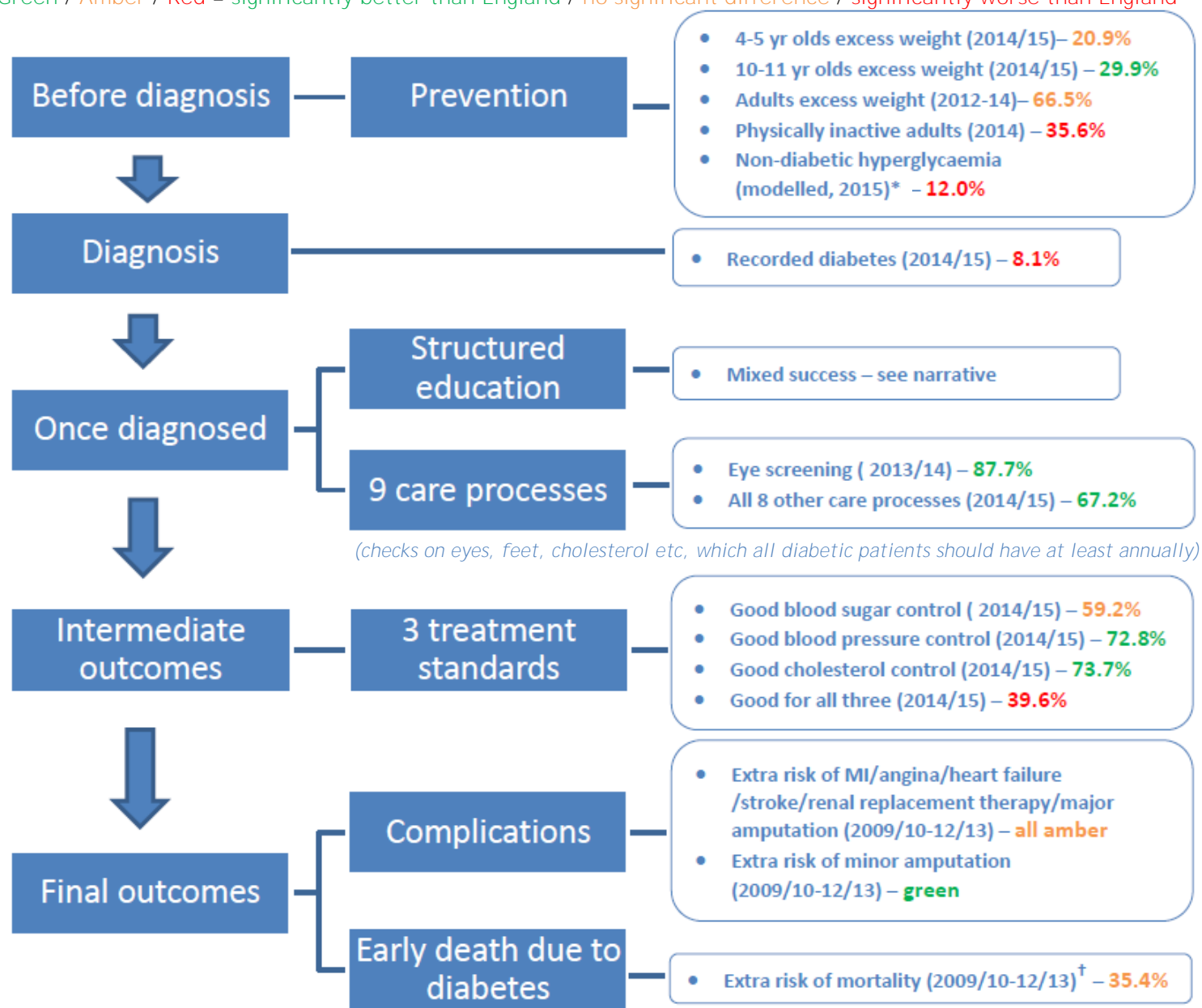
### Structured education

Blackburn with Darwen has one of the highest rates of referral to programmes of structured education, designed to help patients manage their condition and hopefully reduce the risk of complications.<sup>104</sup> However, both locally and nationally, only a tiny fraction are recorded as actually attending.<sup>108</sup> Several reports have drawn attention to this problem.<sup>105, 108, 106</sup>

When Blackburn with Darwen patients do attend, the main provider, X-pert Health, reports that they show the biggest increase in empowerment out of all its 66 client CCGs nationwide.<sup>107</sup>

### National Diabetes Audit

Much of the data in Figure 71 originates from the National Diabetes Audit (NDA). The NDA switched to an 'opt-in' model two years ago, which has led to reduced participation nationally. In 2014/15, only 15 Blackburn with Darwen practices took part.<sup>108</sup> This has obvious consequences for the quality of the data which the Audit can provide.



\* Hyperglycaemia estimates from PHE.<sup>102</sup> (Red rating denotes worst quintile, rather than statistical significance)

<sup>†</sup> Excess mortality data taken direct from National Diabetes Audit.<sup>101</sup>

Figure 72 - Key Mental Health Risk Factors and Indicators for Blackburn with Darwen  
(Main sources: PHE Health Profile<sup>5</sup>, Common Mental Health Disorders Profile<sup>109</sup>, Severe Mental Illness Profile<sup>110</sup>, Public Health Outcomes Framework<sup>26</sup> as at 20/4/16. See also other parts of this Summary Review.)

## MENTAL HEALTH AND WELLBEING

### Risk factors

The incoming arrows represent factors associated with an increased risk of mental health problems. Many of these risk factors are themselves exacerbated by mental ill-health, so there is really a two-way relationship, but this is not shown in the interests of simplicity.

### Prevalence

Blackburn with Darwen has a higher than average proportion of patients registered with a Severe Mental Illness, and above-average rates of more common mental health problems such as anxiety and depression. However, the prevalence of these problems among social care users is well below average.

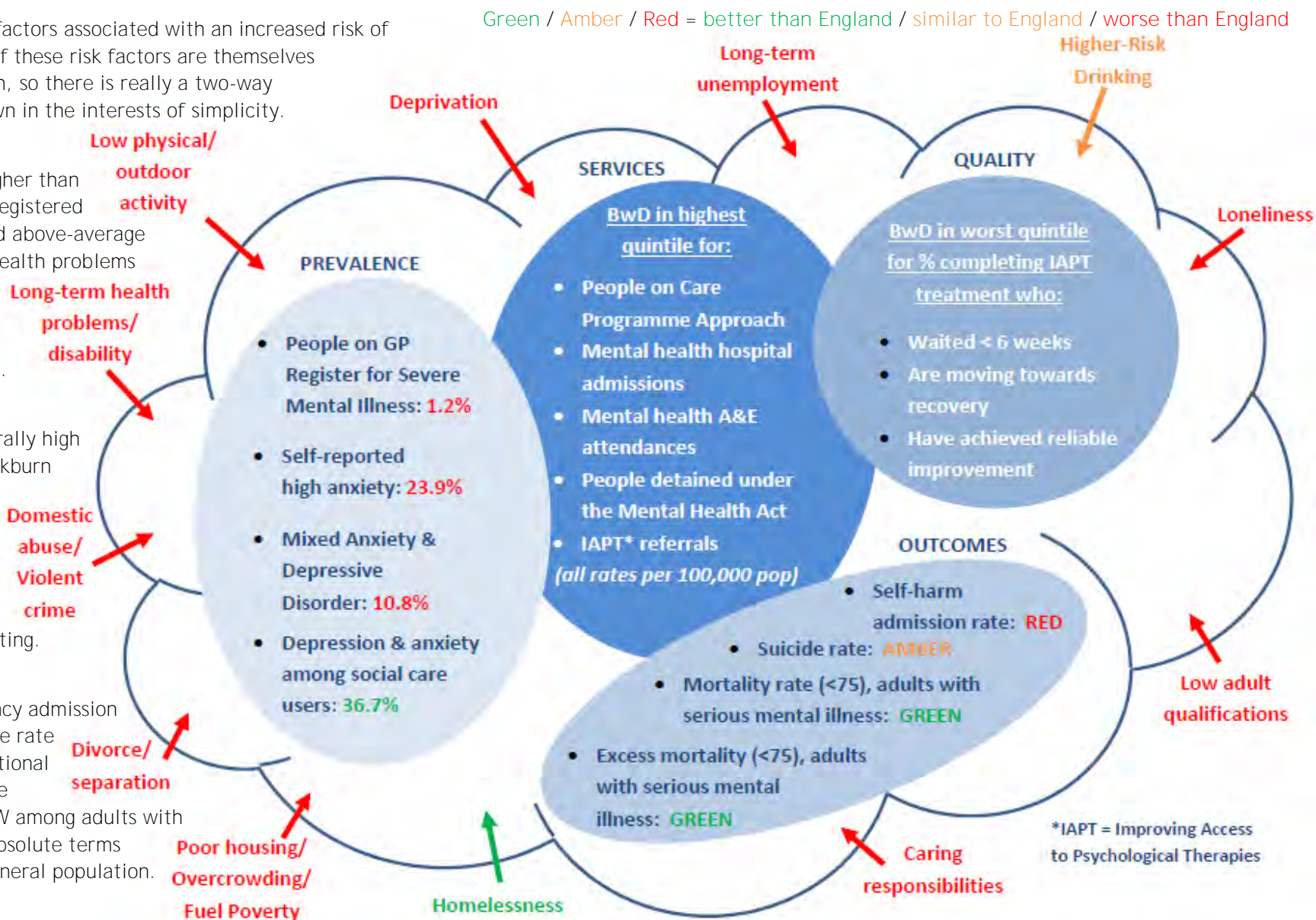
### Services & Quality

The PHE profiles suggest a generally high level of service usage, with Blackburn with Darwen falling in the top quintile on several indicators.\*

IAPT services are not, however, delivering a high level of recovery or improvement, and waiting times are also disappointing.

### Outcomes

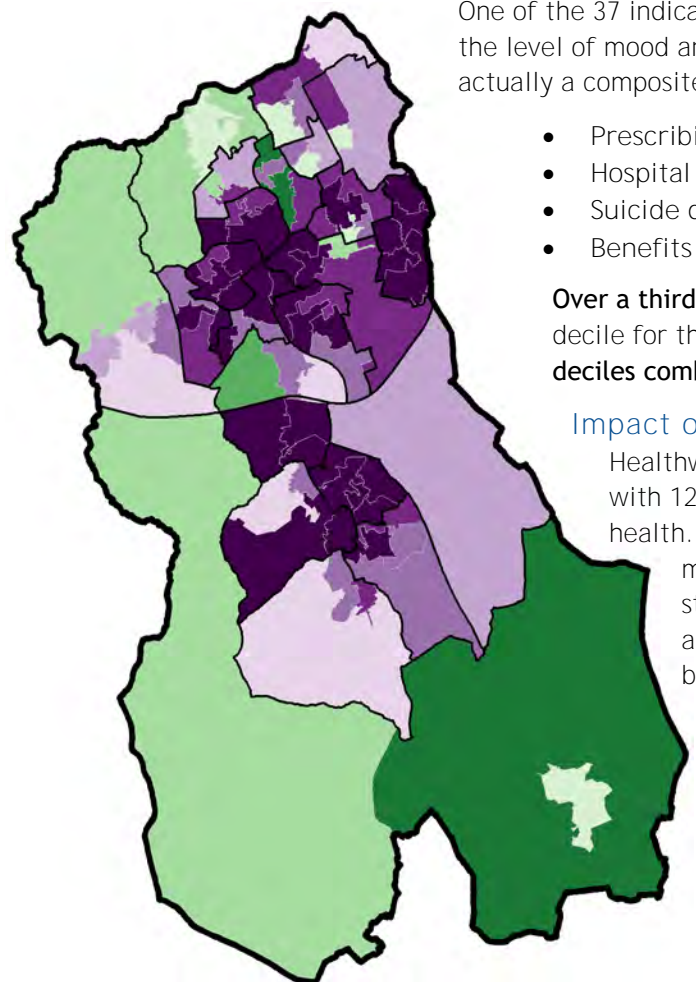
The Borough has a high emergency admission rate for self-harm, but its suicide rate in 2012-14 was similar to the national average. It continues to have the lowest mortality levels in the NW among adults with serious mental illness, both in absolute terms and when compared with the general population.



\* The PHE profiles also suggest that Blackburn with Darwen has the **country's top rate** of entry to IAPT treatment. However, the stated figure equals the referral rate. This is not typical, and may be a mistake.



### Local geography of mood and anxiety disorders



One of the 37 indicators in the Indices of Deprivation 2015, known as the **'Mood and Anxiety Disorders' indicator**, attempts to summarise the level of mood and anxiety disorders among adults living in each Lower Super Output Area or LSOA (see Figure 73). This indicator is actually a composite of four other indicators – in other words, it is a mini-index in its own right. The four component indicators are:

- Prescribing data - based on types and amounts of relevant drugs prescribed by GPs
- Hospital admissions data - based on inpatient spells for reasons of mental ill health
- Suicide data - based on deaths between 2008 and 2012
- Benefits data - based on receipt of incapacity benefits for reasons of mental ill-health

**Over a third (32 out of 91) of Blackburn with Darwen's LSOAs are in the highest national decile for the Mood and Anxiety Disorders indicator, and more than half are in the top two deciles combined. None of the borough's LSOAs are in the least-affected decile.**

### Impact of worklessness on mental health

Healthwatch Blackburn with Darwen has published a report based on research carried out with 120 local residents, drawing attention to the impact of unemployment upon mental health.<sup>111</sup> 79% of respondents felt that their work situation had negatively affected their mental health and wellbeing, often causing financial and housing problems, stress, stigma and social isolation, and 44% were not aware of local mental health and wellbeing services that they could approach for help. These issues are brought to life through the use of case studies and striking graphical illustrations.

### Inpatient psychiatric care: 'out-of-area' placements

The issue of 'out-of-area' care, whereby mental health patients may have to travel miles to be found a hospital bed, has been the focus of much media and political attention this year. Well over 5000 patients in England were sent to out-of-area hospitals in 2015-16, and the problem is increasing year on year.<sup>112</sup>

One of the most acutely affected providers was Lancashire Care Foundation Trust, which serves Blackburn with Darwen. Out-of-area placements across LCFT as a whole rose from 331 patients in 2014-15 to 751 in 2015-16, and in January 2016 it became the first ever mental health trust to declare a major incident. This enabled it to redeploy staff to address the crisis, and develop a number of initiatives to reduce the pressure on beds. By May 2016, the number of patients in hospital beds outside of Lancashire had fallen from 94 to 20.

An independent commission was set up in 2015 under Lord Crisp to investigate concerns about the provision of acute inpatient psychiatric beds, and issued its report in February 2016.<sup>113</sup> Blackburn with Darwen CCG, which is the lead commissioner of mental health services across the whole of Lancashire, has welcomed the report, which calls for an end to the practice of out-of-area placements by October 2017.<sup>114</sup>



Figure 74 - Artwork from Healthwatch Blackburn with Darwen's report on the Impact of Unemployment on Mental Health and Wellbeing<sup>111</sup>



Figure 73 - Mood and Anxiety Disorders indicator from Indices of Deprivation 2015

(Blackburn with Darwen LSOAs overlaid with Wards)

The new CCG Improvement and Assessment Framework also seeks to address the issue of out-of-area placements for mental health patients. It will require CCGs to monitor the number, duration and cost of such placements, and the reasons for them, and to put plans in place to reduce the use of out-of-area placements by the end of 2016/17.<sup>115</sup>

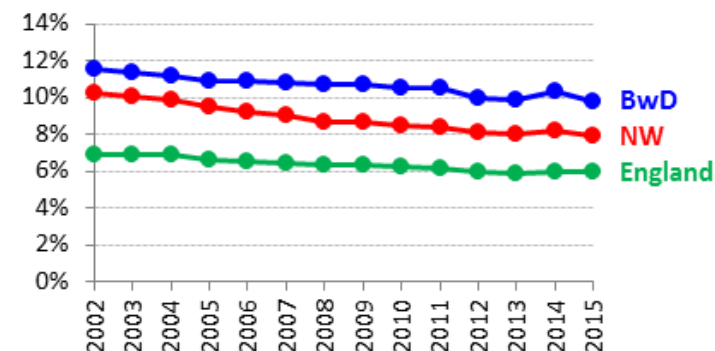


## WORKING-AGE INCAPACITY

### Incapacity benefits claimants

In November 2015, 9.8% of 16-64 year-old residents in Blackburn with Darwen were receiving some sort of incapacity benefit. This gives the borough the seventh highest rate out of 152 upper-tier authorities, after Blackpool, Knowsley, Liverpool, Middlesbrough, Stoke-on-Trent and Hartlepool. It continues an established pattern of consistently higher rates in Blackburn with Darwen than in the region or England as a whole (Figure 75).

Figure 75 - Proportion of residents aged 16-64 claiming Employment Support Allowance and other incapacity benefits (November each year)<sup>9</sup>

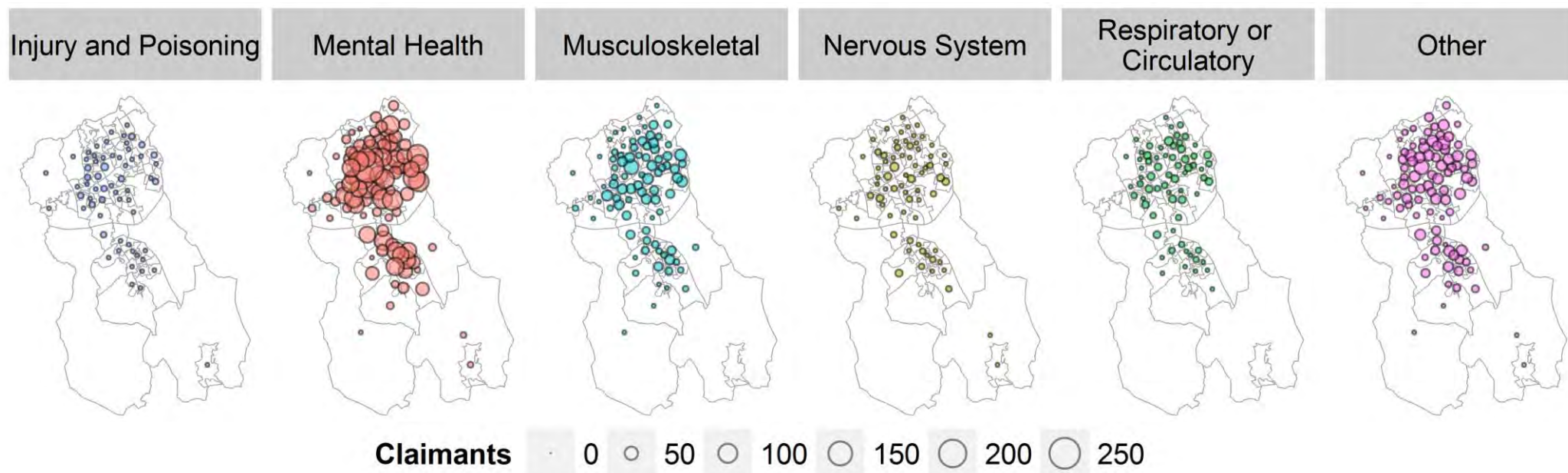


Within the borough, the proportion of the working-age population claiming incapacity benefits ranges from under 5% in six wards, to 17.0% in Shadsworth with Whitebirk and 19.1% in Wensley Fold.

### Conditions leading to incapacity benefit claims

By far the biggest category of condition resulting in the receipt of incapacity benefits is mental health problems, which account for just over half of all claims (Figure 76):

Figure 76 - Recipients of ESA and other incapacity benefits by qualifying condition (Lower Super Output Areas in Blackburn with Darwen, Aug 2015)<sup>116</sup>



## VISUAL IMPAIRMENT

### Risk factors and impacts<sup>121, 117, 118, 119, 120</sup>

Sight loss is related to many of the other topics in this ISNA, often as a possible cause or consequence (Error! Reference source not found.). Several of the risk factors on the left hand side of the diagram are modifiable, and it is roughly estimated that about 50% of sight loss can be avoided.<sup>121</sup>

### Blind and partially sighted residents - certified & registered

In 2013/14, 94 new patients in Blackburn with Darwen were certified as blind or partially sighted.<sup>26</sup> Registering with the council is optional, but as at March 2014, Blackburn with Darwen had approximately 545 residents registered as blind, and 800 as partially sighted.<sup>122</sup> Approximately half of those in each category were over the age of 75. However, it is possible to have a degree of sight loss which affects daily life without qualifying for certification, so these figures are only the tip of the iceberg.

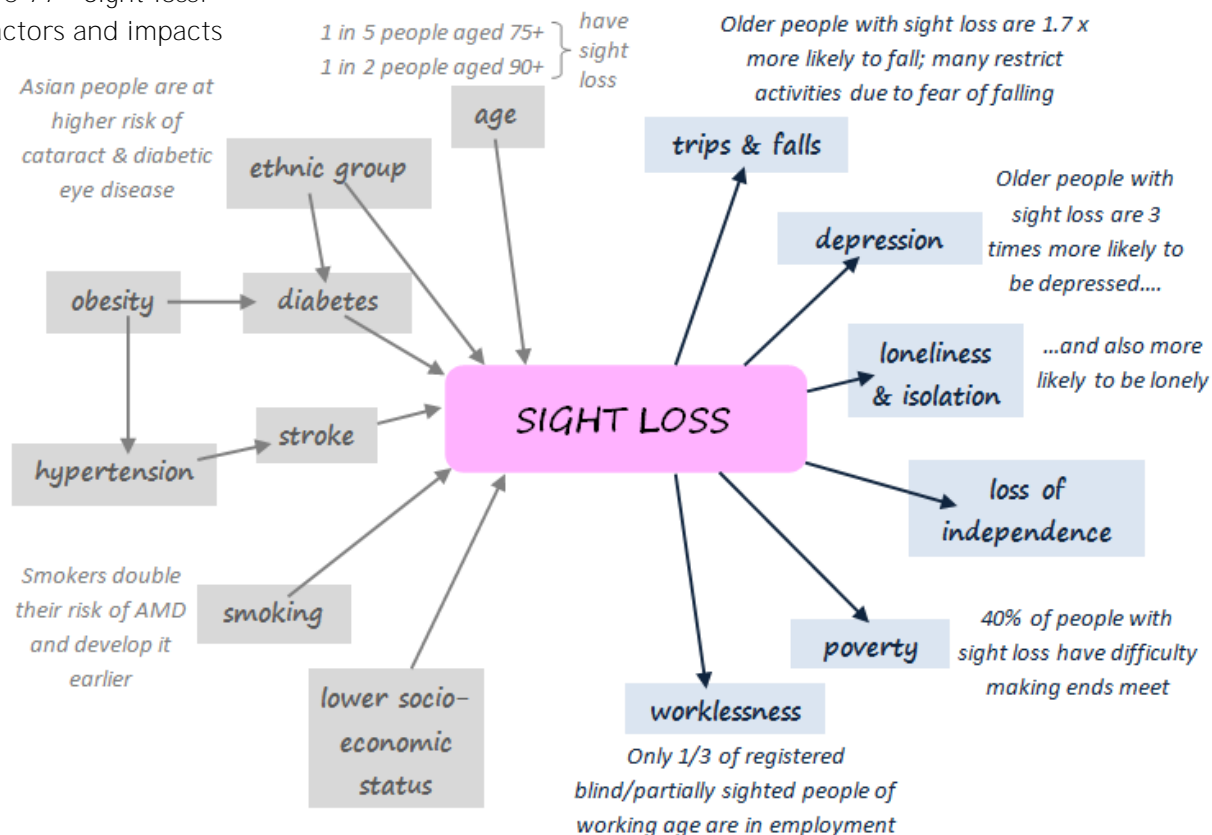


Figure 78 - Modelled estimates of number of people living with sight loss in Blackburn with Darwen (source: RNIB<sup>123</sup>)

### Cost to the local economy

NHS spending on problems of vision in Blackburn with Darwen was £4.6m in 2013/14, but it is estimated that an additional £10.5m goes on indirect costs such as lower employment, absenteeism and the provision of informal care.<sup>123</sup>

Figure 77 - Sight loss: risk factors and impacts



### Modelled estimates

The RNIB estimates that the true number of people affected by sight loss in Blackburn with Darwen may be in the order of 3,700.<sup>123</sup> Its Sight Loss Data Tool provides modelled estimates of how the number of people with mild, moderate and severe sight loss is likely to change over the coming years (Figure 78).

The Sight Loss Data Tool also provides modelled estimates of the numbers of people living with specific conditions that could threaten their sight (Table 1).

	2015	2020	2030
Early stage AMD	4910	5380	5880
Late stage dry AMD	350	380	430
Late stage wet AMD	710	950	880
Cataract	1110	1240	1390
Glaucoma	1270	1300	1330
Diabetic retinopathy	2770	2800	2840

Table 1 - Modelled estimates of people living with particular sight-threatening conditions in Blackburn with Darwen<sup>123</sup>

## ROAD SAFETY

### Overall rates

In Blackburn with Darwen in 2014 there were 553 recorded road traffic casualties (of all ages), down from 576 in 2013, and 638 the year before that. Expressed as a rate per resident, this puts Blackburn with Darwen 27<sup>th</sup> highest out of 152 upper-tier authorities in England.

477 of these injuries were slight\*, 73 were serious, and three were fatal, giving a total of 76 killed or seriously injured (KSI) in 2014.<sup>124</sup> If we look at three years combined, Blackburn with Darwen had the 24<sup>st</sup> highest KSI rate out of 151 upper-tier authorities in 2012-14, and was significantly worse than England.<sup>26</sup>

### Pedestrian casualties

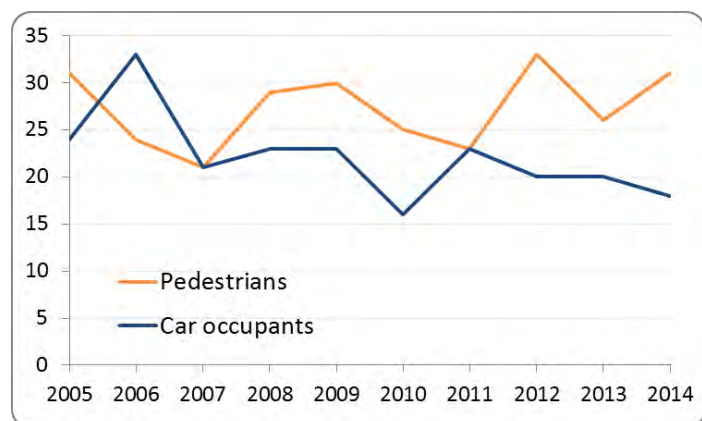


Figure 79 - Number of KSI casualties (BwD, 2005-14)

### Alternative rates

All the analysis so far relates to accidents *occurring* in Blackburn with Darwen, whether the casualty was local or not. Dividing by the resident population to obtain a rate may not therefore seem particularly logical.

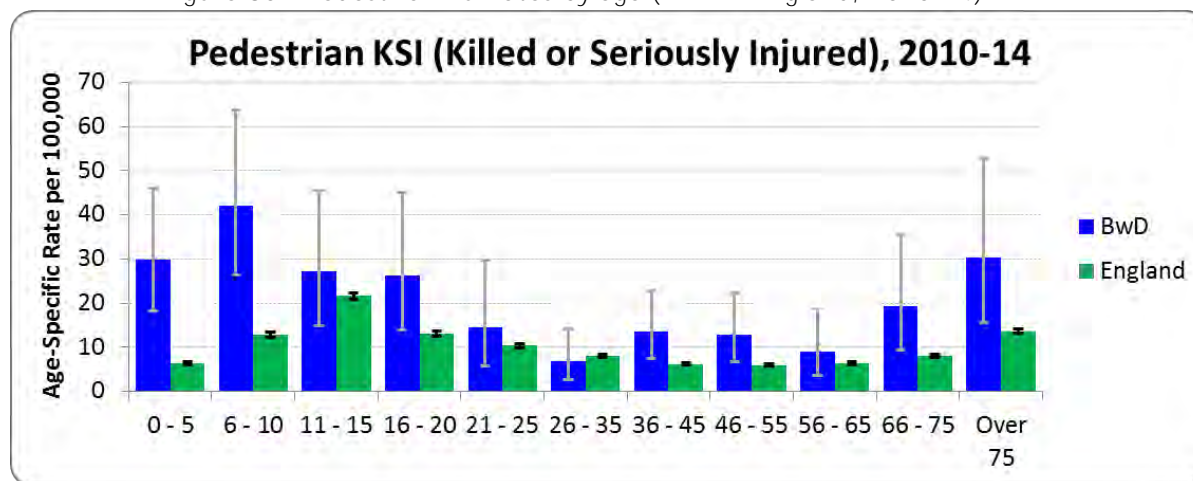
If we want to assess the risk to our own residents, we may prefer to count casualties according to where they *come* from, regardless of where their accident occurred. This is done in a recent report, but for constituencies rather than local authorities.<sup>127</sup>

In 2009-14, the rate of KSI casualties from Blackburn constituency was 24% higher than the Great Britain average, and for those from Rossendale & Darwen constituency it was 34% higher. When all severities of casualty are considered (not just KSI), Blackburn constituency comes 10<sup>th</sup> highest out of 632 constituencies. If we focus on pedestrian casualties of all severities, Blackburn constituency comes second highest in the country (after Tottenham), with more than twice the national average rate.<sup>127</sup>

In 2014, Blackburn with Darwen had the 11th highest overall rate of pedestrian casualties in England (per 100,000 population), and the highest of all outside London.<sup>124</sup> If we focus on the more serious injuries, Blackburn with Darwen tends to have more pedestrian KSIs than car occupant KSIs (Figure 79).<sup>125</sup> This is the opposite of the national picture, where there were over 1½ times as many car occupant as pedestrian KSIs in 2014.<sup>126</sup>

The *rate* of pedestrian KSI casualties in Blackburn with Darwen is higher than average for almost every age-group (Figure 80), and significantly so for the youngest residents (aged 0-10) and the oldest (aged 66+).

Figure 80 - Pedestrian KSI rates by age (BwD v. England, 2010-14)



\* The recording of non-serious injuries is often less than complete.

## ASYLUM SEEKERS

Asylum seekers are those who have entered the UK and applied for refugee status, and are waiting for their claim to be assessed. They are allocated Home Office accommodation on a **no-choice basis, are not allowed to work for twelve months, and are reliant on cash payments to meet their 'essential living needs'**. These payments were initially set at a level of 70% of Income Support, but were frozen between 2011 and 2015. A new flat rate per person was introduced in August 2015, which represents a **'substantial reduction' for single parents and families with children**.<sup>128, 129, 130, 131, 132</sup>

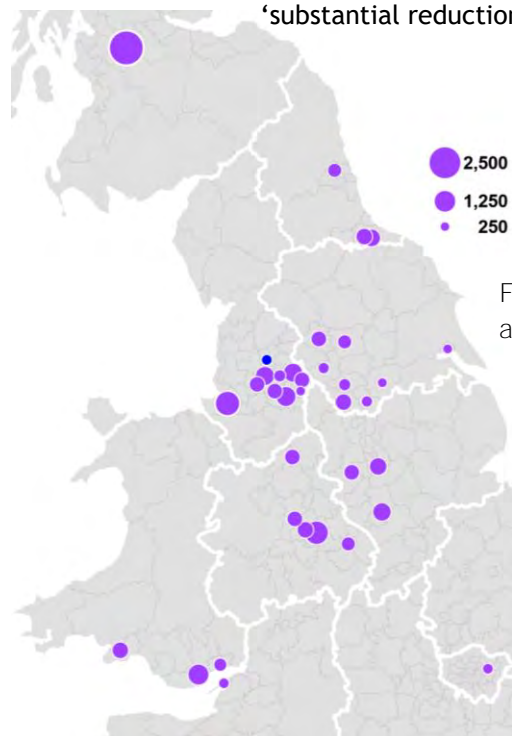


Figure 81 - Districts with 250+ asylum seekers at end September 2015  
(also Belfast, not shown)  
Source: Home Office<sup>133</sup>

Asylum seekers are far from evenly spread around the country. Blackburn with Darwen is one of the 36 districts in the UK to have 250 or more asylum seekers as at the end of September 2015 (Figure 81). Between them, these districts account for over 80% of all asylum seekers in the country, while many other districts have none at all.

The national total number of asylum seekers is much lower than a decade ago, although it has been rising again for the past three years. Blackburn with Darwen's latest count of 278 is also well down on its previous peak (Figure 82).

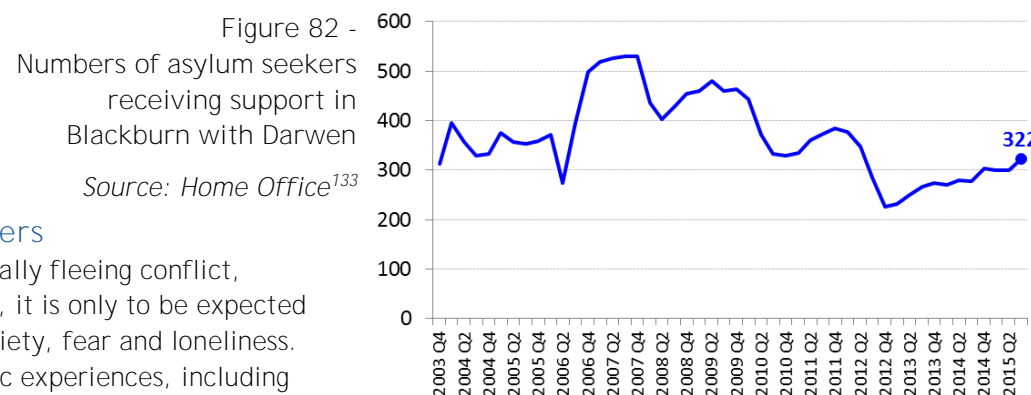


Figure 82 - Numbers of asylum seekers receiving support in Blackburn with Darwen  
Source: Home Office<sup>133</sup>

### Health needs of asylum seekers

Given that asylum seekers are typically fleeing conflict, politically upheaval and persecution, it is only to be expected that they will be suffering from anxiety, fear and loneliness. Some may have had highly traumatic experiences, including violence, torture and war, and be suffering mental distress as a result. They may also come from countries where TB, HIV and hepatitis are prevalent, or have chronic non-communicable diseases, such as diabetes, which may have gone untreated.<sup>129</sup>

### Healthwatch engagement programme

Asylum Seeker and Refugee drop-in sessions take place weekly at Wesley Hall in Blackburn and the United Reformed Church in Darwen. By attending these sessions to offer advice and information, Healthwatch Blackburn with Darwen has been able to build up a relationship with asylum seekers and refugees, and conduct interviews and focus groups. It has now published its findings as an online report.<sup>134</sup>

Asylum seekers reported that they often encountered communication barriers when seeking healthcare. This could bring added anxiety and confusion, and meant that conditions and treatments were often poorly understood. Children were sometimes called upon to act as an interpreter, which was an imposition on them and could inhibit the frank discussion of medical problems. Respondents also found it difficult and costly to obtain an appointment, and often needed multiple slots in order to deal with all their issues in the face of language barriers. There were also problems relating to staff attitudes, with some residents feeling they were looked down upon or not taken seriously. Others had been put off seeking healthcare because of doubts or misunderstandings about patient confidentiality.



AGE WELL

## ISSUES PARTICULARLY AFFECTING OLDER PEOPLE

## TRIPS AND FALLS

## Hospital admissions

Each year, 30% of over-65s will experience one or more falls, rising to 50% of over-80s.<sup>135</sup> The Public Health Outcomes Framework records the annual age-standardised rate of falls-related emergency hospital admissions among residents aged 65+. Blackburn with Darwen is consistently higher than average, with 515 such admissions in 2014/15, putting it just within the top quintile nationally.<sup>26</sup>

## Hip fractures

Following a hip fracture, only one in 3 sufferers return to their former level of independence, and another third have to leave their own home and enter long-term care.<sup>136</sup> **Blackburn with Darwen's** rates of hip fracture at ages 65-79 and 80+ were both close to average in 2014/15.<sup>26</sup>

## Local initiatives and engagement

**Blackburn with Darwen's 'Fallstop' campaign**<sup>137</sup> aims to raise awareness of some simple steps that people can take to prevent falls in their own home, and how to access professional advice and help. The Fallstop advice leaflet is widely available through GP practices, pharmacies, libraries etc as well as online.<sup>138</sup>

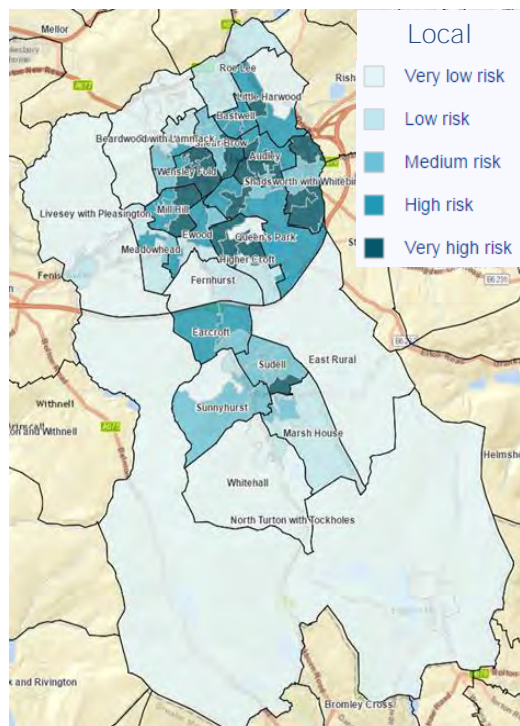


Figure 83 -  
Modelled  
prevalence of  
loneliness in 65+  
population  
(LSOAs overlaid  
with Wards)

Source: Age UK<sup>142</sup>

In an engagement programme in 2015, Healthwatch Blackburn with Darwen gathered real-life stories about the circumstances of trips and falls, the risk factors leading to them, the care and treatment received, and the longer term impacts on the patient and their carers. Many experienced loss of confidence and may in turn lead to isolation.<sup>139</sup>

## LONELINESS AND ISOLATION

Lonely people have a higher risk of depression and suicide, visit their GP more, have a higher use of medication, higher incidence of falls, and are at increased risk of entering long-term care.<sup>140</sup> Key risk factors for loneliness include being in later old age (over 80 years), on a low income, in poor physical or mental health, and living alone or in deprived urban communities.<sup>141</sup> A good source of guidance for local authorities is the updated *Combating loneliness guide*, from the LGA and the Campaign to End Loneliness.<sup>141</sup>

## Extent of the problem

Age UK has devised a way of modelling the prevalence of loneliness in the over-65 population, using data from the 2011

Census.<sup>142+143</sup> They estimate that Blackburn with Darwen as a whole is the 39<sup>th</sup> loneliest district out of 326 in England. The map on the left shows their model at the Lower Super Output Area (LSOA) level. One-fifth of the LSOAs in Blackburn with Darwen are shaded in each colour. However, the whole of the top *two* quintiles (i.e. highest 40%) in Blackburn with Darwen falls within the highest-risk quintile (i.e. top 20%) nationally.

The only official measures of social isolation are for adult carers, and those receiving social care. In 2014/15, 41.1% of carers surveyed in Blackburn with Darwen said they had as much social contact as they would like (England 38.5%). This puts the borough in the second best quintile. Among adults receiving social care, 52.7% had as much social contact as they would like, which is the third best result in the country (England 44.8%).<sup>26</sup>



Figure 84 - Reducing the risk of dementia - PHE infographic on the role of local government and Health and Wellbeing Boards<sup>147</sup>

## DEMENTIA

### Research & policy

Although the number of people with dementia is still predicted to rise as the population ages, recent research lends weight to the suggestion that it may not be quite such a fast-growing epidemic as was feared. One particularly influential paper from Cambridge University has reported a 22% drop in UK prevalence in a generation.<sup>144,145</sup> The researchers suggest that these improvements may reflect better education and living conditions in the post-war era, and improved prevention and treatment of chronic conditions such as vascular disease. They recommend that the most fruitful direction for dementia research is to focus on prevention rather than cure, by improving health across the life-course. The decline in dementia incidence has been particularly striking in men, as they have adopted healthier lifestyles and cut down on smoking.<sup>146</sup>

Public Health England and NICE have both responded to this message by bringing out guidance on the actions that people in midlife can take to reduce the risk of dementia or postpone its onset, and what local authorities and other agencies can do to help them.<sup>147,148</sup>

### Local prevalence

#### ESTIMATES

NHS England has concluded that the Cognitive Function and Ageing Study II (CFAS II)<sup>149</sup> at Cambridge University provides the best scientific evidence of dementia prevalence, rather than the updated Dementia UK study.<sup>150</sup> However, the CFAS II rates are only available for ages 65+, so the Dementia UK rates are still used below that age.<sup>151,152,153</sup> Applied to the Blackburn with Darwen population, the approved rates suggest that there may be about 1371 residents with dementia, of whom 1280 are aged 65+.<sup>152,154</sup>

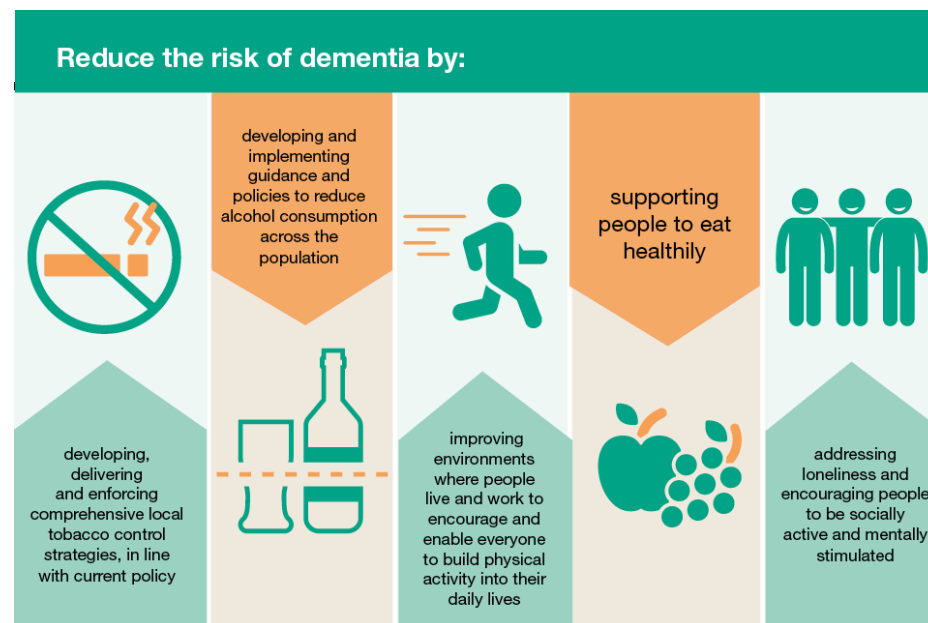
#### RECORDED VERSUS ESTIMATED PREVALENCE

The prevalence estimates cover *all* people with dementia, whether diagnosed or not. **NHS England's** ambition is for 66.7% of this number to have received a diagnosis, which was achieved earlier this year. At the local level, the official measure uses the number of recorded diagnoses among the *registered* population of each CCG, divided by the estimated number of *residents* with dementia. On this basis, Blackburn with Darwen scores 81.7% (April 2016).<sup>152</sup> However, more people have a GP in Blackburn with Darwen than live in the borough, so this is probably a slight exaggeration. A recalculated version comes out about 10 percentage points lower, but still above the 66.7% threshold.

### Dementia-friendly communities<sup>155</sup>

For people who already have dementia, Blackburn with Darwen offers many examples of communities and services where they can feel safe, understood and respected:

- A **'dementia-friendly' initiative at Blackburn Rovers**, with special checkouts and easy-read signs both at the ground and at its stores and cafes.<sup>156</sup>
- **The borough's first 'dementia-friendly' GP practice**, with specially trained staff, extra reminders, longer appointments and improved signage.<sup>157</sup>
- A pioneering dementia-friendly ward at the Royal Blackburn Hospital, developed **with support from the King's Fund**, providing a calm and comforting, yet stimulating, environment. With its specially-designed layout, colour scheme, lighting effects, Lancashire photos and nostalgic furnishings, and optoinal entertainments and activities, it is now being emulated by neighbouring authorities.<sup>158</sup>
- A new state-of-the-art 64-bed care-home, offering the latest in person-centred care and dementia-friendly design. It features everything from a cinema and vintage tea rooms to a special football-themed room created in partnership with Blackburn Rovers Community Trust.<sup>159</sup>



## QUALITY AND LENGTH OF LIFE

HEALTHY LIFE EXPECTANCY

Everything within the Public Health Outcomes Framework is geared towards achieving two ‘overarching outcomes’, one of which is:

*“Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life”*<sup>160</sup>

The importance accorded to this indicator reflects the philosophy that the public health system should be concerned not just with extending life, but with improving health and wellbeing across the life course. The calculation involves splitting total **Life Expectancy** into the portion spent in ‘good’ health and the remainder spent in ‘not good’ health, based on responses to a survey question such as: *“How is your health in general?”* (Figure 85):<sup>161</sup>

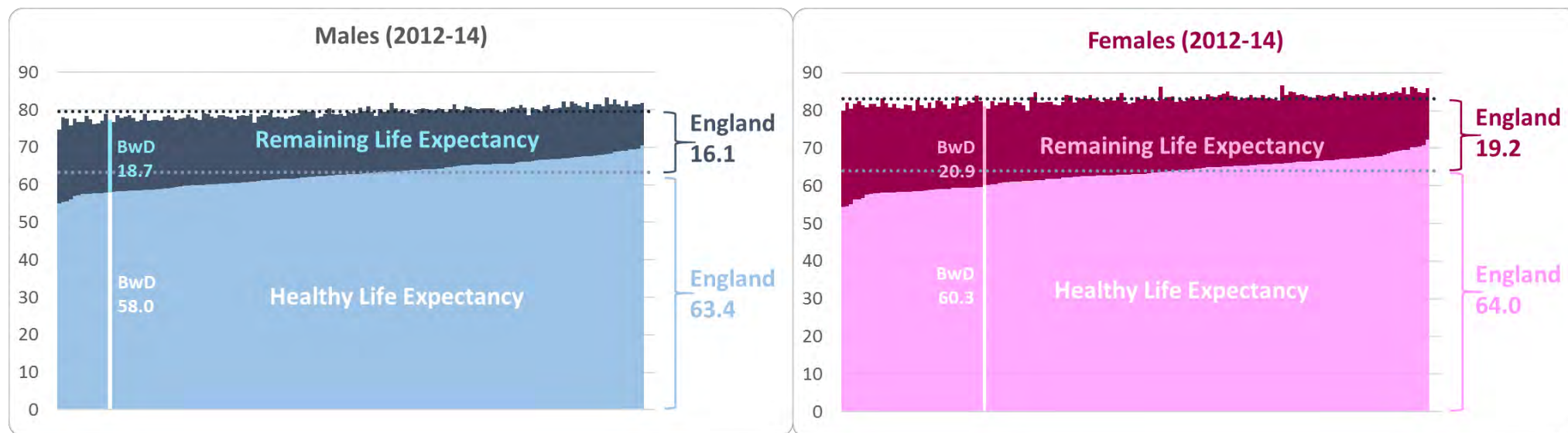


Figure 85 - Healthy Life Expectancy - Blackburn with Darwen compared with 150 upper-tier local authorities and England (2012-14)

It can be seen that Healthy Life Expectancy in Blackburn with Darwen is 58.0 years for males and 60.3 years for females, both of which are significantly lower than the England average. When Healthy Life Expectancy is divided by total Life Expectancy, we find that males in Blackburn with Darwen can expect to spend 75.6% of their life in good health, and females 74.3%, which again is below average for both sexes.

The 2012-14 data provides the first opportunity to compare Healthy Life Expectancy for non-overlapping time periods, as the series only started in 2009-11. However, the change over time is statistically insignificant in most local authority areas, including Blackburn with Darwen.

The Public Health Outcomes Framework acknowledges that Healthy Life Expectancy is the sort of measure which can take a long time to show any marked improvements, which is why the overarching outcomes are underpinned by a large collection of supporting indicators.<sup>160</sup>

## END OF LIFE

## CAUSE OF DEATH

## Main causes of death in Blackburn with Darwen 2014

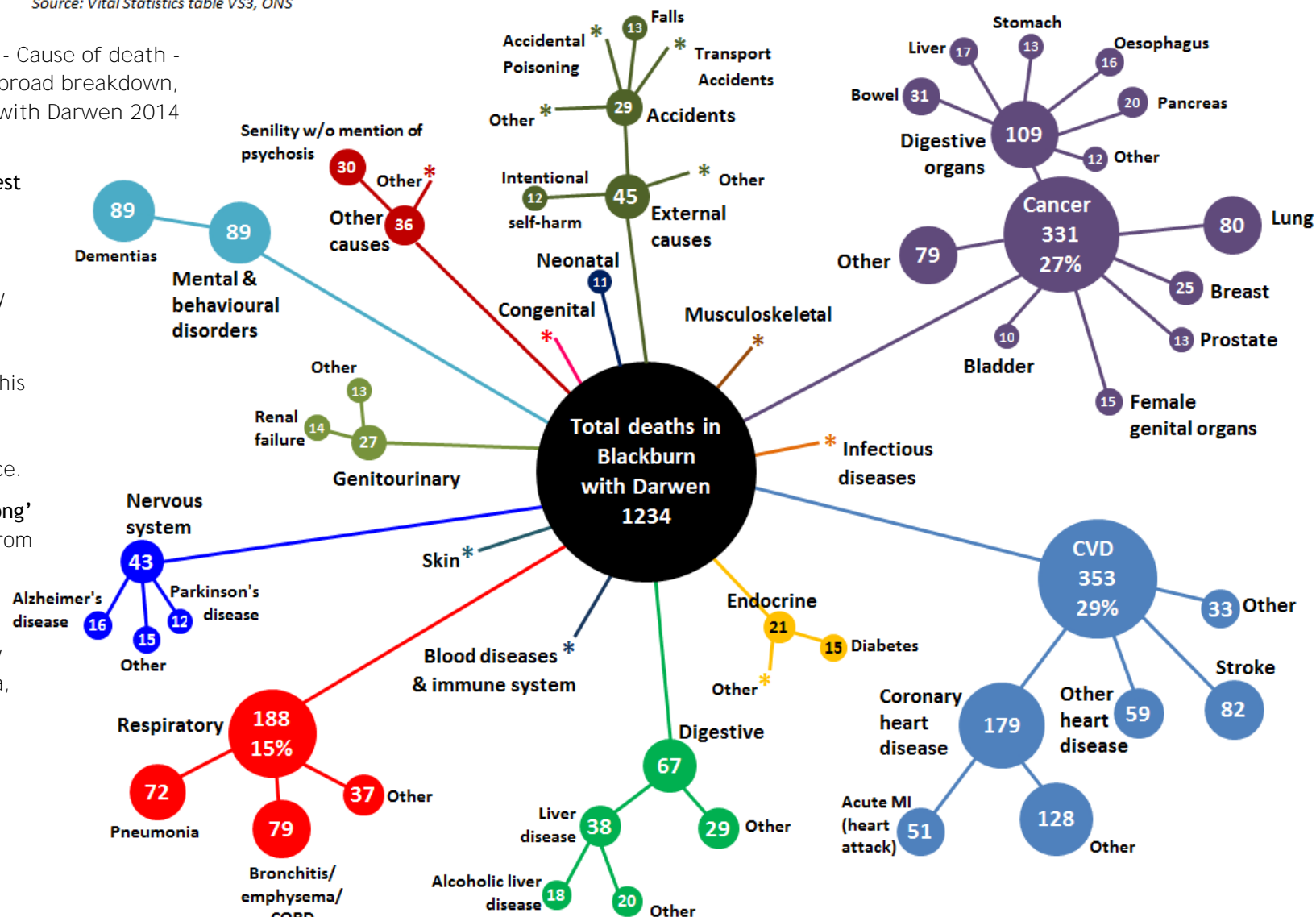
\* signifies less than 10 deaths

Source: Vital Statistics table VS3, ONS

Figure 86 - Cause of death -  
broad breakdown,  
Blackburn with Darwen 2014

It is natural to ask 'What is the biggest cause of death in Blackburn with Darwen?'. This depends on how the causes have been grouped into categories, but if we accept the very broad classification used here, the answer is 'CVD' (with 353 deaths in 2014), followed by 'Cancer' (331). This contrasts with England as a whole, where Cancer overtook CVD in 2011, and has remained slightly higher since.

There is, however, no 'right' or 'wrong' way to split up the causes. Figures from the ONS suggest that Dementia and Alzheimer's disease is the second biggest cause of death nationally. However, this has been arrived at by combining various forms of dementia, and splitting up CVD and cancers.<sup>162</sup>





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