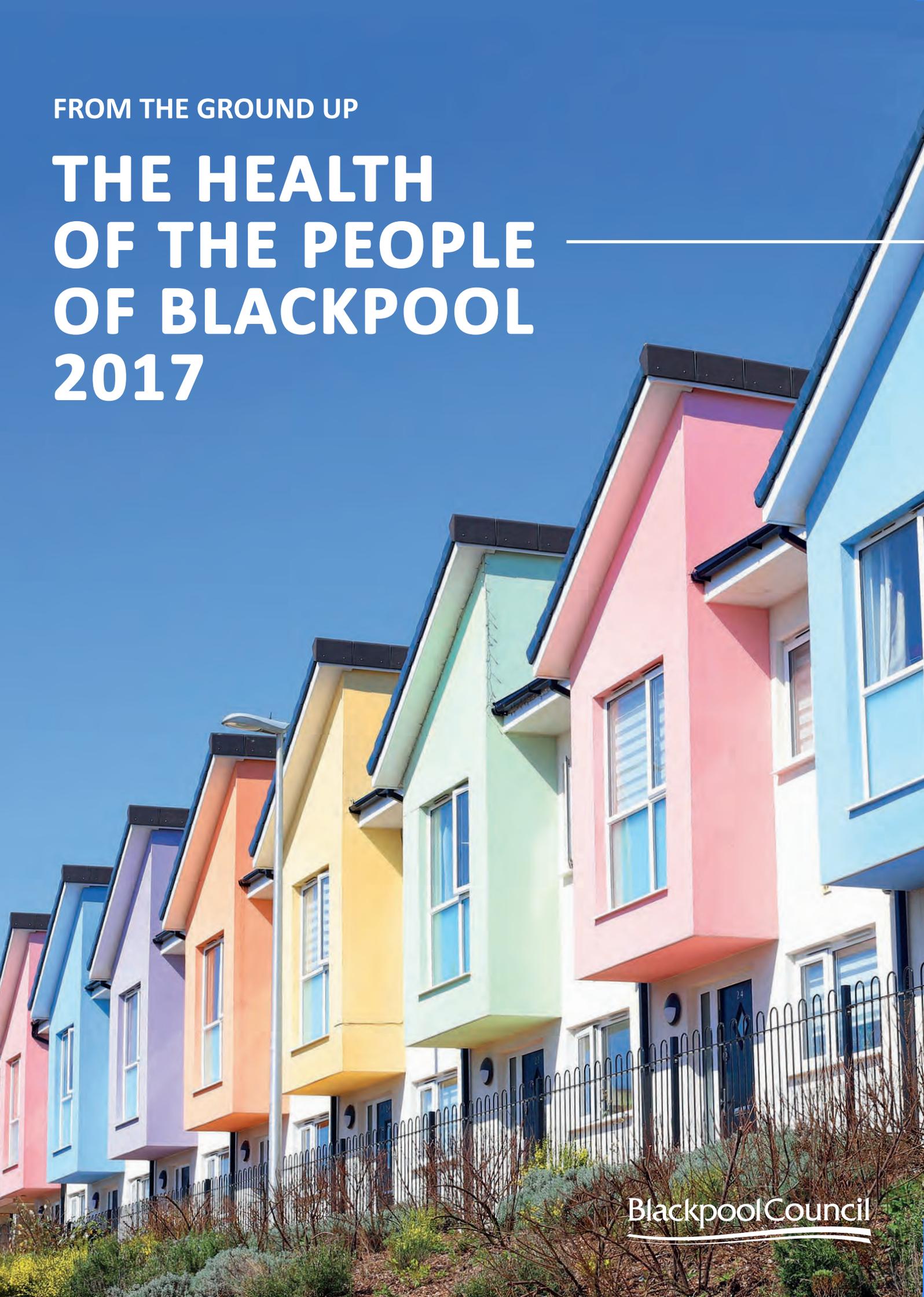


FROM THE GROUND UP

THE HEALTH OF THE PEOPLE OF BLACKPOOL 2017



Blackpool Council

Foreword

1. How health in Blackpool is changing
 2. Housing and health in Blackpool
 3. Interventions to make a difference
 4. Recommendations
- Appendix Health Profile 2017: Blackpool



Foreword



This year marks my tenth anniversary as Director of Public Health for Blackpool. 2017 has seen the completion of a number of major pieces of work that will help improve the health and wellbeing of Blackpool residents.

These include collaboration with Blackpool's Better Start programme to introduce a new model for health visiting, which will see all young children within the town benefit from at least eight contacts with their health visitor to monitor their development, and provide support to parents. The new approach aims to ensure that all our infants and young children can achieve their full potential in terms of growth and development, and are fully ready to learn when they start school. I look forward to seeing this new model embed over the coming year. Staying with young children for a moment, I am pleased to report that we will be working with national Public Health England colleagues after being identified as a pilot site for their Start Well programme to promote good oral health amongst our children.

Members of my public health team have worked closely with Positive Steps and Horizon drug and alcohol treatment services to submit a successful bid to Public Health England to take part in a research project on Individual Placement Support for people with Drug and Alcohol addiction.

The project will offer support to those in drug and alcohol treatment services to gain training, education and employment. The project will run as a pilot over the next two years and is anticipated to make a difference to supporting these individuals back to work and sustain their employment.

There has been excellent progress in work with the local NHS on the development of new neighbourhood models of care and support to patients and communities. We have played a key role in making sure that commissioning decisions have been made based on the needs, opportunities and solutions to improving community health and wellbeing to ensure that health and social care providers move beyond medical intervention, treatment and care. Social prescribing, using our new Directory of Service (FYI) is now a key element of any treatment and care intervention planning.





Members of my team have taken a lead in putting people and communities at the heart of current and future planning of services, with the ambition to incorporate fully this ‘coproduction’ approach as the way forward. We have facilitated discussions (including Integration 20:20 events) between the NHS and wider partners, such as my Council colleagues and the voluntary, community and faith sectors, to ensure that all are aware of the plans and ambitions with these new models of care.

All new neighbourhood models need all key partners around the table; and that includes people and communities if they are to be fully integrated. A Self Care Strategy for the Fylde Coast has recently been completed and sets the tone of our ambitions to ensure everyone has the opportunity to make informed lifestyle decisions, can access healthy lifestyle choices and are equal partners in any decisions about the care and support they may receive as patients should they fall ill. Our work on resident-led Citizens Inquiries will continue in 2018 as we take a further step towards Integration 20:20.

The priority of reducing inequalities in health has featured in some way in all my reports as Director of Public Health for Blackpool and indeed many of those by my predecessors. The latest release of data for local authorities shows that not only do Blackpool residents continue to experience the lowest life expectancy in the country, but this has slightly dropped for the first time in 20 years. Blackpool is not alone and it offers no comfort to note that other disadvantaged areas of the country also see this happening. Life expectancy is a useful indicator of the population’s health, but it does mask important changes in the types of health conditions experienced. In the first section of this report, I describe how health has changed for the residents of the town over the past ten years.

The importance of lifestyle and wider social and environmental conditions in determining our population’s health is another common feature of my reports. New analyses by my team has explored wider factors that may be contributing to reduced life expectancy in the town and has focused attention on the issue of the abundant supply of poor quality, cheap housing and how this may be driving poor health in the town in a number of ways. The links between physical conditions of homes and residents health are well accepted and the evidence-base can point us towards effective intervention. The relationship between housing supply, population flow and population health is more complex and there

is concern that this may be drawing people with poor health into the town. This is an important area for further research and discussion. In section two, I present local analyses that I hope will stimulate this debate.

In 2018, I look forward to the publication of a Green and Blue Infrastructure Strategy by Blackpool Council. Together with the ten year action plan, this will help to make the most of Blackpool’s existing assets, identify where more parks or green spaces are required, build green infrastructure into plans for the future of the town centre and explain how we plan to increase the engagement of local people to maintain our local gardens, trees and parks. A key part of the plan is the creation of a Community Farm as part of the redevelopment of the former City Learning Centre site. This development, known as @theGrange, brings a new community-focused centre for the Grange Park community and people living in the surrounding area. The centre will include our first community shop, sponsored by Blackpool's Fairness Commission, which will sell, amongst other things, produce from the farm @theGrange will be the hub at the heart of the plans to develop further housing on Grange Park.

Over the coming year we can also expect to see work progress on plans to develop Whyndyke Garden Village, a new housing development on the boundary of Blackpool and Fylde. Backed by NHS England, this will be a demonstrator site promoting good practice nationally and internationally in putting health and wellbeing at the centre of new housing developments.

It is evident to me that the health and wellbeing of Blackpool's residents is improving, however, there remain considerable challenges we must address in order to build on and accelerate the progress made.



Dr Arif Rajpura Director of Public Health

2. HOW HEALTH IN BLACKPOOL IS CHANGING



Ten years on from my appointment as Blackpool's Director of Public Health, it seems timely to look at how the health of residents in the town has changed over the decade.

We can use life expectancy to summarise today's death rates amongst different age groups in our population in a single figure. Over the past ten years, life expectancy in Blackpool has increased from 73.2 to 74.3 for men and from 78.8 to 79.4 for women. Whilst life expectancy is a convenient summary, there is more to learn about how our population's health is changing by looking at a range of indicators including trends in specific diseases, health risk factors and wider determinants of health. Blackpool's Health Profiles include a selection of indicators and the 2017 release is included in Appendix 1 of this report.

In the analyses that follow, I present a selection of indicators from this profile and from Public Health England's Public Health Outcomes Framework (<https://fingertips.phe.org.uk/>) that show particularly notable changes.



1. HOW HEALTH IN BLACKPOOL IS CHANGING

Trends in premature deaths from heart disease, stroke and cancer

Cardiovascular disease (heart disease and stroke) and cancer are the two most common broad causes of death locally and nationally. According to the Office for National Statistics (ONS), for England and Wales in 2016, cardiovascular disease accounted for 28.5% of all deaths registered and cancer accounted for 25.5%. Therefore, taken together, these two broad causes account for over half of all deaths.

I am pleased to report significant improvements in Blackpool. Most notable is that early deaths from cardiovascular disease have reduced by a third and we now see more than 65 fewer people each year in Blackpool die before they reach their 75th birthday. The improvement in premature deaths from cancer is more modest at around 4%, but still important given the numbers of people affected.

These diseases are major killers and even small improvements in death rates can have a significant impact on our population's life expectancy. The NHS Health Checks Programme, commissioned locally by the council, is a systematic way of finding people with high blood pressure and other risk factors, and providing advice and referral for treatment.

Refer to Figure 1

Trends in smoking

The prevalence of smoking in a population is a major contributor to the differences or inequalities in health seen between populations. Over the last ten years in Blackpool, we have seen a steady improvement in smoking rates and hints of an acceleration in this decline in the past few years. This trend follows the national pattern, and whilst rates in Blackpool are above average, they have kept pace with the national improvement. Rates amongst the population subgroup of 'Routine and Manual' workers, who typically have the highest rates of smoking, have similarly improved in line with the national picture. It is encouraging to see indications that this may be happening at a faster rate in Blackpool, which has the effect of narrowing the gap between our rates and the national average.

Smoking related deaths appear to have slightly improved overall. Although higher than average, this again appears to reflect the national trend. It will be some years before reduced rates of smoking impact on smoking related death rates.

Smoking remains the single biggest lifestyle factor affecting health in the town and we must continue to make progress to reduce smoking. My team is currently developing new arrangements to provide effective support to help people quit.

Refer to Figure 2

Overweight and obesity

The weight of our children has been the subject of much attention in the media in recent years. Disadvantaged areas across the country report higher than average rates of overweight and obesity amongst children. Rates have been rising over the past ten years, and this rise became more pronounced from 2011/2012 onwards. The latest set of figures appear to show a change in our local rates that may provide early signs of improvement. It is important to be cautious in interpreting this single figure and we need to see this sustained if we are to conclude that rates have turned around. The current rates for Year 6 children (aged 10-11) in Blackpool are in line with the national average. However, I consider the national average is unacceptably high. It remains that one in four young children are overweight or obese when they start school and one in three children leave primary school overweight or obese.

Obesity places individuals of any age at increased risk of a number of serious health conditions. Losing weight and keeping a healthy weight can be very difficult to achieve. The environment around us can often undermine our best efforts to make healthier choices. The underlying causes of obesity are complex and it is too simplistic to expect education and messaging alone to make a difference. We have to make healthier choices easier wherever we can. Blackpool Council's Declaration on Healthy Weight and the resulting actions will see the Council doing its part and encouraging organisations, businesses and communities across the town to join in action.

Refer to Figure 3

Trends in self-harm and suicide

Suicide rates and admissions to hospital for self-harm offers an indication of the mental health of our population. Deaths from suicide tend to occur amongst younger and middle age groups and this can have a disproportionately large impact on the life expectancy figure. Deaths from suicide make a significant contribution in explaining the lower than average life expectancy rate amongst the town's residents.

The relatively small number of deaths from suicide seen amongst Blackpool residents means that on a technical level, trends can be unstable and need careful interpretation. However, the overall picture is that suicide rates are moving in the right direction and improving.

Rates of self-harm have increased sharply over the last decade. They appear to have stabilised and slightly improved over the past four years, but remain very high and strikingly different to the national picture. This highlights the importance of programmes such as HeadStart that promote mental wellbeing and support the development of emotional resilience.

Refer to Figure 4

Figure 1 **Premature mortality (age <75) from cardiovascular diseases and cancer**

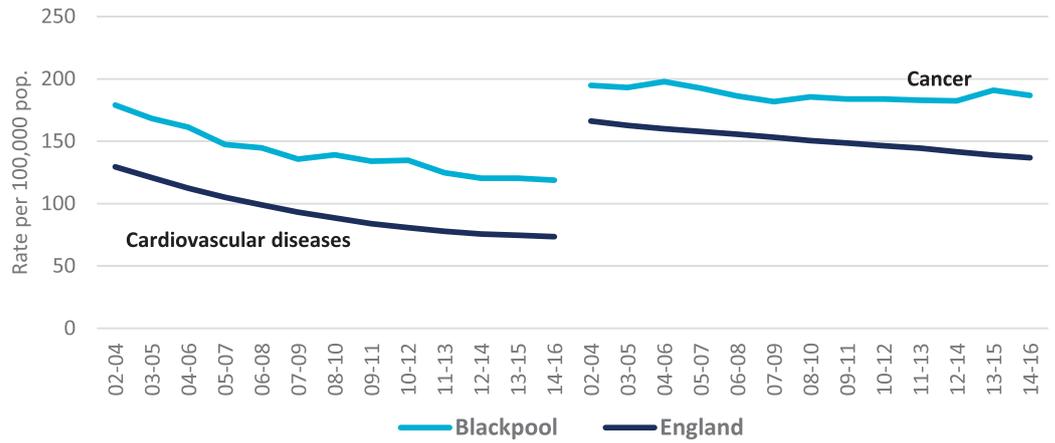


Figure 2 **Smoking**

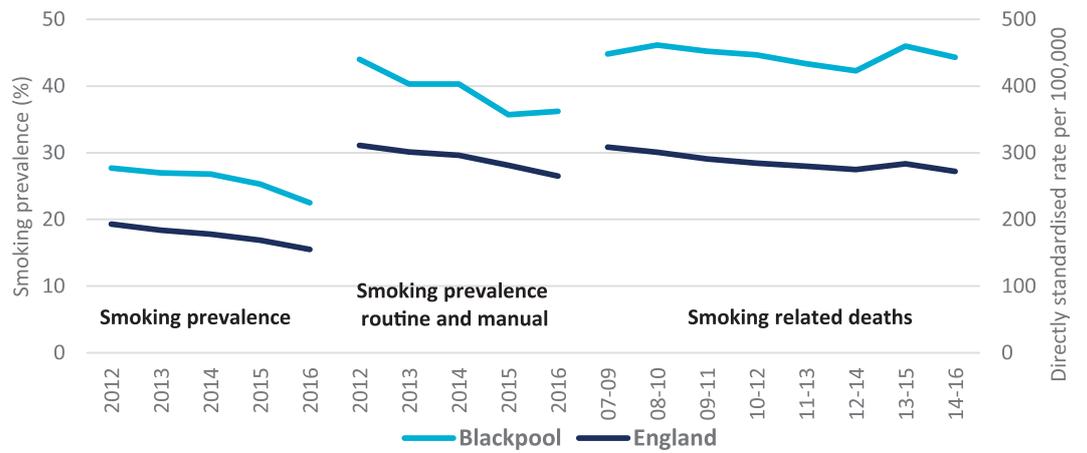


Figure 3 **Prevalence of overweight (including obese) among children in Reception and Year 6**

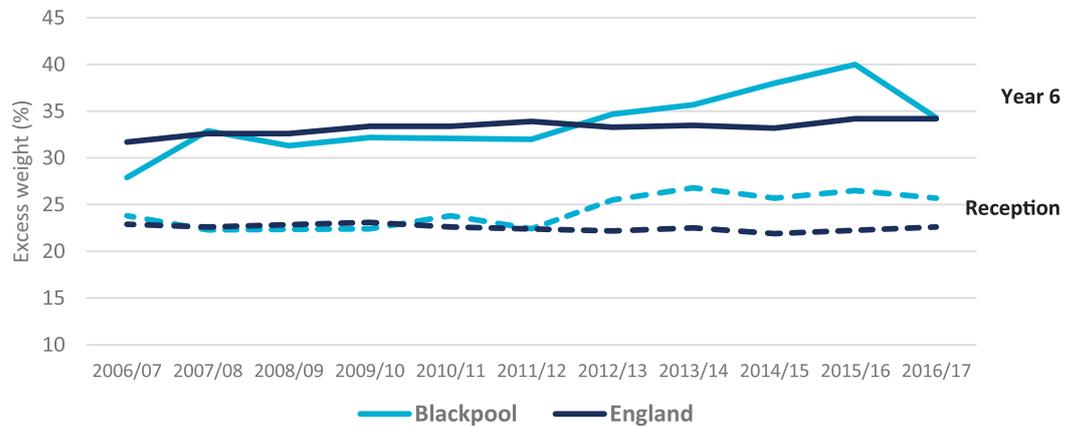
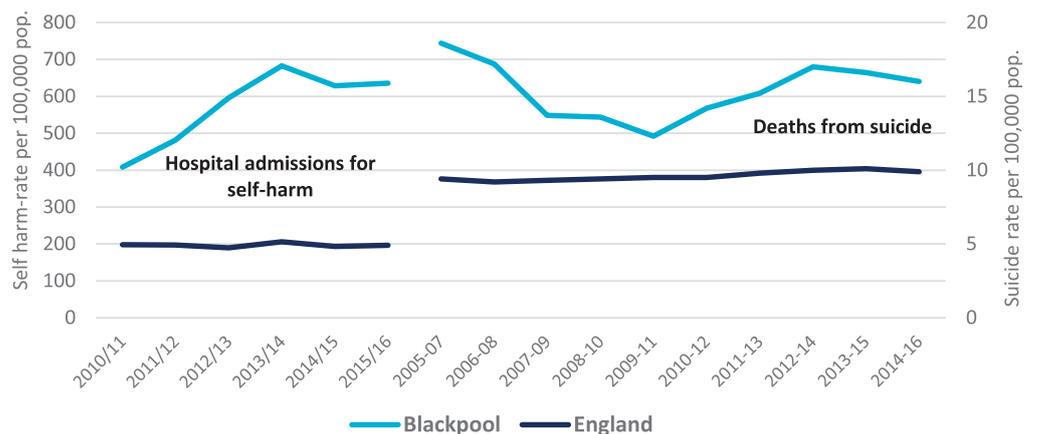


Figure 4 **Self harm and suicide**



1. HOW HEALTH IN BLACKPOOL IS CHANGING

Trends in alcohol-related harm, substance misuse and drug-related deaths

Higher than average rates of alcohol-related conditions and substance misuse are, along with suicide, important factors that help explain Blackpool's lower than average life expectancy. Rates of alcohol-related harm have risen steadily over the decade and diverged from the national average, although have improved over the last few years. Rates of substance misuse amongst young people have risen steeply and at very much greater rates than the national average. To me this highlights just how vital it is that the Council and other organisations across the town work alongside the community to improve the opportunities and aspirations of our young people.

Drug-related deaths rates for Blackpool are based on small numbers and so show considerable year on year variation, but overall the trend is increasing. These deaths tend to occur amongst younger age groups and therefore even small numbers of deaths can make a significant impact on the life expectancy figure for an area. These trends are recognised and my team has recently led the production of a Drug Prevention Strategy for the town. I commend this strategy to colleagues across the Council and to partner organisations, who can all play a part in addressing this issue.

Refer to Figure 5 & 6

Trends in teenage pregnancy

Teenage pregnancy is an acknowledged public health issue since it is associated with poorer social, economic, educational and health and wellbeing outcomes for young parents and their children. The number of teenage pregnancies has fallen considerably over the past decade from 176 during 2005 to 108 in 2015.

Blackpool rates remain high relative to the national average, but these have changed more quickly in Blackpool than they have nationally and the gap has narrowed. This is significant progress and it is important to recognise the evidence-based strategy that has been in place tackling this issue in Blackpool.

Refer to Figure 7

Homelessness

My final choice of indicator is particularly relevant in the context of the following section, which looks at the links between housing and health. Homelessness is associated with severe poverty and is a social determinant of health. It is also associated with adverse health, education and social outcomes, particularly for children. The data discussed here relates to the number of households that have presented themselves to their local authority, but under homelessness legislation have been deemed not in priority need. The majority of the people that fall under this cohort are single homeless people. Households and individuals that are eligible, but not in priority need or are in temporary accommodation can have greater public health needs than the population as a whole.

Data published in the Public Health Outcomes Framework appears to indicate a rise in the number of households accepted as non-priority homeless in Blackpool. These figures require careful interpretation as they are partly driven by whether councils have chosen to undertake a homelessness assessment, and practices in regards to assessments varies between councils and over time. However, we can say that overall the picture is one of consistently high levels of homelessness in Blackpool over the last five years with some slight rises in recent years.

Refer to Figure 8

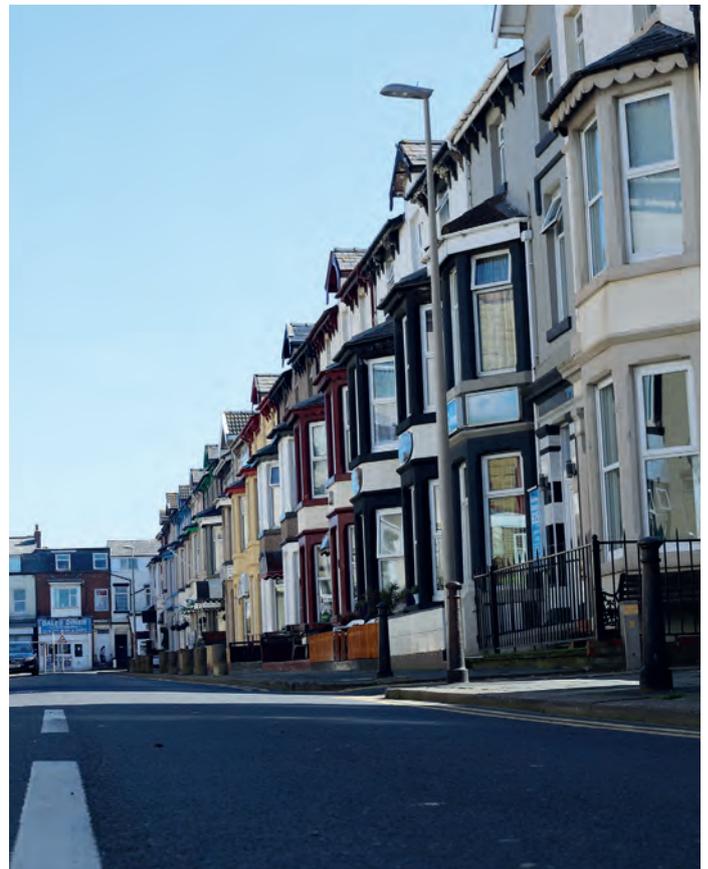


Figure 5 Hospital admissions from alcohol

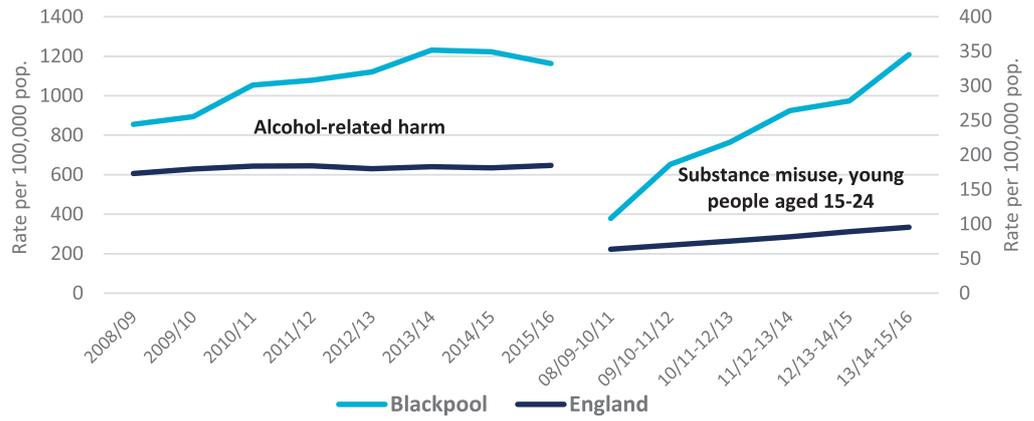


Figure 6 Drug related deaths

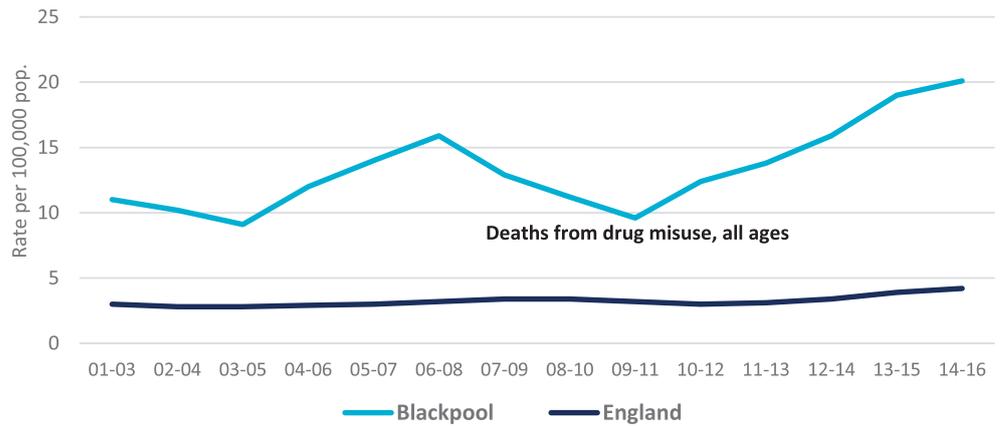


Figure 7 Trend in conception rates, all ages and under 18 years

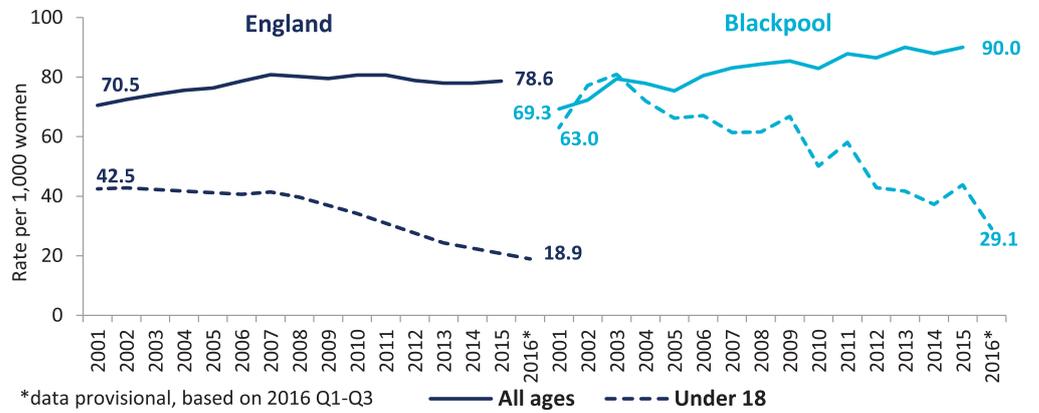
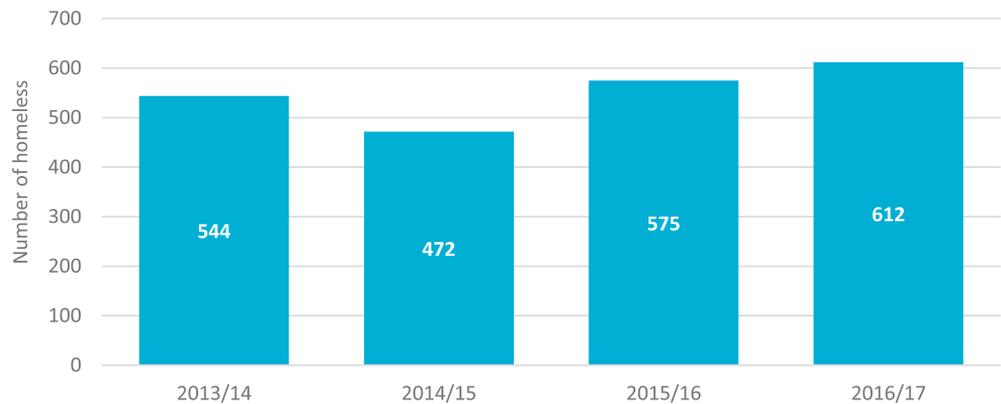


Figure 8 Statutory homelessness - eligible homelessness people not in priority need, Blackpool



1. HOW HEALTH IN BLACKPOOL IS CHANGING

Summary

We can see that overall the health of our resident population has improved over the past decade. Particularly significant are the improvements in early deaths from major killers of heart disease, stroke and cancer, as well as in deaths from suicide. There is good progress too in improving smoking rates, one of the major lifestyle factors influencing health.

It is important to continue with action to maintain this momentum if we are to secure the contribution this can make to reduce inequalities in the years to come.

Similarly, there have been significant reductions in teenage pregnancy, which will help improve social, health and wellbeing and educational outcomes for young women in the town.

The steep rises seen in self-harm and in drug and alcohol-misuse especially amongst young people are alarming and a cause for concern. I take this opportunity to highlight the importance of programmes such as HeadStart and of the Drug Prevention Strategy, both of which offer real chances to make a difference.

It's great to see some of the progress that has been made, and vital that we continue to build on this. Understanding the underlying drivers of our population health statistics is key to developing and refining action to improve health. One area that is worthy of closer inspection is the role of that housing, in particular the characteristics of the local housing market, plays in driving migration to the town. There are concerns that people moving into the town are in poorer health. I explore this consideration in more detail in the next section which presents analyses by my team on migration.



2. HOUSING AND HEALTH IN BLACKPOOL



In this section, I firstly consider the issue of housing and health from a range of perspectives including housing quality and health, homelessness and health and the impact of housing supply and demand on migration and population.

Secondly, I present recent local analyses that explore the impact of population change on our local population health indicators.

Thirdly, I look at housing related interventions that could improve our local population's health and wellbeing.



Housing and health: issues to consider

Housing quality and health

There is little doubt that for individual residents, living in poor housing exposes them to a range of physical hazards and may be associated with overcrowding and social isolation. These issues can have a disproportionate impact on vulnerable groups in our communities. For individuals, the impact of the physical condition of housing on health is well understood. Hazards such as excess cold, damp and mould or structural problems (such as poor lighting or lack of handrails on stairways) increase the risk of cardiovascular disease, respiratory disease, depression and anxiety and accidents.¹

Homelessness

Being homeless or not having a stable home are also well documented risk factors for poorer health, particularly mental health problems.

You count as homeless if you are:

- staying with friends or family
- staying in a hostel, night shelter or Bed and Breakfast (B&B)
- squatting (because you have no legal right to stay)
- at risk of violence or abuse in your home
- living in poor conditions that affect your health
- living apart from your family because you do not have a place to live together²

Source: Shelter, 2016

1. Parliamentary Office of Science and Technology. Housing and Health. POSTNOTE Number 371, January 2011

2. http://england.shelter.org.uk/housing_advice/homelessness/rules/what_is_homelessness

Population turnover and health

A number of academic researchers have written about population change and mobility and have proposed models for describing these patterns. In this section I describe two of these models that have been applied within UK populations. These models are helpful in understanding the factors driving population movement, some aspects of the models may require modification for the context in Blackpool. The term 'spatial segregation' describes the phenomenon where residents become grouped in areas according to socioeconomic status, so that people on low incomes are concentrated in more disadvantaged areas. The subject has been recognised and discussed amongst academic researchers for many years and it is evident that the picture varies over time and between places.

However, the processes and scale of flows that drive such changes in populations and communities are less clear. A study of 2001 England and Wales Census data suggested that population flows act to continually reinforce spatial segregation particularly in deprived areas through net loss of better qualified individuals (those who get on, get out). The researchers offer some evidence to support this although it is somewhat weak and they suggest the effect may be small.³ The same study concluded that demographics, not deprivation, drives population turnover. Neighbourhoods with high proportions of young adults and families with young children are most likely to have high turnover.

A more recent study of working age people using the 2001 Scottish Census has attempted to quantify flow and found that the 1991 and 2001 populations comprised very different individuals and that one third of the original people had 'exited' and been replaced with others ('entries').⁴ The same author suggests that exits tend to increase segregation, whereas entries tend to reduce it. This conclusion assumes that entries into deprived communities are typically younger, healthier and better educated and that a process known as the 'demographic conveyor' is at work. This process describes how populations in deprived areas steadily turnover in relation to the age of residents. Younger people tend to move up the neighbourhood hierarchy as they age and their incomes rise, although applied to the Blackpool context, we will see shortly that this assumption may not hold true locally. The same authors also note that individual decisions to move are dominated by housing needs and demand and how easy it is to move. If people are not able to move, then segregation falls.

In summary, the research literature suggests that a number of processes may be driving mobility and population changes in our deprived communities. Three broad processes appear to feature:

1. demographic characteristics and age-related churn;
2. housing needs and demands; and
3. how easy or difficult it is for people to move.

3. Bailey N and Livingston M. Population turnover and area deprivation. Joseph Rowntree Foundation (JRF), 2007. <https://www.jrf.org.uk/report/population-turnover-and-area-deprivation>

4. Bailey N. How spatial segregation changes over time: sorting out the sorting processes. Environment and Planning A 2012, volume 44, pages 705-722

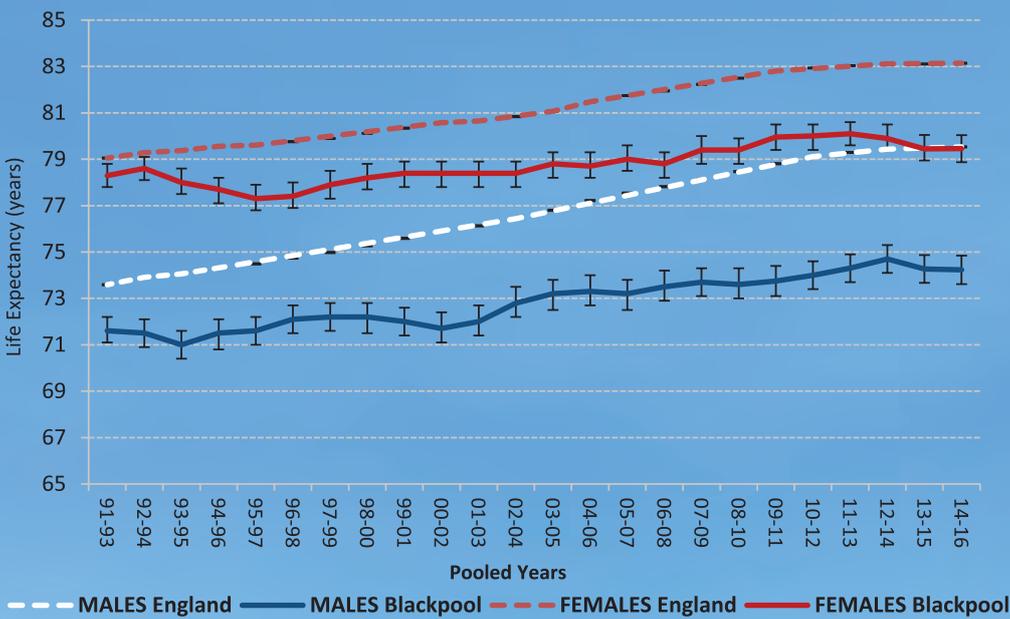
Analyses: Local life expectancy trends and migration patterns

Life expectancy is one of the key indicators of health in a population. Life expectancy is the average number of years that a new baby is expected to live if current age-specific mortality rates continue to apply through their lifetime. Across England, a steady improvement in life expectancy has been seen since the Second World War, but that has slowed in recent years for both males and females, and this pattern is evident in Blackpool. **Figure 9** shows that although life expectancy in Blackpool has continued to improve over the past 20 years, it has not kept pace with England as a whole and now a considerable gap in life expectancy exists between Blackpool and England. Life expectancy in males in Blackpool is 74.2 years, compared to 79.5 years for England, a gap of 5.3 years. Life expectancy in females in Blackpool is 79.5 years, compared to 83.1 years in England, a gap of 3.6 years. The factors that create this long-term, structural gap in life expectancy between Blackpool and England as a whole are important to explore.

Male life expectancy in Blackpool is the lowest of any local authority in England and female life expectancy is the second lowest.

Figures 10 and 11 show there is considerable variation within the town. Male life expectancy in Stanley ward is 78.8 years compared to 65.8 years in Bloomfield ward, a 13-year difference. Male life expectancy in Bloomfield ward is the second lowest of all electoral wards in England. There is a gap of seven years in female life expectancy between Stanley ward (83.8 years).

Figure 9 Trend in life expectancy at birth



Male Life Expectancy by Ward

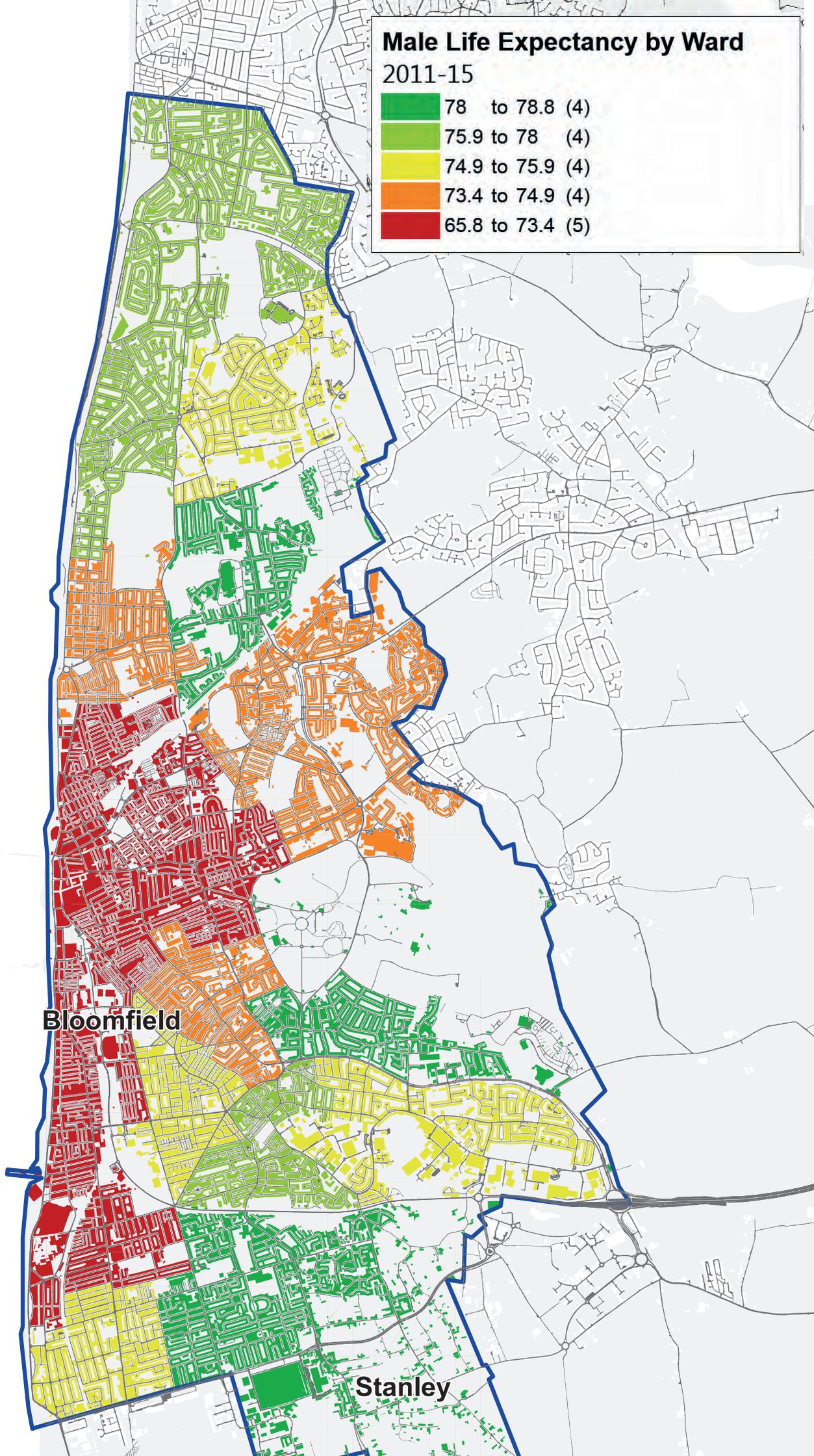
2011-15



Figure 10

Male life expectancy by ward 2011-15

Source: PHE Local Health



Bloomfield

Stanley

Female Life Expectancy by Ward

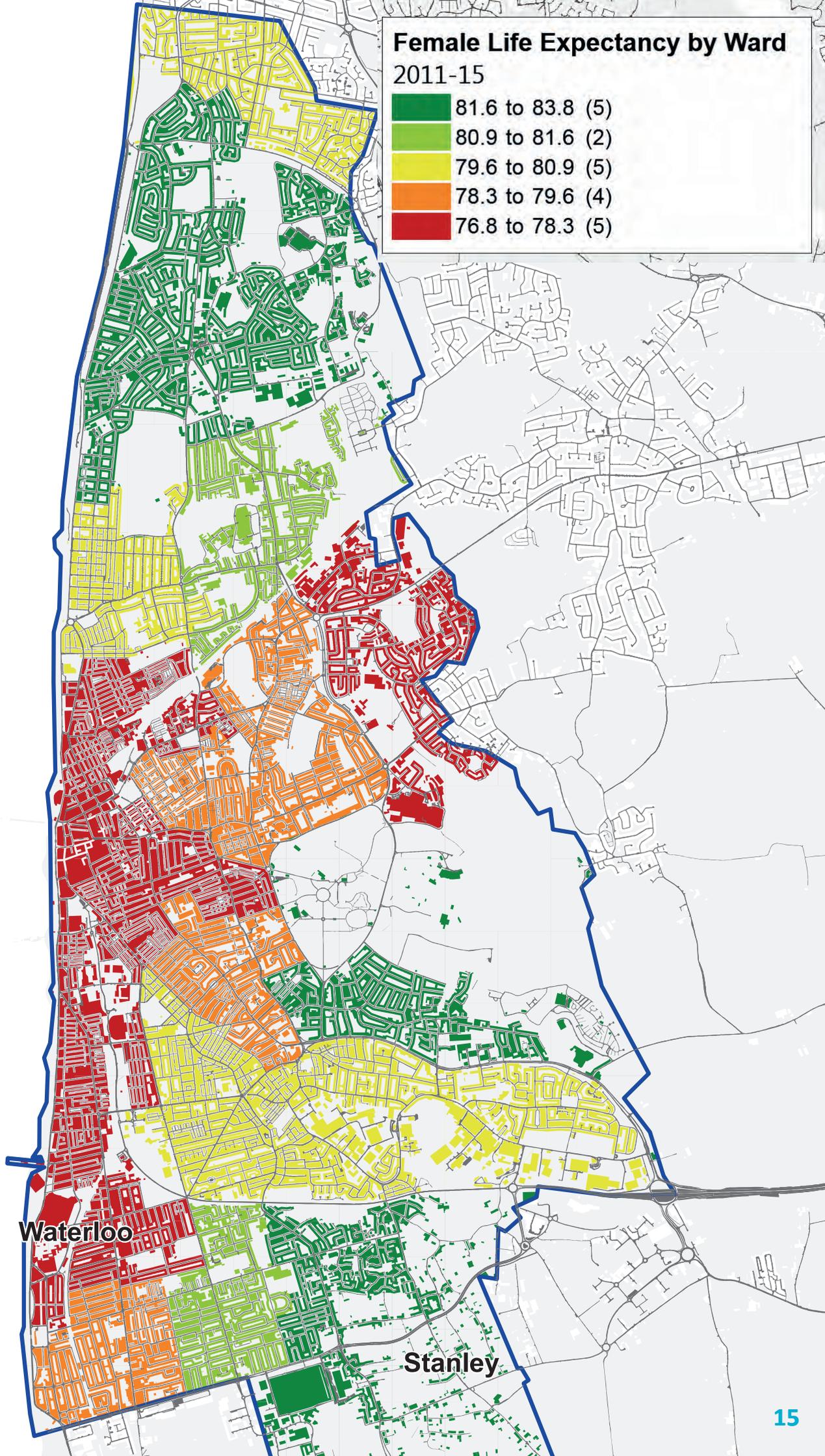
2011-15

Dark Green	81.6 to 83.8 (5)
Light Green	80.9 to 81.6 (2)
Yellow	79.6 to 80.9 (5)
Orange	78.3 to 79.6 (4)
Red	76.8 to 78.3 (5)

Figure 11

Female life expectancy by ward 2011-15

Source: PHE Local Health



Waterloo

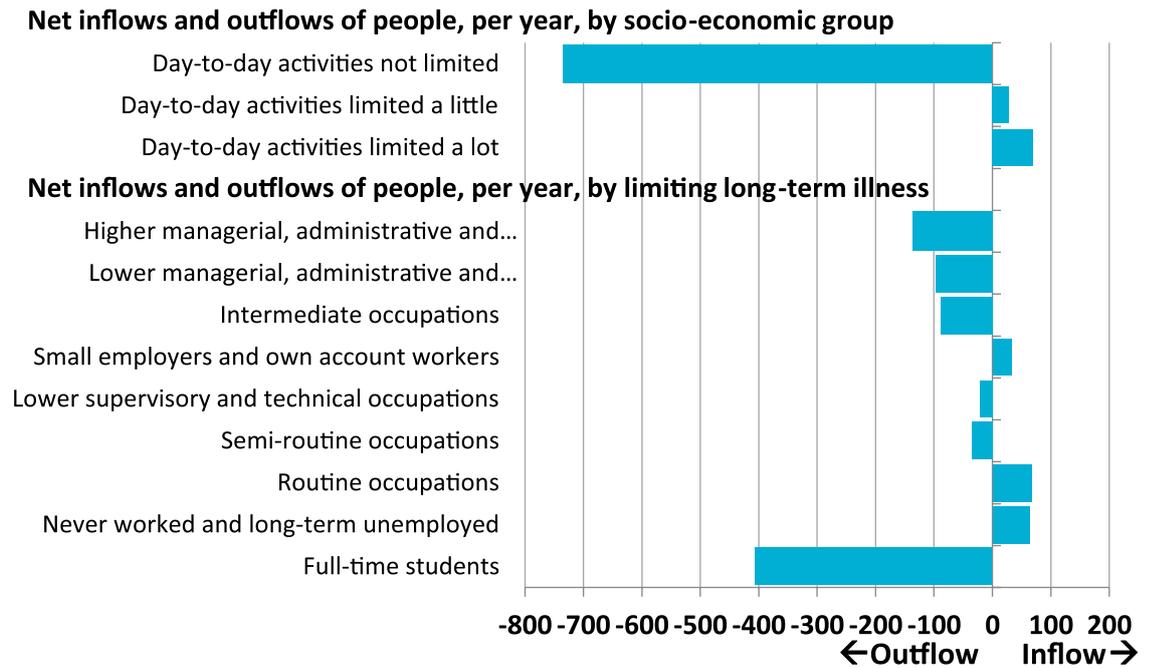
Stanley

2. HOUSING AND HEALTH IN BLACKPOOL

Migration and population turnover

Figure 12 presents data gathered in the 2011 census and suggests that Blackpool is a net importer of people with poorer health, unemployment and precarious labour and a net exporter of people with good health and skilled labour.

Figure 12 **Blackpool Net Inflow and Outflow of People per Year, 2011**



Source: Census 2011. Tables UKMIG005 & UKMIG007

The availability of seasonal employment and low cost accommodation are two key drivers of the type of migration we see in **Figure 12**. Many holiday flats and Bed and Breakfasts in the central area of Blackpool have been converted into houses of multiple occupancy (HMOs). In Blackpool there are a large number of buildings that have been converted for use by more than one household, with many of these made up of self-contained flats. While the latest local planning policies require higher quality conversions, the town has a legacy of more than 3,000 poor quality HMOs producing high yields for landlords, fuelled by Housing Benefit payments and a constant demand from people migrating to Blackpool from other parts of the country. Surrounding areas of small terraced houses have also become part of this transient market. As over 50% of homes in inner Blackpool are privately rented, this creates entrenched deprivation and is the antithesis of stable communities.

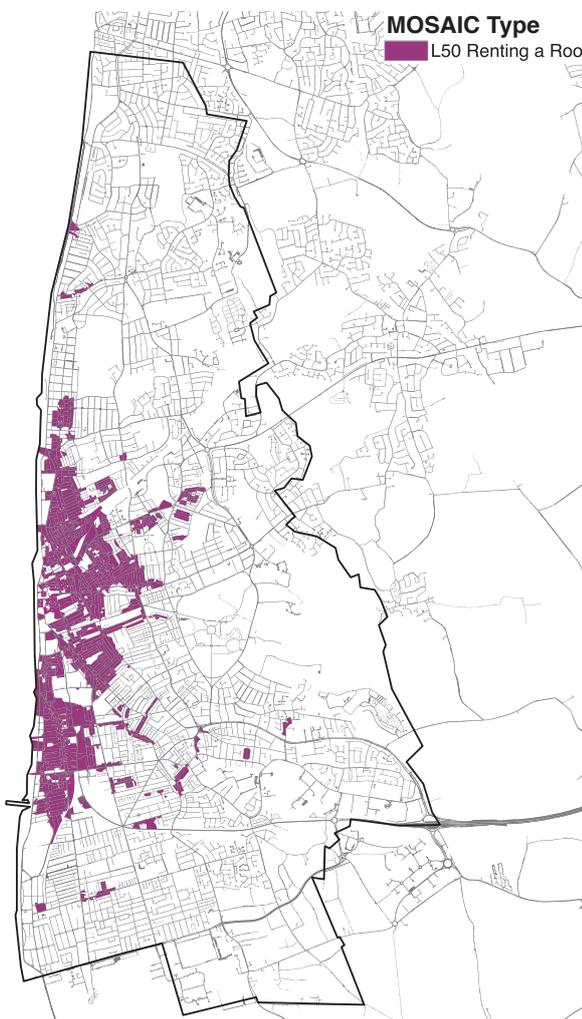
Approximately 8,000 people move to Blackpool from elsewhere in the UK each year, with a similar number leaving the town. This level of migration helps explain the 5,667 entirely new housing benefit claimants in Blackpool in the financial year 2013/2014. 86% of these claimants had a last address outside of Blackpool borough.

On a person's death, coroners record where individuals were born and this data can be examined. For Blackpool residents who died between the ages of 35 and 74 (an important group in contributing to Blackpool's lower life expectancy) over the three years between 2012 and 2014, 21% of people were born in Blackpool compared to 45% in Lancashire and 48% in Blackburn with Darwen. In Blackpool, only 4% of those born elsewhere were born outside the UK. It is not recorded at what age individuals moved to Blackpool, but this analysis supports what is known about the high level of migration to Blackpool and the potential vulnerability of some of the people who move to the town.

Quality of housing in Blackpool

The 2008 Private Sector House Condition Survey showed that 38.7% of all private sector dwellings in Blackpool were classed as non-decent compared to an average 27.1% for England. The same survey found that poor housing conditions in Blackpool were mostly associated with pre 1919 properties, the private rented sector, converted flats, occupiers on the lowest incomes and those in receipt of benefits. 46.7% of private sector dwellings occupied by vulnerable tenants are estimated to be non-decent with the majority being concentrated in inner Blackpool.

Figure 13
Approximate location of HMOs



Houses of multiple occupancy (HMOs)

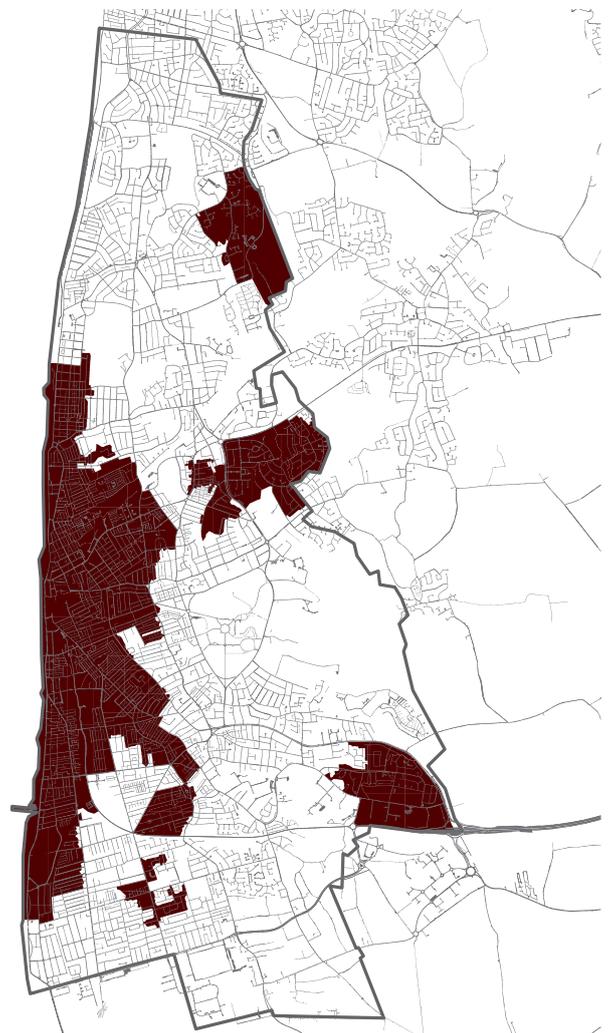
The relocation of potentially vulnerable people into the town and high level of transience within Blackpool leaves many people socially isolated and in poor quality housing. The extent of houses of multiple occupancy (HMO) in Blackpool is estimated using the MOSAIC population segmentation tool, with its classification L50 – Renting a room a good match to HMO locations in Blackpool.⁵ Figure 13 shows the spread of HMOs across the town. The locations identified in Figure 13 are the same areas that experience the highest levels of disadvantage in Blackpool, as can be seen when compared against Figure 14. The location of HMOs also correlates closely with the electoral wards with the lowest life expectancy identified in Figures 10 and 11. In Blackpool, approximately 23,000 people live in the type of accommodation identified in Figure 13.

Figure 14
Communities in the 10% most Deprived in England (IMD 2015)

Source: Index of multiple deprivation 2015

5. Source: MOSAIC

<http://www.experian.co.uk/marketing-services/products/mosaic/mosaic-in-detail.html>



2. HOUSING AND HEALTH IN BLACKPOOL

Figure 15 shows areas of Blackpool where over 10% of the population have moved from elsewhere in the UK to the neighbourhood in the previous year, as at the 2011 census. This demonstrates that the same central areas of the town highlighted in previous charts, have the highest levels of inward migration. In fact, in the areas highlighted in Figure 15, 13.3% of the population arrived from elsewhere in the UK in the previous year, compared to 7.7% in the rest of Blackpool and 8.2% across the North West.

Figure 15
Migration to Blackpool from with the UK over a single year

Source: ONS – Census 2011

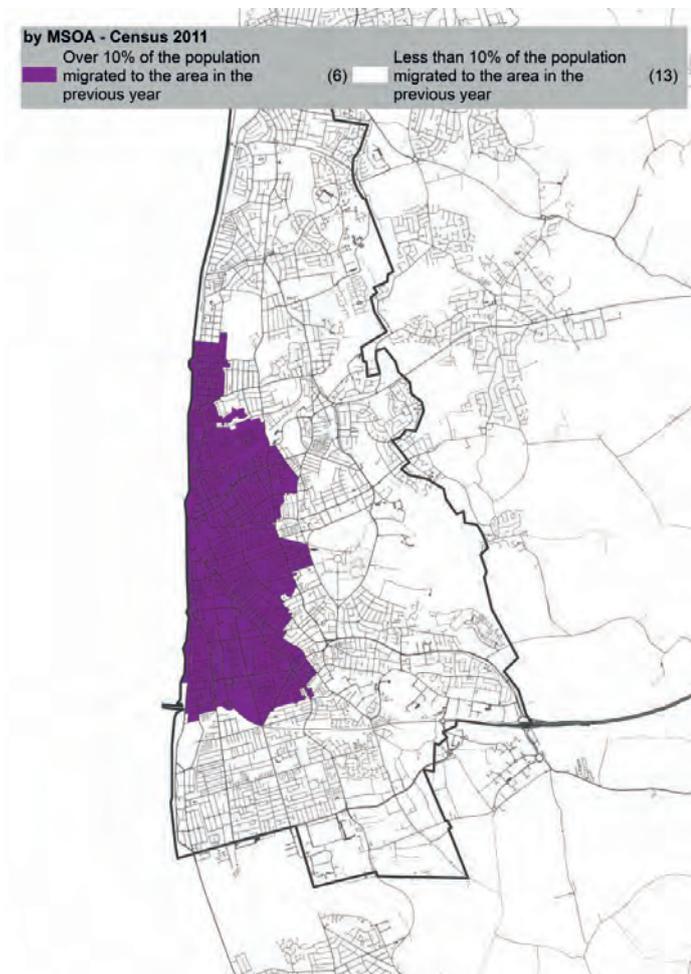
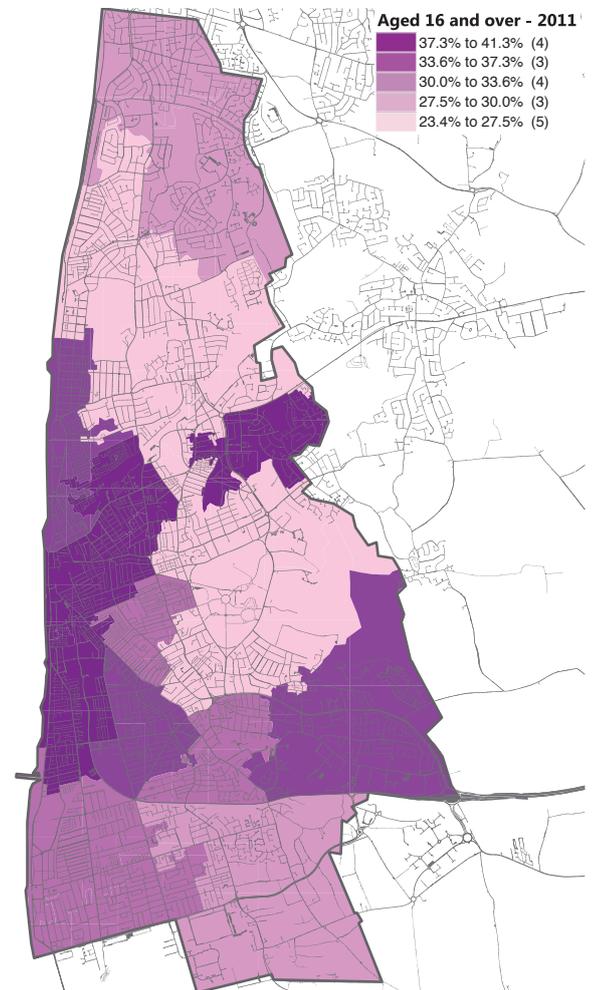


Figure 16 shows that, as well as the high level of migration into the central neighbourhoods of Blackpool, educational attainment of the adult population tends to be lower, with 35.7% of adults holding no qualification in the central areas, compared to 29.5% in the rest of Blackpool and 24.8% across the North West.

Figure 16
Educational Attainment - No Qualification

Source: Census 2011



The central area of Blackpool has a younger population profile than the rest of the town, with 44.1% of residents under the age of 35, compared to 39.2% across the rest of the town. Deaths that occur at younger ages have a disproportionate impact on the overall life expectancy of a community. This pattern of mortality at much younger ages is something that can be seen quite clearly in the L50 – Renting a room group, with high rates of mortality in those aged under 65 and particularly among men.

High levels of substance misuse, particularly of alcohol, opiate and crack cocaine is seen in these areas of the town and contribute to the unusual pattern of mortality.

For example, 16.5% of the Blackpool population lived in this type of accommodation, in the period 2011 to 2015, yet 48.0% of drug related deaths and 37.0% of alcoholic liver disease deaths occurred in this group of Blackpool residents. 30.5% of suicides of Blackpool residents also occurred in this group. This is likely a reflection that residents of HMOs are more likely to be socially isolated with no supportive networks, and corresponds with very high rates of substance misuse.



2. HOUSING AND HEALTH IN BLACKPOOL

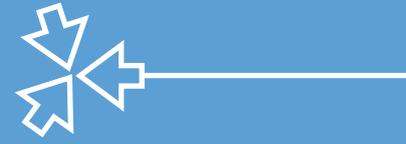
Summary and conclusions

Much of the data presented is descriptive in nature or based on modelled estimates and aspects of these local analyses are not without limitations. However taken together, the picture that is beginning to emerge from this collection of analyses can be summarised as follows:

- Blackpool has a net outflow of working people in managerial and intermediate occupations.
- Central areas of the town see high levels of inward migration and a younger population. This process initially seems to fit with the ‘demographic conveyor’ effect, however some factors that underpin the ‘demographic conveyor’ effect appear not to hold true for Blackpool. We do not see inward migration of healthy, well-educated and relatively well-paid young people in the same way that deprived areas of big cities do, which would serve to limit socio-economic polarisation.
- Instead, we appear to see a variation of this effect and suggest that an abundance of low cost accommodation is driving migration of a less healthy and less well-educated population into the central area of Blackpool. The population leaving (exits) is replaced with individuals (entries) with less means and greater needs.
- Blackpool has a very large quantity of low quality, low cost private rented accommodation, largely consisting of HMOs. This means it is easy to move to Blackpool and easy to move within Blackpool.
- Our local analyses appear to support a hypothesis that Blackpool is a net importer of poor health and net exporter of good health, a scenario which is consistent with increasing spatial segregation along socioeconomic lines.



3. INTERVENTIONS TO MAKE A DIFFERENCE



There are three things to focus on in this section.

Firstly, the national toolkit developed by Professor Chris Bentley for the Department of Health, which sets out opportunities for achieving reduced inequalities and improved life expectancy through local action at scale.

Secondly, the Council's Housing Strategy, which is currently being prepared.

Thirdly is the Council's Homelessness Strategy, also in preparation at the time of writing.



3. INTERVENTIONS TO MAKE A DIFFERENCE

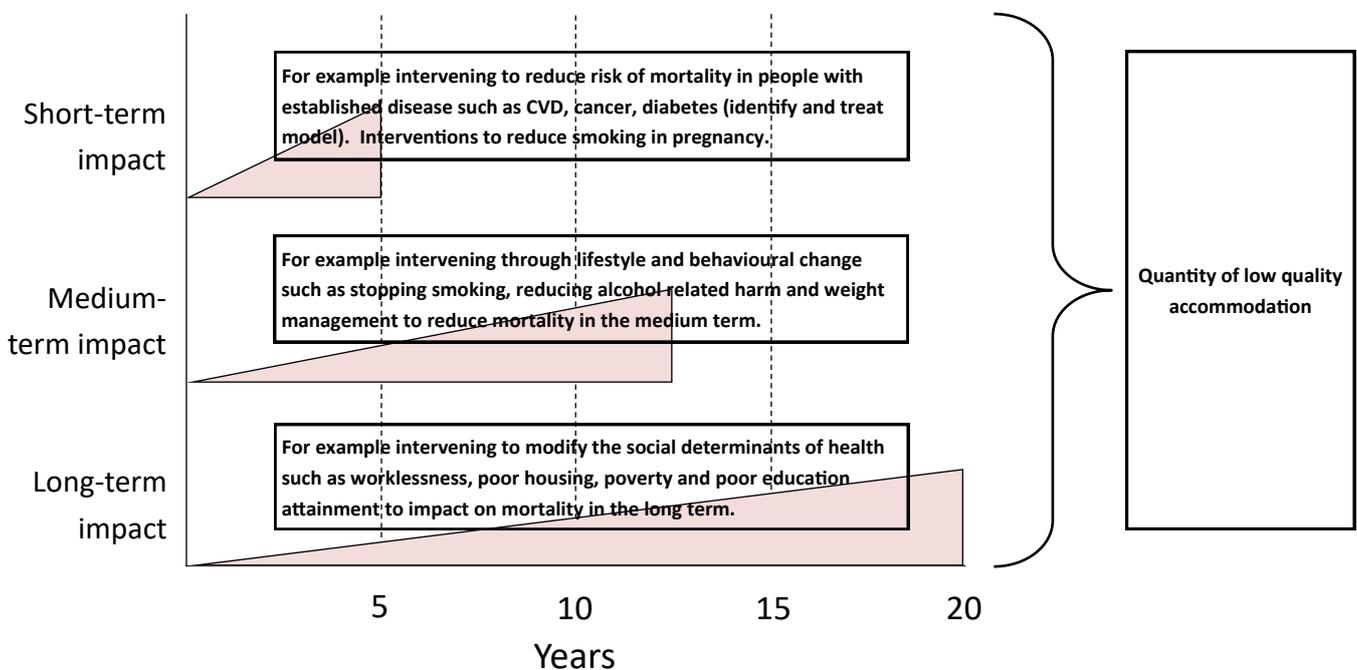
Reducing health inequalities through action at scale

Several years ago I had the pleasure of welcoming Professor Chris Bentley, an expert in interventions to reduce inequalities, to Blackpool as part of the Department for Health initiative to increase life expectancy. Professor Bentley's work focused on local analyses of the causes of reduced life expectancy, identifying effective interventions and introducing these at scale. Following this work, some good progress has been made particularly with regard to some of the shorter-term interventions. For example, I described earlier the marked improvement in premature deaths from cardiovascular diseases. It is helpful to revisit aspects of Professor Bentley's work as action on poor housing featured in the underlying model.

Figure 17 is based on a model developed by Professor Bentley and illustrates interventions that can have a positive impact on the overall life expectancy of a population and includes action on poor housing. The interventions have been categorised according to whether the impact is likely to be over the short, medium or long term. The national model indicates that tackling poor housing as an action can drive positive health outcomes in the longer term. However, we have seen that in Blackpool the volume of low-cost rental accommodation may be importing a population with poorer health into the town.

Reducing the supply of this type of housing should have an impact on migration to the town, internal transience within the town and the overall quality of housing within Blackpool. We have included a suggested adaptation to the model, to reflect the opportunities that action across a range of housing issues offer in terms of affect across the short and medium term, as well as the longer-term indicated in the original model.

Figure 17 Timescales for interventions to increase life expectancy



Source: Public Health England (modified)

Blackpool Council's Housing Strategy 2018: Building a Better Blackpool

At the time of writing, colleagues within the Council are in the final stages of drafting a Housing Strategy for the town and kindly allowed me to have sight of the draft. The Housing Strategy presents the Council's approach to address the housing issues within the borough. It sets the vision and priorities to support the delivery of the Council's plan to make Blackpool a great place to live in, with a thriving economy that supports a happy and healthy community.

The Strategy identifies four priorities for action:

1. New housing supply

Local authorities are uniquely placed to address housing supply, acting as both a direct provider and as an enabler of private and social housing developments. Local action includes introducing Supplementary Planning Documents (SPDs) for New Affordable Housing and to manage transition of guest houses to quality homes. The strategy highlights the need for government funding to enable action to reduce the density of established HMOs and bring forward quality new housing stock.

2. Improving the private rented sector

Local action includes the establishment of 'My Blackpool Home' a wholly owned Council Company to buy up failing HMOs and guest houses to improve quality, reduce density and promote standards in the private rental sector through lettings and property management.

3. Stabilising lives

In recent years, pressures on budgets have seen withdrawal of housing-related support, but new funding opportunities are being secured to alleviate homelessness, support vulnerable residents and address transience.

4. Increasing delivery capacity

A key action here is the creation of a Housing Board to pioneer new ways of tackling issues faced by local communities and coordinate activities within the town.

The overall message of the Housing Strategy is that there is an urgent need to re-structure the housing stock, particularly in inner Blackpool, to deliver a more sustainable and attractive mix of accommodation. This must take into account needs associated with those in the population with specific needs including a growing older population.

The priorities within the new Housing Strategy will provide opportunities for important action to improve the quality of the existing housing stock and promote mixed-income communities. The legacy of over 3,000 poor quality HMOs, primarily located in central areas of the town is a very significant challenge and reducing the volume of this stock is required at scale and pace if we are to reduce inward migration and to stabilise communities.



Use of existing enforcement tools, such as selective licensing and additional licensing can help improve quality, but these tools can only enforce to statutory standards, which are low.

3. INTERVENTIONS TO MAKE A DIFFERENCE

Homelessness Prevention Strategy 2018-21

Reducing homelessness and helping people to establish themselves and maintain a stable home is important both for the individuals themselves and of the wider town. A stable home can support successful education, employment and good health.

Also in preparation, at the time of writing this report, is the Council's Homelessness Prevention Strategy. This sets out how the Council will deliver its new duties with regard to reducing homelessness, which are effective from April 2018.

The strategy focuses on three key areas of the Homelessness Reduction Act:

1. Preventing homelessness by working with partners to identify risk and intervene earlier.
2. Resolve homelessness efficiently to minimise harm to an individual's health and wellbeing.
3. Support individuals to avoid repeat homelessness.

The Strategy identifies the role of the poor quality accommodation on offer in the private rental section and notes that, alongside the town's low wage economy, this continues to drive transience and disadvantage, which directly affect levels of homelessness within the town.



4. RECOMMENDATIONS



1.

I welcome the forthcoming Blackpool Housing Strategy and the recommendations within it to deliver new housing supply, improve the private rental sector, stabilise lives to prevent and resolve homelessness, and increase delivery capacity internally within the Council. The key to success will be to deliver all these recommendations at scale and pace.



2.

Blackpool Council has experienced amongst the highest budget cuts of authorities across the country and this has been especially challenging given the high levels of need and transience within the town.

Although the Council has been very creative in managing these significant challenges, it is important now to recognise the need for future funding formulas to fully incorporate the high level of need and allow us to address the root causes of ill health locally.



APPENDIX

Health Profile 2017: Blackpool

Health summary for Blackpool

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain	Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1 Deprivation score (IMD 2015)	2015	n/a	42.0	21.8	42.0	○	5.0
	2 Children in low income families (under 16s)	2014	8,410	32.1	20.1	39.2	●	6.6
	3 Statutory homelessness	2015/16	575	8.9	0.9			
	4 GCSEs achieved	2015/16	666	45.5	57.8	44.8	●	78.7
	5 Violent crime (violence offences)	2015/16	5,157	36.7	17.2	36.7	●	4.5
	6 Long term unemployment	2016	665	7.8 ^{Λ20}	3.7 ^{Λ20}	13.8	●	0.4
Children's and young people's health	7 Smoking status at time of delivery	2015/16	463	26.0	10.6 ^{\$1}	26.0	●	1.8
	8 Breastfeeding initiation	2014/15	1,189	61.6	74.3	47.2	●	92.9
	9 Obese children (Year 6)	2015/16	341	22.5	19.8	28.5	●	9.4
	10 Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	76	87.8	37.4	121.3	●	10.5
	11 Under 18 conceptions	2015	108	43.8	20.8	43.8	●	5.4
Adults' health and lifestyle	12 Smoking prevalence in adults	2016	n/a	22.5	15.5	25.7	●	4.9
	13 Percentage of physically active adults	2015	n/a	47.9	57.0	44.8	●	69.8
	14 Excess weight in adults	2013 - 15	n/a	73.9	64.8	76.2	●	46.5
	15 Cancer diagnosed at early stage	2015	265	41.7	52.4	39.0	○	63.1
Disease and poor health	16 Hospital stays for self-harm†	2015/16	866	635.3	196.5	635.3	●	55.7
	17 Hospital stays for alcohol-related harm†	2015/16	1,612	1163.3	647	1,163	●	374
	18 Recorded diabetes	2014/15	10,477	7.4	6.4	9.2	●	3.3
	19 Incidence of TB	2013 - 15	40	9.5	12.0	85.6	●	0.0
	20 New sexually transmitted infections (STI)	2016	1,005	1150.3	795	3,288	●	223
	21 Hip fractures in people aged 65 and over†	2015/16	182	642.4	589	820	●	312
Life expectancy and causes of death	22 Life expectancy at birth (Male)	2013 - 15	n/a	74.3	79.5	74.3	●	83.4
	23 Life expectancy at birth (Female)	2013 - 15	n/a	79.4	83.1	79.4	●	86.7
	24 Infant mortality	2013 - 15	34	6.5	3.9	8.2	●	0.8
	25 Killed and seriously injured on roads	2013 - 15	183	43.4	38.5	103.7	●	10.4
	26 Suicide rate	2013 - 15	59	16.6	10.1	17.4	●	5.6
	27 Smoking related deaths	2013 - 15	1,188	459.7	283.5			
	28 Under 75 mortality rate: cardiovascular	2013 - 15	460	120.3	74.6	137.6	●	43.1
	29 Under 75 mortality rate: cancer	2013 - 15	733	190.8	138.8	194.8	●	98.6
	30 Excess winter deaths	Aug 2012 - Jul 2015	309	17.7	19.6	36.0	●	6.9

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Further reading:

JSNA website

www.blackpooljsna.org.uk



FROM THE GROUND UP

THE HEALTH OF THE
PEOPLE OF BLACKPOOL

2017



Blackpool Council