The Annual Report of the Director of Public Health
2011 - 2012
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<td>Area Partnership Board</td>
<td>APB</td>
<td>an enabling body that can bring together and involve a wide range of people who have an interest and responsibility for delivering improvement in the area. Five Area Partnership Boards are found in the geographical boundaries of Cheshire West and Chester Council. See also Local Area Partnerships</td>
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<tr>
<td>Atherosclerosis</td>
<td>-</td>
<td>is a condition in which an artery wall thickens as a result of the accumulation of fatty materials such as cholesterol</td>
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<tr>
<td>Binge Drinking</td>
<td>-</td>
<td>is defined as drinking, over a short period of time, eight or more units of alcohol in one session if you are a man, and more than six units in one session if you are a woman - twice the recommended maximum amount of alcohol. Studies are starting to reveal that drinking a large amount of alcohol over a short period of time may be significantly worse for your health than frequently drinking small quantities</td>
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<tr>
<td>Body Mass Index</td>
<td>BMI</td>
<td>is a scientific measure that is used to indicate whether a person is underweight, a healthy weight, overweight or obese. It is calculated by dividing a person’s weight by their height in metres squared. Also see obesity and overweight</td>
</tr>
<tr>
<td>Brief Interventions</td>
<td>BI</td>
<td>brief interventions provide a structured way to deliver advice. Brief interventions aim to equip people with tools to change attitudes and handle underlying problems. As part of a range of methods, brief interventions may contain brief advice and may use a motivational interviewing approach in the delivery</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>CVD</td>
<td>refers to those diseases affecting the circulation of the blood in the heart, arteries, capillaries or veins and includes coronary heart disease and stroke. CVD is the leading cause of death in the UK</td>
</tr>
<tr>
<td>Care pathway</td>
<td>-</td>
<td>a care pathway is “anticipated care placed in an appropriate time frame, written and agreed by a multidisciplinary team. It has locally agreed standards based on evidence where available to help a patient with a specific condition or diagnosis move progressively through the clinical experience”</td>
</tr>
<tr>
<td>Central and Eastern Cheshire Primary Care Trust</td>
<td>CECPCT</td>
<td>is the health service commissioner for the central and eastern areas of Cheshire. CECPCT'S overall commissioning aim is to improve the health of the population and reduce health inequalities. In carrying out its commissioning responsibilities it is expected to work in partnership with other agencies. Also see Commissioning</td>
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| Cheshire and Warrington Health and Wellbeing Commission              | -            | formed in April 2010, Cheshire and Warrington Health and Wellbeing Commission is one of seven commissions established as part of the sub-regional architecture that was developed following the local government re-organisation. The Commission comprises of multi-agency partners including local councils, Directors of Public Health, Social Services, the police, the fire service and health professionals. **Key objectives of the commission include:**  
  • reducing alcohol related harm in Cheshire and Warrington (including support for a minimum price per unit of alcohol)  
  • improving health and reducing health inequalities  
  • working efficiently as a multi-agency group utilising resources effectively |
<p>| Cheshire East Council                                                | CEC          | is a unitary authority area with borough status in the ceremonial county of Cheshire. The borough was established in April 2009, as part of the 2009 structural changes to local government in England, and is an amalgamation of the former boroughs of Macclesfield, Congleton and Crewe and Nantwich, together with a disaggregated share of the former Cheshire County Council |
| Cheshire West and Chester Council                                   | CWandC       | is a unitary authority area with borough status in the ceremonial county of Cheshire. The borough was established in April 2009, as part of the 2009 structural changes to local government in England, and is an amalgamation of the former boroughs of Chester City, Ellesmere Port and Neston and Vale Royal, together with a disaggregated share of the former Cheshire County Council |
| Chronic Disease                                                      | -            | a disease that persists over a long period. The symptoms of chronic disease are sometimes less severe than those of the acute phase of the same disease. Chronic disease may be progressive, result in complete or partial disability, or even lead to death |
| Circulatory Disease                                                  | -            | see CVD                                                                                                                                                                                                  |
| Clinicians                                                          | -            | are qualified healthcare professionals - doctors, nurses and members of the allied health professions, for example, dieticians, occupational therapists, physiotherapists, podiatrists and speech and language therapists |
| Clinical Commissioning Group                                         | CCG          | the bodies which will carry out local commissioning of NHS services. They will be public bodies holding their meetings in public. Their members will be primary and secondary care doctors, nurse specialists, lay people and others |</p>
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<tr>
<td>Commissioning</td>
<td>-</td>
<td>in health terms commissioning is the process of deciding which health services are needed for a given population, acquiring them and ensuring that the services meet the defined needs. The process ranges from assessing population needs, agreeing priorities, setting targets and outcomes, to procuring services and monitoring the service providers. Also see Central and Eastern Cheshire PCT</td>
</tr>
<tr>
<td>Commissioning for Quality Indicators</td>
<td>CQUIN</td>
<td>a payment framework used in the NHS by commissioners to reward high quality services, by linking healthcare providers’ income to the achievement of quality improvement goals</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>CHD</td>
<td>encompasses sudden cardiac collapse, acute coronary syndromes, exertional angina and heart failure. The major lifestyle causes of coronary heart disease are poor diet, smoking and physical inactivity</td>
</tr>
<tr>
<td>Foundation Year 2 Doctor</td>
<td>F2</td>
<td>an F2 Doctor is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme - a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. Being a Foundation Doctor is compulsory for all newly qualified medical practitioners in the UK from 2005 onwards. Foundation Doctors have the opportunity to gain experience in a series of posts in a variety of specialties and healthcare settings, including Public health. The CECPCT Public Health have had an F2 doctor positioned with them since 2010</td>
</tr>
<tr>
<td>Harmful Drinking</td>
<td>-</td>
<td>is defined as drinking at levels which can cause harm to physical and mental health. Women who regularly drink over six units a day (or over 35 units a week) and men who regularly drink over 8 units a day (or over 50 units a week) are drinking at harmful levels - also known as ‘high risk’ drinkers</td>
</tr>
<tr>
<td>Hazardous Drinking</td>
<td>-</td>
<td>occurs when women consume between 15-35 units per week and men 22-50 units per week - also known as ‘increasing risk’ drinkers</td>
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<tr>
<td>Health Inequalities</td>
<td>-</td>
<td>term that describes the gap between the health experience of different population groups such as the well-off compared to poorer communities or people from different ethnic backgrounds</td>
</tr>
<tr>
<td>Health and Social Care Act</td>
<td>HSCA</td>
<td>the Health and Social Care Act 2012 is the healthcare reform legislation introduced in the House of Commons on 19th January 2011 and enacted in March 2012. The Act is the most extensive reorganisation of the structure of the National Health Service in England to date</td>
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<tr>
<td>Health and Wellbeing Boards</td>
<td>HWBB</td>
<td>a statutory committee of a local authority which will lead and advise on work to improve health and reduce health inequalities among the local population. It will have a performance monitoring role in relation to NHS clinical commissioning groups, public health and social care. Members will include councillors, GPs, health and social care officers and representatives of patients and the public, including HealthWatch.</td>
</tr>
<tr>
<td>Healthy Life Expectancy</td>
<td>-</td>
<td>average number of years that a person can expect to live in “full health” by taking into account years lived in less than full health due to disease and/or injury</td>
</tr>
<tr>
<td>Healthy Lives, Healthy People</td>
<td>-</td>
<td>national Public Health White Paper that sets out the Government’s long-term vision for the future of public health in England. Documents prefaced Healthy Lives, Healthy People are part of this strategy either as plans for specific issues such as Tobacco or guidance such as the Public Health Outcomes framework</td>
</tr>
<tr>
<td>Hotspot Wards</td>
<td>-</td>
<td>defined as electoral wards with significantly higher rates of teenage conceptions than the Cheshire rate. This encompasses all wards with a greater than 60 per 1,000 under 18 conceptions. These wards mirror those where high levels of deprivation, higher rates of benefit claimants and lower educational attainment is also present</td>
</tr>
<tr>
<td>Index of Multiple Deprivation</td>
<td>IMD</td>
<td>a national measure of social deprivation published every few years by (what is now) the Department for Communities and Local Government. It combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each LSOA in England. This allows areas to be ranked relative to one another according to their level of deprivation. The latest IMD is from 2007</td>
</tr>
<tr>
<td>Influenza</td>
<td>-</td>
<td>commonly referred to as the flu. Influenza is a more severe disease than the common cold and is caused by a different type of virus. It is transmitted through the air by coughs or sneezes, creating aerosols containing the virus. Influenza can also be transmitted by direct contact with contaminated surfaces</td>
</tr>
<tr>
<td>Joint Health and Wellbeing Strategy</td>
<td>JHWS</td>
<td>the JHWS strategy is the mechanism for local authorities and Clinical Commissioning Groups (CCGs) to address the needs identified in JSNAs, setting out agreed priorities for collective action by the key commissioners - the local authority, the CCGs and the NHS Commissioning Board. The aim of the JHWS is to jointly agree what the greatest issues are for the local community based on evidence in JSNAs, what can be done to address them; and what outcomes are intended to be achieved</td>
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<td>Joint Strategic Needs Assessment</td>
<td>JSNA</td>
<td>a process that identifies the current and future health and wellbeing needs of a local population. The requirement for local authorities and Primary Care Trust’s to undertake JSNA was created by the Local Government and Public Involvement in Health Act (2007) and strengthened in the Health and Social Care Act 2012. The process should lead to stronger partnerships between communities, local government and the NHS. It should inform the priorities and targets set by Local Area Agreements, and provide a firm foundation for commissioning, including practice based commissioning</td>
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<tr>
<td>Life Expectancy</td>
<td>LE</td>
<td>the number of years a person could expect to live if they experienced the age-specific mortality rates of the given area and time period for the rest of their life. Life expectancy is calculated separately for males and females. See also Healthy Life Expectancy</td>
</tr>
<tr>
<td>Local Involvement Network</td>
<td>LINks</td>
<td>local organisation of individual and organisational members which collects and represents the views of health and social care service users and the public. Under the Health and Social Care Act, LINks will be superseded by local HealthWatch</td>
</tr>
<tr>
<td>Local Area Partnership</td>
<td>LAP</td>
<td>an enabling body that can bring together and involve a wide range of people who have an interest and responsibility for delivering improvement in the area. Seven Local Area Partnerships are found in the geographical boundaries of Cheshire East Unitary Authority. See also Local Area Partnerships</td>
</tr>
<tr>
<td>Local Authority</td>
<td>LA</td>
<td>the structure of local government varies from area to area. In much of England, there are two tiers - county and district - with responsibility for council services split between the two tiers, however London, other metropolitan areas and parts of shire England operate under a single tier structure. In total there are five possible types of local authority in England. These are:</td>
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<td>• county councils - cover the whole county and provide 80% of services in these areas, including children’s services and adult social care</td>
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<td>• district councils - covering a smaller area, providing more local services (such as housing, local planning, waste and leisure but not children’s services or adult social care), can be called district, borough or city councils</td>
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<tr>
<td></td>
<td></td>
<td>• unitary authorities - just one level of local government responsible for all local services, can be called a council, a city council or borough council</td>
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<td></td>
<td></td>
<td>• London boroughs - each of the 33 boroughs is a unitary authority, but the Greater London Authority provides London-wide government, including special responsibility for police, fire, strategic planning and transport</td>
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<td></td>
<td></td>
<td>• metropolitan districts - effectively unitary authorities, the name being a relic from past organisational arrangements. They can be called metropolitan borough or city councils</td>
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<td>Local Strategic Partnership</td>
<td>LSP</td>
<td>a single, non-statutory, multi-agency body, which matches local authority boundaries, and aims to bring together at a local level the different parts of the public, private, community and voluntary sectors. LSP’s are key to tackling deep seated, multi-faceted problems, requiring a range of responses from different bodies. Local partners working through an LSP will be expected to take many of the major decisions about priorities and funding for their local area.</td>
</tr>
<tr>
<td>Lower Super Output Area</td>
<td>LSOA</td>
<td>a geographic hierarchy designed to improve the collection, analysis and reporting of small area statistics in England and Wales. LSOAs have an average population of 1,500. CECPCT contains 290 LSOAs.</td>
</tr>
<tr>
<td>Marmot Review</td>
<td>-</td>
<td>a review of the causes and the “causes of the causes” (i.e. the social and economic determinants) of health inequalities in England, carried out by Professor Sir Michael Marmot in 2010. It was commissioned by the previous Government and its findings were endorsed by the present Coalition Government. It identifies a number of key areas for action to reduce health inequalities, the most important of which is “giving every child the best start in life”. The review, Fair Society, Healthy Lives, is an invaluable resource to assist with developing priorities for the JHWS.</td>
</tr>
<tr>
<td>Middle Super Output Area</td>
<td>MSOA</td>
<td>a geographic hierarchy designed to improve the collection, analysis and reporting of small area statistics in England and Wales. MSOAs contain around three to five LSOAs and have an average population of 7,200. Central and Eastern Cheshire PCT contains 65 MSOAs.</td>
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<tr>
<td>Morbidity</td>
<td>-</td>
<td>term used to describe the burden of illness caused by disease or lifestyle factors (for example, smoking).</td>
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<tr>
<td>Morbidity Rate</td>
<td>-</td>
<td>the number of people affected by disease expressed as a rate (for example, the number of cases per 100,000 population)</td>
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<tr>
<td>Mortality</td>
<td>-</td>
<td>synonym for death. Generally used in connection with rates of death caused by disease or lifestyle factors (for example, smoking)</td>
</tr>
<tr>
<td>Mortality Rate</td>
<td>-</td>
<td>number of deaths expressed as a rate (for example, the number of cases per 100,000 population)</td>
</tr>
<tr>
<td>National Child Measurement Programme</td>
<td>NCMP</td>
<td>the NCMP weighs and measures children at school in Reception year (aged 4-5 years) and Year 6 (aged 10-11 years). The information is used by the NHS to plan and provide better health services for children. Local parents of children that are underweight, overweight or very overweight receive their child’s results.</td>
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<tr>
<td>National Institute for Health and Clinical Excellence</td>
<td>NICE</td>
<td>NICE develop evidence-based guidelines on the most effective ways to diagnose, treat and prevent disease and ill health. NICE have made recommendations on a wide range of topics, including many of the big issues in today's society such as smoking, obesity and excessive alcohol consumption</td>
</tr>
<tr>
<td>NHS Commissioning Board</td>
<td>NHSCB</td>
<td>the NHSCB is a national body created under the Health and Social Care Act, whose role includes supporting, developing and holding to account the system of clinical commissioning groups, as well as being directly responsible for some specialist commissioning</td>
</tr>
<tr>
<td>NHS Constitution</td>
<td>-</td>
<td>lays down the objectives of the NHS, the rights and responsibilities of the various parties involved in healthcare (patients, staff, trust boards) and the guiding principles which govern the health service</td>
</tr>
<tr>
<td>NHS Future Forum</td>
<td>-</td>
<td>the NHS Future Forum is a group of clinicians, patient representatives, voluntary sector representatives and others from the health field, including frontline staff, that have been overseeing the NHS listening exercises related to the recent NHS reforms</td>
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<tr>
<td>Obesity</td>
<td>-</td>
<td>when a person is carrying too much body fat for their height and sex, increasing the risk of developing a variety of diseases. A person is considered obese if they have a BMI of 30 or greater. Also see BMI and overweight</td>
</tr>
<tr>
<td>Office for National Statistics</td>
<td>ONS</td>
<td>the Executive Office of the UK Statistics Authority, a non-ministerial department, which reports directly to parliament. ONS is the UK government's single largest statistics producer and collects and disseminates data on all aspects of economy and society</td>
</tr>
<tr>
<td>Outcome Framework</td>
<td>-</td>
<td>a national framework which sets out the outcomes and corresponding indicators against which achievements in health and social care will be measured. There is currently an NHS outcomes framework, an outcomes framework for adult social care and one for public health</td>
</tr>
<tr>
<td>Overweight</td>
<td>-</td>
<td>when a person is carrying additional body fat for their height and sex above what is considered normal for a healthy weight. A person is considered overweight if they have a BMI between 25 and 29.9. Also see BMI and Obesity</td>
</tr>
<tr>
<td>Premature Death</td>
<td>-</td>
<td>any death that occurs before average life expectancy is achieved could be called “premature,” but because that would not allow for a range around the average, the term is usually reserved for deaths that occur a considerable but undefined number of years before average life expectancy is achieved</td>
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<tr>
<td>Prevalence</td>
<td>-</td>
<td>measure of how common a condition is within a specified population over a certain period of time. Prevalence of a disease in a population is defined as the total number of cases of the disease in the population at a given time divided by the number of individuals in the population</td>
</tr>
<tr>
<td>Primary Care Trust</td>
<td>PCT</td>
<td>Primary Care Trusts cover all parts of England and receive budgets directly from the Department of Health in order to commission health services from providers, for example, hospital services. Strategic Health Authorities monitor performance and standards. Collectively PCT’s are responsible for spending around 80% of the total NHS budget. Also see CECPCT and Commissioning. The Health and Social Care Act will see the abolition of PCTs at the end of March 2013</td>
</tr>
<tr>
<td>Public Health</td>
<td>-</td>
<td>“the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.” (UK Faculty of Public Health, 2010). Public health is generally thought of as being concerned with the health of the entire population, rather than the health of individuals - and therefore requiring a collective effort - and as being about prevention rather than cure. The three domains of public health are: health improvement; health protection; and health services</td>
</tr>
<tr>
<td>Public Health England</td>
<td>PHE</td>
<td>the new national public health service which will integrate the work of a large number of disparate public health organisations into a single, expert body providing advice and services across the range of public health functions. It will allocate ring-fenced funding to local authorities and will also act on behalf of the Secretary of State in the process of appointing Directors of Public Health at the local authority level</td>
</tr>
<tr>
<td>Public Health Outcomes Framework</td>
<td>-</td>
<td>the public health outcomes framework sets out the desired outcomes for public health and how these will be measured. The framework concentrates on two high-level outcomes to be achieved across the public health system. These are: ‘increased healthy life expectancy’ and ‘reduced differences in life expectancy and healthy life expectancy between communities’</td>
</tr>
<tr>
<td>Quality, Innovation, Productivity and Prevention</td>
<td>QIPP</td>
<td>a framework for the NHS intended to deliver efficiency savings while maintaining quality</td>
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<tr>
<td>Respiratory disease</td>
<td>-</td>
<td>includes conditions of the upper respiratory tract, trachea, bronchi, bronchioles, alveoli, pleura and pleural cavity, and the nerves and muscles of breathing. Respiratory diseases range from mild and self-limiting, such as the common cold, to life-threatening entities like bacterial pneumonia and lung cancer</td>
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<tr>
<td>Service Level Agreement</td>
<td>SLA</td>
<td>an SLA is a part of a service contract where the level of service is formally defined. In practice, the term SLA is sometimes used to refer to the contracted delivery time (of the service) or performance. In the NHS context SLAs are used commonly between NHS Trusts and with Local Authorities.</td>
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<tr>
<td>Service Specification</td>
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<td>a service specification sets out what the Commissioner of Health Services is getting from the Provider of Health Services. It usually starts with a brief description of the nature and scope of the service required, the user group for whom the service will be provided and the overall purpose and aims of the service. Locally agreed principles or values underpinning the service are normally included at this point as well as relevant information about partnership working in this area. It may also be useful to include an explanation/definition of any technical terms used in the document as well as the recent background of the service or client group, for example is it a new service or existing one?</td>
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<tr>
<td>Tariff</td>
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<td>in relation to payment by results, the tariff is the calculated price for a unit of healthcare activity, for example, a hip replacement operation</td>
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<td>Ward</td>
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<td>an administrative area within a local council area</td>
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<td>Wellbeing</td>
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<td>used by the World Health Organisation (1946) in its definition of health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. More recently the concept was described as “feeling good and functioning well” (New Economics Foundation, 2008). Creating wellbeing (of which good physical health is a component) requires the mobilisation of the widest assets to ensure community cohesion, safety and so on</td>
</tr>
<tr>
<td>World Health Organisation</td>
<td>WHO</td>
<td>the WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends</td>
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<tr>
<td>World Class Commissioning</td>
<td>WCC</td>
<td>the World Class Commissioning programme aimed to transform the way health and care services were commissioned. It aimed to deliver a more strategic and long-term approach. It was comprised of four elements: Competencies, Assurance, Vision, and Support and Development</td>
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I am delighted to be able to introduce to you the Annual Report of the Director of Public Health 2011 for the Central and Eastern Cheshire area. This year’s report is being written in the context of organisational change and economic challenge across the country and indeed the world.

During such periods, the importance of maintaining and supporting health and wellbeing cannot be understated. The current report highlights some recent achievements and a number of areas for future attention, which must be addressed collaboratively, to maximise local health.

The Health and Social Care Act changes the national and local approach to public health, along with many other parts of the NHS. From 2013 many responsibilities for public health will move from Primary Care Trusts within the NHS to Local Authorities. Locally, many of the current Primary Care Trust Public Health functions will move to Cheshire East and Cheshire West and Chester Councils. The remaining functions will migrate to a new national organisation called Public Health England who will in turn influence the NHS Commissioning Board and Clinical Commissioning Groups to buy services to improve public health.

The opportunities for public health within Local Authorities are substantial, for example, there will be an enhanced ability to influence and support areas such as housing, environment, sports, education and social care with consequential long term benefits to health. These and the new commissioning role for Local Authorities around lifestyle services are looked at in Chapters One and Two.

There is also potential for public health to retain its relationship with NHS services in the future. The new Clinical Commissioning Groups have a critical role in improving health in the short and medium term. Indeed, Directors of Public Health and their teams will be required to work with local commissioning groups (as well with health protection colleagues across the NHS and Department of Health) to ensure the potential for high quality, cost effective safe local services is maximised. The delivery of a refreshed and robust local Joint Strategic Needs Assessment will provide the foundations for this work. However, it has been recognised locally that in order to deliver the change in outcomes that the local community and GP commissioners desire this supportive relationship will need to develop. Examples of how we can approach service delivery collaboratively are explored in Chapter Three.

In Central and Eastern Cheshire we have had considerable experience of managing increased efficiency with limited resources. Historically, we have risen to this challenge, often in partnership, and managed to improve health. This report highlights that we need to continue in this direction and ensure that the current reforms strengthen our approach.

Heather Grimaldeston
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Helping people live healthy lifestyles, make healthy choices and reduce differences in health outcomes

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“Healthy Lives, Healthy People: Our strategy for public health in England” was published in November 2010 and outlined the Coalition Governments intention to transfer the health improvement commissioning responsibilities of Primary Care Trusts (PCT’s) to local government from 1st April 2013. It also confirmed the government’s commitment to ‘protecting the population from serious health threats; helping people live longer, healthier and more fulfilling lives; and improving the health of the poorest, fastest’. This was in response to Professor Sir Michael Marmot’s ‘Fair Society, Healthier Lives’ report and adopts its life course framework for tackling the wider social determinants of health and reducing health inequalities.

The next key guidance released which further identified and clarified the health improvement commissioning responsibilities for local authorities was ‘Healthy Lives, Healthy People: Update and way forward’ and the ‘Public Health in Local Government’ factsheets.

These two sets of guidance confirmed the Governments expectation that the following services be commissioned by local authorities:

- tobacco control and stop smoking services
- alcohol and drug misuse services
- public health services for children and young people aged 5 - 19 years
- National Child Measurement Programme (NCMP)
- interventions to tackle obesity
- locally led nutrition initiatives
- physical activity
- NHS Health Check assessments
- public mental health services
- accidental injury prevention
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace
- sexual health services
Sexual health services, the NCMP and NHS Health Check assessments are mandated health improvement services to be commissioned by local authorities.

In January 2012, ‘Healthy lives, healthy people: Improving outcomes and supporting transparency: a public health outcomes framework for England, 2013-2016’ was released which outlined the vision for Public Health in England:

“to improve and protect the nations health and wellbeing, and improve the health of the poorest fastest”

Two main outcomes were identified for public health which if achieved will contribute towards the national vision:

**Outcome One:** increased healthy life expectancy

**Outcome Two:** reduced differences in life expectancy and healthy life expectancy between communities

The document outlined the set of 66 supporting public health indicators which local areas will need to choose to work to towards achieving the desired outcomes for public health. The indicators cover the full spectrum of public health and what can be currently realistically measured to ascertain progress towards achieving the two outcomes, and are grouped into four ‘domains’:

- **Domain One:** improving the wider determinants of health and
- **Domain Two:** health improvement
- **Domain Three:** health protection
- **Domain Four:** healthcare public health and preventing premature mortality

The list of 66 indicators within the four domains can be seen in Appendix One.

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**The health and wellbeing concerns for Central and Eastern Cheshire**

The Central and Eastern Cheshire area has the fastest growing ageing population in the North West and England. It has also been identified as having one of the highest life expectancies in the North West; however this masks considerable within-area differences and between area differences in life expectancy and healthy life expectancy.

The main cause of all deaths and the biggest contributor to the life expectancy gaps experienced by both males and females is cardiovascular disease (CVD). CVD includes heart disease, heart attacks, heart failure and stroke. Cancers are the second major cause of all deaths within our area but are the major cause of premature (early) death. Breast, colorectal and lung cancers are the main forms of cancer that cause premature death within Central and Eastern Cheshire.

Risk factors of greatest concern are smoking, binge drinking, obesity, low breastfeeding rates and pockets of high teenage pregnancy. Although some indicators are similar to the England average (smoking, obesity, and teenage pregnancy) this masks much higher levels at middle super output area (MSOA) level. MSOAs are areas which contain approximately 7,200 people with similar characteristics and they are designed to improve the collection, analysis and reporting of small area statistics in England and Wales.

The Cheshire East Joint Strategic Needs Assessment (JSNA) indicates that the areas of greatest priority are:

- CVD
- cancer
- alcohol harm
- health of older people
- health of children
An initial analysis of the Cheshire East JSNA refresh, completed in November 2011 confirms this picture.

The Cheshire West and Chester JSNA indicates the overall priorities for this area are:

- delivery of services that meet people's personal needs
- health of children and young people
- lifestyle issues that place people most at risk of developing long term conditions
- older people
- inequalities

This chapter describes the lifestyle choices and behaviours that affect the health of the residents of Central and Eastern Cheshire and which are of particular concern. It also highlights examples of national and local actions to improve health and prevent illness caused by these lifestyle choices and behaviours. Linked to this chapter Appendix Two identifies a number of examples of where within the Central and Eastern Cheshire area health improvement and lifestyle services have either been commissioned by the PCT or work has occurred in partnership with other agencies to target areas of need and reduce health inequalities.

Many of the indicators listed in all of the four Public Health Outcomes Framework domains could have a link to any or all of the lifestyle areas as set out below. Those indicators that are a direct indicator against / for a specific lifestyle area are highlighted.

### Tobacco control and stop smoking services

Smoking remains one of the greatest preventable causes of sickness (morbidity) and premature death (mortality). It is the single biggest reversible risk factor for CVD and as a life threatening addiction it kills half of all regular persistent smokers.

Both nationally and locally, significant progress has been made to decrease the number of smokers, however the reductions have not occurred equally across all the socio-economic groups, which will contribute to widening the inequalities gap. Smoking prevalence is highest in urban areas and appears to be linked with deprivation.

The adult smoking rate in Central and Eastern Cheshire has been falling with the current adult smoking prevalence at 17.6%, compared with the national average of smokers 22.2%.

Although the local average smoking rate is lower than the national average there is still considerable variation across the Central and Eastern Cheshire area with the Crewe Local Area Partnership (LAP) rate at 23.2%, Winsford and Rural East Area Partnership Board (APB) at 21.0% and Poynton LAP at 11.1%.

Smoking in pregnancy is measured as the smoking status of the mother at the time of delivery (SATOD). Local SATOD rates have reduced in recent years from 19.7% in 2006/07 to 17.3% in 2010/11, although this is higher than the national average (13.6%) and the national target (15%, with 1% reduction in each year from 2010/11).

There is a variation between the two Maternity Units - the rate for East Cheshire NHS Trust (Macclesfield) for 2010/11 is 12.8% and for Mid Cheshire Hospitals NHS Foundation Trust (Crewe) is 21.3%. The rate for Mid Cheshire Hospitals NHS Foundation Trust has been reducing during 2011/12.
What works

The national strategy ‘Healthy Lives, Healthy People: A Tobacco Control Plan for England’ supports comprehensive tobacco control across the six internationally recognised strands of:

- stopping the promotion of tobacco
- making tobacco less affordable
- effective regulation of tobacco products
- helping tobacco users to quit
- reducing exposure to second-hand smoke
- effective communications of tobacco control

National Institute for Health and Clinical Excellence (NICE) guidelines have been published to provide evidence based advice on a number of areas of tobacco control including smoking in pregnancy, school based interventions to prevent smoking, workplace interventions to promote smoking cessation and Smoking Cessation Services.

In regard to stopping smoking, evidence has shown that a combination of behavioural support from a stop smoking adviser plus nicotine replacement can increase a smoker’s chances of stopping by up to four times. This will require multiple sessions and potentially a number of attempts on the part of the smoker.

Local action

Central and Eastern Cheshire Primary Care Trust (CECPECT) commissions the East Cheshire NHS Trust Community Business Unit to provide a Stop Smoking Service. The Service ensures stop smoking services are targeted in areas of high smoking rates but are accessible to all smokers through services based in every town across Central and Eastern Cheshire. The service also targets routine and manual workers who experience high smoking rates, the polish community and people with mental health problems, all of which are groups of people who are more likely to smoke than the general public. The service also targets smoking in pregnancy.

Target achievement. The Stop Smoking Service over achieved its 2010/11 four week quit target of 2,425 by supporting 3,205 smokers to stop smoking. This equates to a fall in prevalence of approximately 0.5%, and thus between 69 and 173 premature deaths prevented. The Service has a history of both achieving its targets and successfully redistributing services to meet need. The service has also in the last three years pioneered a new data collection system, which is being adopted across the North West and implemented innovative carbon monoxide monitoring for pregnant women.

Real-time patient experience pilot. In early 2011 as part of ongoing service improvement work and to fulfill a CQUIN contract requirement, real time patient experience surveys were undertaken on 22nd February and 1st March 2011 with users of the Stop Smoking Service clinics held at Waters Green Medical Centre in Macclesfield. Interviews were conducted by members of Cheshire East LINk (Local Involvement Network). Questions used in this survey were particularly focused around staff attitude and communication, two common themes in complaints received and concerns raised via the PALS service. The results of the pilot survey were extremely positive. Out of a total of 38 respondents, 37 said that they would definitely recommend the service to a relative or friend.

CECPECT works in partnership with a variety of organisations, in particular the local Councils, to promote a tobacco free future. The Cheshire East Tobacco Alliance has recently developed their plan to address the national strategy. The members of the Alliance (PCT, local stop smoking service, NHS Trusts, Environmental Health, Trading Standards, Fire, Police, HMP and YOI Styal Prison) are working on smokefree homes and cars, smoke free play areas, illicit tobacco and brief intervention training. CECPECT is also a member of the Cheshire West and Chester Tobacco Alliance.

Recommendations (also see generic recommendations at end of chapter)

- continue to recognise tobacco control as a priority with its high costs to NHS and society and the high numbers of tobacco related deaths
- work with partners and providers to ensure that the gradual reduction in smoking in pregnancy rates is continued
**Diet and nutrition**

Poor diet and nutrition are recognised as major risk factors for ill health and premature death. The World Health Organisation (WHO) recognises that good nutrition (an adequate, well balanced diet) when combined with regular physical activity is a cornerstone of good health.

Poor nutrition can lead to reduced immunity, increased susceptibility to disease and impaired physical and mental development. An unhealthy diet and physical inactivity are major risk factors for chronic diseases.

‘Healthy Lives, Healthy People: Our strategy for public health in England’ includes the need to improve the general diet and nutrition of children and adults, including breastfeeding as one way of doing this for children. It recognises that:

- many premature deaths and illnesses could be avoided by improving lifestyles, including diet. Illnesses include cancer and dementia. Enhanced nutrition has largely eliminated many birth defects and once common conditions such as rickets
- older people can be assisted to remain in their own homes through numerous measures including good nutrition
- breastfeeding gives babies the best start in life through good nutrition and it helps reduce infant mortality through tackling maternal obesity
- the Healthy Child Programme includes breastfeeding support and a range of other proven preventative services
- a need to support breastfeeding in the workplace by working in partnership with employers to encourage breastfeeding friendly employment policies
- the national government scheme ‘Change4Life’ promotes healthy eating. The scheme aim is to prevent people from becoming overweight by encouraging them to eat better and move more

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**Public Health Outcomes Framework domains and indicators**

**Domain 2 Health Improvement**

- i.21 Breastfeeding
- i.30 Diet

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**Breastfeeding** gives a baby the best nutritional start in life and also give health benefits to the mother. Breastfeeding protects the baby from ear infections, asthma, eczema, chest infections, obesity, gastrointestinal infections, childhood diabetes and urine infections. The mother gains protection from breast cancer, weak bones in later life and ovarian cancer. Also women who breastfeed regain their pre-pregnancy weight faster.

Locally breastfeeding initiation rates are lower than the national average and lower than expected when compared with levels achieved by similar PCT’s. Although the PCT initiation rates are mid-range in the North West - achieving a 67.7% in 2010/11 - it is low compared with the 80% initiation rate of the best performing PCT’s within the same Office for National Statistics (ONS) grouping ‘Prospering Smaller Towns (c)’. This is a classification used by the ONS to group together geographic areas according to key characteristics common to the population in that grouping.

In 2010/11 38.8% of mothers in the Central and Eastern Cheshire area were breastfeeding at 6 - 8 weeks. However there is variation across the area. The 6 - 8 week rates vary across the Local Area Partnerships (LAPs) and Area Partnership Boards (APBs) within Central and Eastern Cheshire from 26.9% in Crewe LAP to 56.9% in Knutsford LAP. Wilmslow LAP also has a high rate at 54.8%.8
A healthy diet is measured by fruit and vegetable consumption - a minimum of five portions of fruit and vegetables a day. Across central and Eastern Cheshire 31.5% of residents aged 16 years and over eat a healthy diet according to this measure. This is higher than the England average of 28.7% but still leaves a large majority (68.5%) that are not eating a healthy diet. Across the Central and Eastern Cheshire area Knutsford LAP and Poynton LAP have the highest percentage of adults eating a healthy diet (36% and 37.0% respectively) and Crewe LAP and Winsford and Rural East APB the lowest (26.4% and 26.7% respectively).

What works

The eatwell plate is a plate model which represents the types and amounts of foods we should be eating for a healthy balanced diet over the course of a day or a week. It makes healthy eating easier to understand by giving a visual representation of the types and proportions of foods needed for a healthy and well balanced diet, and by encouraging the choice of different foods it helps to ensure that a person can obtain a wide range of nutrients needed to remain healthy.

The ‘eatwell plate’ is appropriate advice for most people including people of all ethnic origins and people who are of a healthy weight or overweight. It is also suitable for vegetarians. However, it does not apply to children under two years of age because they have different needs. Between the ages of two and five, children should gradually move to eating the same foods as the rest of the family, in the proportions shown on the eatwell plate. People under medical supervision or with special dietary needs might need to check with their GP, or a registered dietician, to be clear about whether or not the eatwell plate is suitable for them.

Local action

Breastfeeding - Pregnant women are given information about breastfeeding early on in their pregnancy. A local project run in both the towns of Crewe and Winsford is giving pregnant women access to Breastfeeding Support Workers in addition to midwives during their pregnancy, to give continuity in support from initiation (with a midwife) at birth to continuing after leaving hospital and handover to the health visiting service. This targeted work has helped increase breastfeeding continuation rates.

All breastfeeding mothers are given support by health visitors and have access to a number of support mechanisms under the local brand Cherubs (Cheshire Really Useful Breastfeeding Support).

All local NHS and local authority organisations across Cheshire use the branding to promote their support for breastfeeding. Cherubs is supported by a website which gives pregnant women and breastfeeding mothers information and support about breastfeeding. Cherubs support groups are held in Children’s Centres all across the Central and Eastern Cheshire area and local mothers who have breastfed their babies can be trained as Peer Supporters to help new mothers with breastfeeding. A Cherubs Charter is also awarded to those businesses that are breastfeeding friendly and support breastfeeding mothers.

Further information: www.cherubsbreastfeeding.co.uk
Healthy Eating - There are many initiatives across Central and Eastern Cheshire promoting healthy eating and cooking.

Down To Earth
A Community Food and Gardening Initiative

The ‘Down To Earth’ project is based in St. John’s Wood Community Centre, on the Longridge estate in Knutsford, but has expanded to cover much of the Cheshire East area, either working alone or in partnership with other organisations and community groups.

It has already reached over 1,200 beneficiaries and has been developed to improve the communities’ health, well being and lifestyles through food and gardening initiatives, and more recently through taking regular exercise. The project is encouraging people to make healthier food choices and empowering the local community to take ownership of their continued health and wellbeing. It also aims to encourage local people to take part in physically growing their own food.

The project is open to all age groups from babies to the elderly but specifically targets people who may feel isolated, who are on benefits, are out of work, have mental health problems, disabilities or are suffering from abuse.

Further information:
www.cheshireeast.gov.uk

Grozone

In Northwich a 0.9 hectare derelict site has been transformed through the Grozone project led by Groundwork Cheshire, to create a welcoming outdoor community space to encourage the local community, including those who experience barriers to participation, to join in a range of activities. The Grozone project includes growing food, learning about nutrition and health and participating in exercise. 60 people have signed up as Friends of Grozone and there are a regular number of people who attend the volunteer sessions.

Workplace Health Initiative. Cheshire East Council is working toward the Workplace Wellbeing Charter which involves attaining the standards for:
- leadership
- attendance management
- health and safety requirements
- mental health and wellbeing
- smoking and tobacco control
- physical activity
- healthy eating
- alcohol and substance misuse

Further information:
www.wellbeingcharter.org.uk
www.cheshireeast.gov.uk

Further information:
www.northwest.groundwork.org.uk/cheshire.aspx
http://talkingwestcheshire.org/love_to_live/grozone.aspx

Further information:
www.wellbeingcharter.org.uk
www.cheshireeast.gov.uk

Cheshire East Council staff receive advice on healthy eating and healthy options are promoted for members of the public in Leisure Centres. Information on health improvement is easy to access and well promoted throughout the organisation.
A further healthy eating project by Cheshire East Council is working with the Food for Life Partnership to transform the food culture in schools. The Food for Life Partnership helps schools engage in cookery and gardening clubs, which many of the Council’s catering staff have been assisting with.

The council has been awarded the Bronze Soil Association Catering Mark for the school meals served in primary schools across the authority.

Further information:
www.foodforlife.org.uk

In conjunction with the local Cheshire and Merseyside Public Health Network CECPCT is holding training courses for community and health practitioners in healthy eating and exercise for young children, known as HENRY (Health, Exercise, Nutrition for the Really Young).

The aim is to help address child obesity. The training gives community and health practitioners the opportunity to develop confidence and skills in working with families of young children to promote a healthy lifestyle and address issues of overweight.

The HENRY approach introduces ways of working with parents that improve their motivation to change by developing strengths-based and solution-focused strategies to explore the key lifestyle issues:

• healthy eating patterns
• the food children eat
• being active
• parenting skills
• emotional wellbeing

Recommendations (also see generic recommendations at end of chapter)

• local organisations to adopt and support the breastfeeding Cherubs brand in order for the local area to become breastfeeding friendly
• continue to support healthy eating programmes and roll out other evidence based approaches to healthy eating

Further information:
www.champspublichealth.com
Physical activity

The physical and mental benefits of regular physical activity have been clearly set out across the life course. Physical activity during childhood has a range of health benefits including healthy growth and development and improved psychological wellbeing and social interaction.

Regular physical activity participation in childhood is also seen as an essential tool in the prevention of adult overweight and obesity as it is recognised that early engagement in encouraging an active lifestyle can lead to a physically active lifestyle in later life.

‘Healthy Lives, Healthy People: Our strategy for public health in England’ advocates the need to increase physical activity. It recognises that:

- many premature deaths and illnesses could be avoided by improving lifestyles, including physical activity
- the need to design communities for activity including active ageing
- it is necessary to work collaboratively with business and the voluntary sector through the Public Health Responsibility Deal which includes a physical activity element
- there is a need to improve the environment in which people live to make physical activity part of everyday life
- that physical activity should be included in the personal, social and health education framework in schools
- families need to be supported to make informed choices about their diet and their levels of physical activity, including through updated guidelines on physical activity and the Change4life programme
- active travel and physical activity need to become the norm in communities

Local Evidence

Physical activity rates are measured by the number of adults participating in at least 30 minutes of physical activity on at least three days of the week. The average for the Central and Eastern Cheshire area is 23.6%. Crewe LAP has the lowest participation rate at 20.5%, with Wilmslow LAP and Poynton LAP the highest, both at 26.8%.

What works

NICE reviews have examined evidence for the effectiveness of commonly used methods to increase physical activity, for example promoting physical activity in the workplace, promoting/creating built or natural environments that encourage and support physical activity.

The NICE public health guidance ‘Four commonly used methods to increase physical activity’ concludes that brief interventions in primary care are effective at increasing physical activity levels:

- in the short term (6 to 12 weeks)
- in the long term (over 12 weeks)
- in the very long term (12 months or more)
Health and fitness - Cheshire East Council’s 15 leisure facilities attract nearly 3 million visits every year, providing activities from swimming to fitness suites as well as team sports. Over 5,000 users hold “Everybody Memberships” encouraging long term commitment to physical activity through a membership scheme and over 3,000 young people undertake weekly swimming instruction.

In addition to general public use, the leisure facilities team works in partnership with a number of organisations to deliver specific referral projects. Recent examples have included working with Leighton Hospital weight loss clients, Wulvern Housing and Age UK as well as local referral arrangements for patients with certain medical conditions with various GP surgeries, in conjunction with CECPCT. An exercise referral scheme is also provided in Northwich and Winsford by the leisure services of Cheshire West and Chester Council.

Further information:
www.cheshireeast.gov.uk
www.cheshirewestandchester.gov.uk

A specific physical activity participation promoting intervention for older people who fear, or are at risk of, falling, poor balance or mobility is also run across the towns of Cheshire East. Known as Be Steady, Be Safe, these special exercise classes are designed to improve leg strength and balance in older people and consists of a set of leg muscle-strengthening exercises, balance-retraining exercises and a walking plan.

Further information:
www.cheshireeast.gov.uk

Obesity

Obesity has been defined as “an excess of body fat frequently resulting in a significant impairment of health and longevity”. Currently, one third of children in Britain are obese. It is predicted that if no action is taken 60% of men, 50% of women and 25% of children could be obese by 2050.20

Childhood obesity has both short and long-term impacts. Children may develop the symptoms of metabolic syndrome, including hypertension, dyslipidaemia (lipid imbalance) and hyperinsulinaemia (abnormally high levels of insulin in the blood). Obesity may also cause mechanical problems such as back pain and foot strain, exacerbation of asthma, psychological problems, including poor self-esteem, depression and eating disorders, and Type 2 Diabetes.

Many obese adolescents become obese adults and are at risk of obesity-related disorders and diseases normally associated with middle age, such as type 2 diabetes and hypertension. Studies have shown that the higher a child’s Body Mass Index (BMI) and the older the child, the more likely they will be obese as an adult.

Furthermore, research has demonstrated that the children of obese parents have a greater risk of becoming overweight or obese adults, increasing the likelihood of developing such health problems later in life. Overweight and obesity are largely preventable through lifestyle changes.

Public Health Outcomes Framework domains and indicators

Domain 2 Improving the wider determinants of health
i.25 Excess weight in 4-5 year olds and 10-11 year olds

i.31 Excess weight in adults

Recommendations
(also see generic recommendations at end of chapter)

• to continue to support GP referral schemes and roll out to all areas of need

• Public Health teams to work with others to encourage and support exercise as part of daily living, for example, Highways, Open Spaces
‘Healthy Lives, Healthy People: A call to action on obesity in England’ calls for a distinctive new approach towards obesity, the main components of which are:

- empowering individuals - through provision of guidance, information, encouragement and tailored support
- giving partners the opportunity to play their full part - for example, through the Responsibility Deal
- giving local government the lead role in driving health improvement and harnessing partners at local level
- building the evidence base

The average adult obesity rate within the Central and Eastern Cheshire area is 21.8% compared to an England average of 24.2%. There is a variation across the area from 18.1% of adults being obese in Wilmslow LAP to 24.5% in the Winsford and Rural East APB and 24.9% in Crewe LAP.

Table One highlights data from the 2010/11 NCMP - a national programme operated locally and which weighs and measures all children in Reception year (4 - 5 year olds) and Year 6 (10 - 11 year olds). It shows that the Central and Eastern Cheshire area has a lower prevalence of children in both age groups who are obese than the national average. This is also true of children who live within the geographical boundaries of Cheshire East Council, but not those that live within the boundaries of Cheshire West and Chester Council.

Table One: Obesity prevalence at Reception Year and Year 6 in England, Central and Eastern Cheshire, Cheshire East Council and Cheshire West and Chester Council 2010 - 2011

<table>
<thead>
<tr>
<th></th>
<th>Reception Year</th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>9.4%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Central and Eastern Cheshire</td>
<td>8.4%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Cheshire East Council</td>
<td>7.5%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Cheshire West and Chester Council</td>
<td>9.6%</td>
<td>19.9%</td>
</tr>
</tbody>
</table>

Source: adapted from the 2010/11 NCMP results on the NHS Information Centre (2011)

Further analysis of the 2010/11 NCMP data shows that the Crewe LAP area has the highest levels in Cheshire East in Year 6 at 22.0% respectively, whilst Nantwich LAP the lowest in both Reception Year and Year 6 - 4.8% and 12.8% respectively. Winsford and Rural East APB (includes only schools in the Central and Eastern Cheshire area only) has the highest level of childhood obesity in reception year at 11.0%.

What works

NICE is developing public health programme guidance on ‘overweight and obese adults - lifestyle weight management’. Other NICE guidance includes ‘Weight management before, during and after pregnancy’ and ‘Clinical Guidance Obesity’.

Best practice for weight management programmes includes setting a realistic target for weekly weight loss and weight, focusing on long-term lifestyle changes involving both diet and physical activity, and providing ongoing support. The guidance also states that lifestyle interventions for people actively trying to lose weight should comprise a number of different components (including strategies to reduce energy intake, increase physical activity and change behaviour). Behavioural interventions in a clinical setting should include, for example, self-monitoring, goal setting and relapse prevention.

Local action

CEPCT Public Health commissions East Cheshire NHS Trust School Health Service to carry out the weighing and measuring in schools across Central and Eastern Cheshire. In 2008/09 PCT’s were encouraged to pilot the feedback of individual results to parents and carers on children’s individual weight levels - whether underweight, healthy weight, overweight or very overweight (obese). This is to ensure parents and carers receive their child’s results from the NCMP, regardless of their weight, because:

- providing parents and carers with their child’s results is a vital way of engaging children and families about healthy lifestyles and weight issues;
• national research with parents and carers has indicated that they want to receive them

• research also shows that very few parents and carers can identify if their child is overweight, and so sharing these results is an important way to help keep them informed about their child’s weight

The East Cheshire NHS Trust School Health Service piloted feedback letters in 2009/10, and has since then routinely sent letters to carers and parents of children who are underweight, overweight or very overweight. Information in the form of a local leaflet is included in the letter.

In Northwich, Middlewich and Winsford a weight management service called ‘Reshape’ is provided through GP practices by Practice Nurses with support from a community dietitian. It is available for adults with a BMI of 28 with co-morbidities or BMI 30 without co-morbidities and consists of a programme of ten appointments over the course of a year. The initial assessment of the pilot demonstrated a 5kg average weight loss by patients on the programme. The programme is currently being evaluated and Vale Royal Clinical Commissioning Group will be considering the options available for future commissioning when the full results are available.

Recommendations
(also see generic recommendations at end of chapter)

• recognise the contribution a decrease in obesity rates will make to achieve the Public Health Outcomes and allocate appropriate funding to commission the provision of appropriate evidenced based services, targeting the areas and groups in most need

• on publication of the new NICE guidance consider the recommendations and implement locally as appropriate

• establish an approach to address family weight management problems, along with referral from NCMP and other Childrens’ Services
Alcohol

In recent years the amount of alcohol related health harm in England has been getting worse, with an increase in the total number of men dying from alcohol related causes. ONS data relating to 2010 shows that there were 8,790 alcohol-related deaths in the UK, 126 more than in 2009. There are more alcohol-related deaths in males than in females, with 67% of all alcohol-related deaths in the UK in 2010 being male.

Alcohol misuse is closely related to a wide range of poor health outcomes such as liver disease, heart disease and some cancers. In addition to ill-health, harm from alcohol also includes crime and antisocial behaviour, and loss of productivity for firms and loss of income for individuals. These wide ranging impacts can be assessed using the new national set of public health outcomes and indicators.

A new approach to tackling alcohol harm will be issued in 2012 in an alcohol strategy for England. Local councils will be given the power and the budget to help them tackle the huge variations in levels of harm in different regions of England.

Alcohol consumption is the third leading cause of preventable ill-health in Central and Eastern Cheshire, behind smoking and hypertension.

The Local Alcohol Profile for CECPCT identifies binge drinking affecting 22% of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session. This is slightly lower than the regional average at 23.3% but higher than the England average of 20.1%.

Macclesfield LAP has the highest binge drinking level in Cheshire East (24.8%) with Macclesfield Rural MSOA having the lowest level at 19.9%. Winnington and North Witton MSOA in Northwich and Rural North APB has a binge drinking level of 28.8% which is statistically higher than the Central and Eastern Cheshire rate.

In Central and Eastern Cheshire every person is allocated just over £1400 per annum towards NHS costs. The equivalent of £80 per person per annum of the NHS budget is spent on treatment of alcohol related problems. This is set to rise to £100 per person in 2012/13.

Harm associated with binge drinking is a key issue. Cheshire East Council has the highest percentage of people over 16 binge drinking (modelled) amongst its comparator local authorities (Cheshire West and Chester, Stroud, Tewkesbury and Stafford) at 22.5%. This figure is also 2.5% higher than the England average.

The Cheshire West and Chester JSNA includes a chapter on alcohol. This chapter focuses on the health harms associated with alcohol misuse amongst adults. Brief intelligence on alcohol related crime and disorder and alcohol and children is included but further information can be found in the Cheshire West and Chester Community Safety Partnership Safer Stronger Communities 2011-12 Strategic Assessment Refresh, Children’s Health Joint Strategic Needs Assessment and Supporting People Needs Assessment. These can be accessed via the DORIC (Data Observatory and Research and Intelligence Collaborative) website at: www.doriconline.org.uk

Public Health Outcomes Framework domains and indicators

Domain 2 Health Improvement

i.35 People entering prison with substance dependence issues who are previously not known to community treatment

i.37 Alcohol related admissions to hospital
What works

The NICE Clinical guidance ‘Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence’ offers evidence based advice on the diagnosis and management of harmful drinking and alcohol dependence in adults and in young people aged 10-17 years. Key priorities for implementation include early identification and assessment across all settings, clinical and non-clinical; and comprehensive assessments for all adults referred to specialist services.

For people who are at risk from binge drinking, brief interventions can be an effective way to influence behaviour and eliminate harmful drinking patterns. These can be delivered across a range of settings including primary care, criminal justice, prenatal, college and secondary care.

Local action

The Cheshire Drug and Alcohol Action Team (DAT), a multi agency team accountable to the Home Office, developed an Alcohol Harm Reduction Strategy document in 2009 on behalf of Cheshire East Local Strategic Partnership. A similar strategy document was produced for Cheshire West and Chester, called Rethinking Drinking: Cheshire West and Chester Alcohol Harm Reduction Strategy 2010 - 2013. Both strategies explain the national and local picture from the perspective of health, criminal justice and the children and young people’s agenda.

Both strategies include a summary of the current initiatives taking place to tackle alcohol related harm and the gaps within these interventions and the priority work areas required to fill these gaps.

Alcohol misuse has also been a priority area considered by the Cheshire and Warrington Health and Wellbeing Commission, with a task and finish group proposing minimum unit pricing for alcohol. Cheshire East Council is also leading a sub-regional large scale change programme to reduce alcohol related harm.

Minimum Unit Pricing for Alcohol. Research carried out by Sheffield University in 2008, identified that 50 pence per unit of alcohol would target irresponsible drinking, impacting on hazardous and harmful drinkers, while imposing a minimal financial effect on moderate drinkers and on-trade sales. A minimum unit price of 50 pence in Cheshire and Merseyside has been estimated to achieve a reduction in alcohol related hospital admissions by 4,335 in one year.

The Cheshire and Merseyside Task and Finish Group, set up to investigate this issue is of the view that the introduction of a byelaw, to introduce a minimum unit price for alcohol is currently one of the best ways of reducing alcohol related harm.

For best effect the byelaw would need to be approved and introduced across a number of Local Authorities. Cheshire East Council and Cheshire West and Chester council have given their approval and support to minimum unit pricing with other Local Authorities across Cheshire and Merseyside following in their consideration of support.

Recommendations

(also see generic recommendations at end of chapter)

- identify community champions to galvanise action for the introduction of a minimum price on alcohol across the region / sub region
- use intelligence led social marketing approaches to reduce harmful drinking patterns, targeted to the Local Area Partnerships where binge drinking levels are the highest
- have an up to date alcohol policy that supports customers and staff based on best practice
- integrated sexual health service specifications in future should include the commissioning of alcohol brief interventions
Drug misuse and treatment services

On 8th December 2010, the Government launched its drug strategy, ‘Reducing Demand, restricting supply, building recovery: supporting people to live a drug free life’.27 This strategy describes a different approach to preventing drug use in communities and in supporting recovery from drug and alcohol dependence.

The strategy has three themes:

• reducing demand,
• restricting supply and,
• building recovery in communities

and has two overarching aims:

• to reduce illicit and other harmful drug use and,
• to increase the numbers recovering from their dependence

Across Central and Eastern Cheshire and Western Cheshire drug treatment is commissioned by the DAT. Services are arranged around a four tier model. From April 2009 to March 2010, 561 clients were referred into the structured drug treatment services across Cheshire.

Public Health Outcomes Framework
domains and indicators

Domain 2 Health Improvement
i.34 Successful completion of drug treatment
i.35 People entering prison with substance dependence issues who are previously not known to community treatment
i.37 Alcohol related admissions to hospital

What works

The Marmot Review2 highlights the links between drug experimentation in childhood and problematic drug use thereafter. Interventions need to support young people out of experimentation, to prevent them from becoming addicted as they move into adulthood. Models of care for the treatment of adult drug misusers are available nationally.

Local action

The priorities for the Cheshire DAT have included:

• involvement in integrated offender management
• engagement with Think Family and Safeguarding agendas to ensure “all drug misusing parents with treatment needs have ready access to treatment”
• development of “recovery communities”
• robust information management to be able to report on effectiveness to the partners to inform future planning
• review of treatment services including current contracts and performance

Recommendations
(see generic recommendations at end of chapter)

• an agreed approach across the health economy as to the future model of delivery for drug treatment services taking into account the Governments new national strategy and next steps
• greater emphasis on services for young people at an early stage of drug use experimentation to prevent them moving onto addictive behaviours
• enhance governance arrangements within treatment systems to ensure collective improvements in practice
Sexual health

The first ever holistic strategy for sexual health, ‘Better prevention, better services, better sexual health - The national strategy for sexual health and HIV’ was published in July 2001 and ended in 2011.

Consideration is already being given to what further action will be needed to continue to make improvements to sexual health services and to address the strong association between sexually transmitted infections (STIs), teenage pregnancies, abortions and social deprivation. Joint strategic planning and collaborative action to provide improved sexual health services will start to address this health inequality.

From April 2013, local authorities will take on the responsibility for commissioning comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention). These services have been mandated, in recognition of their importance to protecting health.

A new set of indicators relevant to sexual health have been published in the Public Health Outcomes Framework. The indicator related to under 18 conception rates remains, in recognition of the close links to health inequalities.

Sexual ill health is not an issue across the whole population of Central and Eastern Cheshire, however tackling sexual ill health and improving sexual health services continue to be priorities in Central and Eastern Cheshire with rising levels of Chlamydia and sexually transmitted diseases, high numbers of teenage terminations and a failure to meet the 2010/11 teenage pregnancy target. Three areas of Central and Eastern Cheshire have a higher under 18 conception rate than the area average - West Coppenhall and Grosvenor MSOA and St Barnabus MSOA in Crewe and West Winsford MSOA.

Local action

To date, the PCT has led the strategic direction of the Central and Eastern Cheshire Sexual Health Strategy 2008 - 2011 and engaged a range of stakeholders and key partners who have been essential to the successful development of services and are key contributors to its implementation.

Following the advice and support provided from the National Support Team, significant progress has been made, developing partnership arrangements, robust leadership and governance structures. Valued clinical support and governance is provided from lead clinicians linking into, and influencing strategic planning, prioritisation processes and service developments.

Insight into young people’s experience and attitudes towards sexual health provision in Central and Eastern Cheshire has been gained via various engagement methods including a Young People’s Mystery Shopper reviews, Young People’s survey by Connexions, user focus groups and evaluations.

Public Health Outcomes Framework domains and indicators

Domain 1 Improving the wider determinates of health
i.12 Violent crime (including sexual violence)

Domain 2 Health Improvement
i.23 Under 18 conceptions

Domain 3 Health Protection
i.45 Chlamydia diagnosis (15-24 year olds)
i.47 People presenting with HIV at a late stage
One new area of work in Cheshire and Merseyside is that of moving to a tariff for all sexual health services. The London Sexual Health Programme tariff development work sponsored by the Department of Health sexual health team have developed an agreed set of draft currencies and tariff/s for all sexual health services in a non-GUM setting to be paid by PCTs to providers of services. These cover levels 1, 2 and 3 for sexual reproductive health (SRH) and levels 1 and 2 for STI services and integrated STI/SRH care. The programme is currently developing GUM pathways and pricing proposals to cover GUM Clinic STI services.

The intention is for non London Trusts to sense check and validate the work, including the proposed costing models, tariff prices and activity datasets as these are intended to inform future national currencies and subsequent tariffs. The Cheshire and Merseyside Sexual Health Network are looking to this work to help inform and shape future sexual health commissioning models across Cheshire and Merseyside.

The Northwich and Rural North APB has used local funding along with funding from NHS Western Cheshire and a teenage pregnancy grant to develop a smart phone ‘App’. The App provides easy access to all information about local Sexual Health Services including the local condom distribution scheme and contraception information.

Further information:
www.westcheshiretogether.org.uk

Recommendations
(see generic recommendations at end of chapter)

• joint strategic planning using an evidenced based approach which is targeted to specific at risk groups will help inform the future commissioning of sexual health services
• there needs to be close working partnerships between a range of organisations who will be commissioning different but related aspects of sexual health services including clinical commissioning groups, the local authority, the National Commissioning Board (for elements of HIV treatment) and the third sector
• commissioners should be committed to build on work to engage with young people inviting them to be ‘critical friends’ to inform service planning, influence processes and contribute to service developments
• reduction in service inefficiencies and the duplication of provision by the implementation of integrated services
• reduction in unwanted and teenage pregnancies through improved service provision and access to contraception, thus providing reduction in abortion costs and the wider social costs associated with the support of teenage parents
• reduction in prevalence and improved diagnosis of sexually transmitted infections and HIV
Mental health and wellbeing

Mental ill health is a condition that can severely impact the quality of life of those suffering from it and those immediately around them. It may also lead to other forms of deprivation such as unemployment or homelessness.

In February 2011 the Government issued a new strategy on mental health called ‘No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages’. The strategy looks to communities, as well as the state, to promote independence and choice, reflecting the recent vision for adult social care. It sets out how the Government, working with all sectors of the community and taking a life course approach, will:

• improve the mental health and wellbeing of the population and keep people well; and
• improve outcomes for people with mental health problems through high-quality services that are equally accessible to all

Mild to moderate mental health problems such as anxiety, depression and obsessive compulsive disorder (OCD) are very common.

It is estimated that out of a total population of 447,389 in Central and Eastern Cheshire 61,292 people over the age of 20 will have some level of such a disorder in any given week.

Public Health Outcomes Framework domains and indicators

Domain 1 Improving the wider determinates of health
i.6 People with mental illness or disability in settled accommodation
i.7 People in prison who have a mental illness or significant mental illness
i.8 Employment for those with a long term health condition including those with a learning difficulty / disability or mental illness

Domain 2 Health Improvement
i.27 Emotional wellbeing of looked after children
i.42 Self reported wellbeing

Domain 4 Healthcare public health and preventing premature mortality
i.66 Dementia and its impact
Connect with the people around you.
With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

The Five Ways to Wellbeing is a set of evidence-based public mental health messages aimed at improving the mental health and wellbeing of the whole population. They were developed by the New Economics Foundation as the result of a commission by Foresight, the UK government’s futures think-tank, as part of the ‘Foresight Project on Mental Capital and Wellbeing’.

The subsequent report, ‘Five Ways to Wellbeing: The evidence’ presented five key messages from the review, described in a simple and memorable format:
- Be active
- Connect
- Give
- Keep learning
- Take notice

Further information:
www.neweconomics.org
In the North West, the North West Year of Health and Wellbeing in 2011 saw the launch of a decade-long movement to improve wellbeing and help seven million people to feel good and live well. The movement aims to encourage and support individuals, communities and organisations to connect with the five ways to wellbeing described above. CECPCT has endorsed the five ways to wellbeing and supports the commissioning of future services with the five ways incorporated into service specifications and partnership agreements.

For more information:
www.yearofhealthandwellbeing.org.uk

In conjunction with CECPCT, Cheshire West and Chester Council has developed the ‘Five to Strive’ project. This project has resulted in the production of an evidenced based toolkit to assist individuals and local communities to improve their wellbeing.

The Five to Strive toolkit measures changes in individual and community well being or compares one community, or area, to another. Five to Strive also delivers confidence and well being courses and Winsford residents have attended a course.

For more information:
www.westcheshiretogether.org.uk

Central and Eastern Cheshire NHS
Primary Care Trust

CECPCT developed a joint commissioning plan for mental health from 2007-2011 building on the work commissioned by the former Cheshire County Council. The Strategy set out to commission community mental health services at both primary and secondary care level that were fair, personalised, effective and safe and through which service users and carers were “empowered to shape their own lives and the services they receive”. The local strategy has come to an end and will need to be renewed in light of the new cross-Government mental health outcomes strategy. Local authorities will also take on new responsibilities from April 2013 for the commissioning of public mental health services.

Recommendations
(also see generic recommendations at end of chapter)

• consider the key areas of action for mental health as described in the Government’s cross cutting strategy on mental health outcomes and seek to incorporate these into new commissioning and partnership arrangements
• incorporate the five ways to wellbeing into future commissioning arrangements for mental health services
• promote mental health across the life course
• design services around the identified needs of individuals and communities
• involve service users and carers in the design of services across a commissioning pathway and seek regular feedback through reviews and audits to continuously improve and refine service outcomes
• adopt an asset approach to wellbeing, when working with local communities
Generic recommendations to commissioners for all lifestyle areas

1. Joint strategic needs assessment (JSNA)
   • ensure an up to date needs assessment, refreshed annually, is available through the JSNA, for all the lifestyle areas. Of immediate priority is the needs assessment of patterns of drug misuse amongst young people and adults to inform commissioning of services and for partners to input qualitative and quantitative data and intelligence on mental wellbeing into the JSNA

2. Joint health and wellbeing strategy
   • Health and Wellbeing Boards, through their Joint Health and Wellbeing Strategy, to recognise the importance of lifestyle interventions in contributing to achieving the Public Health outcomes:
     • Outcome 1 - Increased healthy life expectancy
     • Outcome 2 - Reduced differences in life expectancy and healthy life expectancy between communities
   and in reducing health and social care costs

3. Brief interventions
   • ensure a wide range of frontline staff across a range of clinical and non clinical settings are trained and supported to deliver identification and brief intervention in a number of lifestyle areas appropriate to their clientele. Commissioners of services on alcohol and sexual health should promote FRANK as part of a brief intervention for young people

4. Strategies and plans
   • all strategies and plans for all lifestyles areas to be refreshed in view of new national guidance and the Public Health Outcomes Framework. All strategies should include the known links between other lifestyle behaviours, for example, the known links between alcohol and sexual health behaviour

5. Service level agreements and service specifications
   • ensure all contracts which include lifestyle services are supported by a detailed service level agreement or specification for each lifestyle service. Cross referencing of services should be included as appropriate, for example, integrated sexual health service specifications in future should include the commissioning of alcohol brief advice. A priority is for the development of a new single specification for sexual health services, incorporating best practice and a new tariff model of pricing

6. Care pathways
   • ensure care pathways are in place and reviewed regularly in all lifestyle services. Pathways should be co-designed by patients, service users or members of communities where care is needed the most, to make it appropriate, evidence based and needs led. Priority areas are drug misuse, sexual health and alcohol services
   • review existing drug misuse pathways of care to maximise the numbers of clients who successfully complete a treatment cycle
   • develop improved patient pathways and quality of service in sexual health in order to increase patient trust, confidence and experience
   • improve the effectiveness and capacity of specialist alcohol treatment services by reviewing care pathways

7. Targeting
   • using data and information in the JSNA ensure all lifestyle services are commissioned to target areas or groups in most need and with the greatest inequality. A priority area for increased targeting of at risk groups is in Chlamydia and other sexually transmitted infections

8. Workplace
   • ensure partnerships include private businesses, working though business organisations such as the Chamber of Commerce, develop health promoting workplace strategies and sign up to the new Public Health Responsibility Deal on workplace health. A key area is in workplace alcohol policies
‘Every Contact Counts’

The NHS Future Forum\textsuperscript{37} was set up by the Coalition Government as a listening exercise with patients, service users and professionals to inform the NHS reforms. The exercise has provided independent advice on a number of issues including the report ‘The NHS’s role in the public’s health’.\textsuperscript{38} The report, issued in January 2012 included a headline message that every healthcare professional, when in consultation with a patient, should ‘make every contact count’.

The message is for every contact with an individual, whatever their specialty or purpose of the contact, to be used to maintain or improve their mental and physical well being where possible. The Forum recommended that the Government should seek to make this part of the NHS Constitution.\textsuperscript{39}

Currently many health professionals are trained in and provide brief interventions in regard to stop smoking. The local Stop Smoking Service provide the training and professionals can refer or signpost for self referral to the Service. The NHS Future Forum would like to see this good practice carried out by all health professionals and in particular target the four main lifestyle risk factors of:

- diet
- physical activity
- alcohol
- tobacco

The importance of brief interventions on mental wellbeing and on sexual health is also recognised and the important links back to physical health and risk taking behaviours - a holistic perspective of health rather than a disease specific approach. A good example of a successful programme which operates across Central and Eastern Cheshire and which incorporates a holistic approach to brief intervention is the Infolink Champions Programme.
InfoLink Champions is a City and Guilds accredited evidence-based training programme to support the development of ‘community’ based ‘health champions’ who can promote self-care by ‘signposting’ people to appropriate health information and support/services thus making every contact with a member of the public a ‘health promoting’ contact.

The InfoLink training has been founded on social marketing principals. In order to support the training, an InfoLink Champions Toolkit and Website (which provides extra support and information to reinforce the training) has also been developed.

InfoLink Champions training includes the delivery of up to five INFO modules:
- introduction to InfoLink Champions
- using the InfoLink website and information prescriptions
- what is health promotion
- delivering a brief intervention
- signposting and making connections

and five LINK modules:
- five ways to wellbeing
- alcohol effects
- cancer awareness
- stopping smoking and going smoke free
- why weight matters

With additional optional LINK modules covering:
- sexual identity
- sexual wellbeing
- finance and living well
- domestic abuse
- falls prevention
- dementia awareness
- next steps (Wellbeing for 50+)

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Project outcomes and evaluation findings

The pilot of InfoLink saw 100 InfoLink Champions trained across 18 different organisations, including Pharmacy staff, Probation Service, Housing Associations, Citizens Advice Bureau, Healthcare Assistants and volunteers.

Between the period November 2010 and July 2011 over 1495 signposting contacts were made to services such as:
- bowel screening
- stop smoking
- sexual health services
- alcohol services
- many lifestyle services such as exercise groups

Future developments include:
- training of a further 500 Champions (via Social Care Allocations Funding)
- working with Cheshire Police to train frontline police staff
- setting up information hubs in Cheshire libraries
- training prisoners within HMP Styal to develop a service for Styal
- working with NHS Northwest to support pharmacy delivery

The InfoLink Champions was also a successful recipient of a 2011 North West Public Health Award.

Further information: www.infolinkcheshire.nhs.uk
Supporting communities to help themselves

In November 2010 Central and Eastern Cheshire Primary Care Trust (CECPCT) and Cheshire East Council hosted a conference ‘Living Well in Cheshire East: a call to action’. The message was that people across Cheshire East have varying health experiences and outcomes but that there is a belief that good health is a right for all and that differences in health outcomes experienced by the local population are unfair and unacceptable.

The conference participants were asked to sign up to take action. An approach which Marmot2 advocated was the asset based approach because:

“Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill”

Further information:
www.cecpct.nhs.uk

Asset based working promotes wellbeing by building social capital, promoting face-to-face community networks, encouraging civic participation and citizen power. High levels of social capital are correlated with positive health outcomes and wellbeing. It provides a source of resilience, a buffer against risks of poor health, through social support which is critical to physical and mental wellbeing, and through the networks that help people find work, or get through economic or other material difficulties.

It is vital to build social capital at a local level to ensure that policies are both owned by those most affected and are shaped by their experiences. In other words, effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

The asset approach is a set of values and principles and a way of thinking about the world. It:

- identifies and makes visible the health enhancing assets in a community
- sees citizens and communities as the co-producers of health and wellbeing, rather than the recipients of services
- promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment
- values what works well in an area
- identifies what has the potential to improve health and wellbeing
- supports individuals health and wellbeing through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources
- empowers communities to control their futures and create tangible resources such as services, funds and buildings

In Cheshire East, the Local Area Partnerships (LAPs), and in Cheshire West and Chester the Area Partnership Boards (APBs), along with Parish and Town Councils offer a good mechanism for creating a movement towards an asset approach. Congleton LAP was one of the first LAP’s to hear about and sign up to the principles of an asset based approach and have started to map out their assets. More investment into supporting this approach is required in the future.
The Localism Act 2011

This piece of legislation which came into effect on 15th November 2011 could offer local communities some extra freedoms to achieve their own ambitions, including new community rights concerning the ownership of local buildings which are considered to be assets, such as a village shop or community centre.

An important measure of the Localism Act is new rights to allow local communities to shape new development by coming together to prepare neighbourhood plans. This means local people could have an influence over where new homes and businesses should go and what they should look like. This measure very much supports an asset based approach, where communities build on the positive aspects of where they live and grow their own solutions to local issues, based on what people feel they need.

Housing and planning are recognised as major contributors to health and wellbeing, so the impacts of this shift to more localised solutions, looking at building on the existing strengths and resources of communities is a way in which the public health movement with its clinical and non clinical partners needs to move to in the future. One example of this could be to work with LAP's on agreeing local targets for improvements (based on the Public Health Outcomes Framework\(^5\) but flipping deficit targets (such as smoking rates) into a more positive indicator such as non smoking rates.

The public health role of NHS commissioners

The Health and Social Care Act requires the NHS Commissioning Board and Clinical Commissioning Groups to include an assessment in their annual reports of what they have done to fulfill their health inequalities duties.

This will help to ensure a high level commitment to tackling health inequalities across all parts of the health and social care system. We are clear about the public health advice to NHS Commissioners, some of which is set out in Government reform updates and factsheets,\(^4\) but we need to reinforce the converse relationship too, the public health role and duties of all NHS commissioners. Currently, there is a reciprocal and, locally, well recognised need for all commissioners in health and care to recognise the contribution they can make to improve public health.

If we take the ideas and principles from The World Health Organisation (WHO) report 2009, ‘Primary Care Putting People First’,\(^4\) the key message is "good care is about people: to give balanced consideration to health and wellbeing as well as to the values and capacities of the population.”

The key word here is population, so for a Clinical Commissioning Group, it is not just about meeting the healthcare needs of all those who make contact with a health professional, it is understanding and appreciating the health and wellbeing needs of the wider population served. The WHO report states that “A passive, response-to-demand approach fails to help a considerable number of people who could benefit from care, including those who delay seeking care. It also lacks the ambition to deal with local determinants of ill health - whether social, environmental or work related". 
One approach which has been used extensively in America, which develops the wider role of primary care, is that of the development of community orientated primary care (COPC). COPC is a systematic approach to healthcare based upon principles of epidemiology, primary care, prevention and health promotion. Three requirements of implementing true COPC are:

- a primary care practice providing accessible, coordinated, continuous and accountable healthcare services
- a defined community (in this context community refers to geographic or social communities; groups that form within the workplace, church or schools, or persons enrolled in a common health plan. Specifically excluded are communities consisting of the active patients on a GP practice)
- a process including the following four steps:
  - defining and describing the community
  - describing community health issues
  - modifying care pathways and health programmes to address high priority needs
  - monitoring the effectiveness of any changes made as a result

The basic principles described in this approach emphasise what is a public health approach to commissioning healthcare. Research is a key component of this approach and could for example use social marketing techniques to better understand the characteristics and preferences of the local community. Some of the learning from an asset based approach can also be brought in here, making use of local intelligence about the existing strengths and resources already available within communities. Co-designing care pathways and programmes with local communities could offer a different set of outcomes to tackling inequalities.

The challenge will be about NHS commissioners having and using the resources to develop their thinking and acting in a public health way. Public health teams in local authorities and in other organisations such as Public Health England will have the expertise that is required to support this part of the healthcare system, which is outlined further in Chapter Three. It will be up to all of us to work together in new ways to secure better outcomes for local people.

Recommendations

- all partners and commissioners to review the recommendations from the NHS Future Forum, in particular to “make every contact count”
- commissioners of health and social care services look to co-design services with communities, using an asset based approach to build on strengths and resources which already exist
- NHS Commissioners embed a public health approach into all that they do and use the wide range of public health resources, skills and capacities to support them in this task

A progress report on the recommendations and actions of the Annual Report of the Director of Public Health 2010 can be found in Appendix Four.
Health services can contribute significantly to improving population health outcomes when available resources are used to deliver needs led effective services. The key mechanism to make this happen is through the commissioning cycle and related processes.

Commissioning is a multidisciplinary activity and the population health gain perspective (a public health function) is integral to this. Locally, public health input to support commissioning is longstanding and predates the current health reforms. A variety of public health inputs are pertinent to the commissioning function, for example assessing population clinical effectiveness and interpretation of health and healthcare data for service planning. These inputs are key to aspects of the commissioning cycle: developing strategic vision, prioritisation processes, planning for specific services, policy development and supporting processes for handling individual funding requests.

Links between Public Health with the three PBC groups within Central and Eastern Cheshire were established to support their commissioning activities and also to support the PBC contribution to the wider health agenda through their role as local leaders of primary care. Each PBC (later CCG) was supported by a ‘Public Health Link’ (a consultant in public health) to the wider Public Health team. This two way link facilitated PBC groups’ contributions to the wider health improvement and health protection efforts, as well as providing population health gain input to their NHS commissioned activities.

During the development of PBC structures the 2009 Annual Report of the Director of Public Health focused on the health of the population within practice and PBC footprints. This showed the variations in outcomes at Middle Super Output Area (MSOA) level and at GP practice level to inform PBC groups in their planning. This healthcare intelligence was instrumental to helping target efforts to improve primary and secondary prevention opportunities.

Following the release of the government’s July 2010 White Paper ‘Equity and Excellence: Liberating the NHS’ PBC groups emerged into consortia structures and then into their present day Clinical Commissioning Group (CCG) structures. Throughout this time the public health link to CCGs has continued to adapt to support the developing needs of CCGs. Increasingly the support has focused on their roles as commissioners of healthcare for their populations.
More recently the Department of Health has published the draft, ‘Guidance to Support the Provision of Healthcare Public Health Advice to Clinical Commissioning Groups’. This clarifies further the direction of travel for public health advice and expertise in relation to healthcare services that CCGs will commission upon their authorisation and the passing of the Health and Social Care Bill.

The Public Health link function has assisted with the development of this journey through several key strategic inputs:

1. **Framework for Commissioning for Health Gain - for transition and beyond**
   This high level framework (Appendix Three) was developed to show the interdependence between commissioning, public health functions and pragmatic decision-making needed to achieve health gain through commissioning. These key relationships remain relevant whatever the future structure of NHS commissioning organisations.

   In practice the framework has proved useful in enabling that public health inputs are in place to help CCGs work towards authorisation. It also provides a foundation for future prioritised work with CCGs, as well as putting day to day aspects of support in context.

2. **CCG Commissioning Intentions processes (2011/12 and 2012/13).**
   In developing the future commissioning intentions for Clinical Commissioning Groups, public health input was instrumental to developing a strategic vision for health as part of CCGs’ strategic goals and the commissioning processes.

3. **Prioritisation processes development.**
   Strategy developed to support the Eastern Cheshire Clinical Commissioning Board with this important governance process. It was launched via a principles, prioritisation tool and processes workshop. It has been used in current commissioning cycle round. The key benefit of having a structured approach is that health gain can be consistently considered as a factor in decision-making.

4. **Support to policy making/review**
   Inputs to prior approval policy, quality schedules, proposals for redesign.

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**Where are we now?... and the future**

It is important to build on the strong foundations outlined above and to continue to ensure there are effective systems and relationships in place for Public Health support to NHS commissioning across Central and Eastern Cheshire, in order to secure health gain through NHS commissioning locally.

Whatever the configuration of this support it is the intention of the Public Health team within Central and Eastern Cheshire to:

- support CCGs towards authorisation by providing a population health gain perspective to strategic and tactical aspects of commissioning including prioritisation; specific inputs to CCG priority areas; advocating primary care contributions to public health outcomes, facilitating effective use and development of the Joint Strategic Needs Assessment (JSNA)
- support CCGs in reviewing priority programme budgeting areas. To report as part of the annual commissioning round process to inform future commissioning
- find the most effective ways to continue to provide Public Health input to CCGs with given resources taking into account the needs of the CCGs and other commissioning organisations
- identify NHS and Public Health outcome crossover priority areas. Ensure these are priority areas for the CCG
- clarify which aspects of primary care function can contribute most effectively to improving Public Health and NHS outcomes in priority areas. Clarify the role of the CCG as local leaders of primary care with respect to those
- continue to support CCGs after authorisation to improve health and reduce variations in health outcomes
Building on the foundations of the last two years in this arena, healthcare public health is committed to supporting the new commissioning landscape to commission for health gain. Outlined below are four examples with recommendations where health gain can be achieved: excess winter deaths, children with long term conditions, children in hospital and premature deaths from cardiovascular disease.

Excess winter deaths

Changes in the seasons have important effects on our health, partly mediated through temperature and radiation, but also linked to other influences including diet, infections and allergens.

As part of the South Cheshire Clinical Commissioning Group’s Protected Learning session in October 2011, the Public Health team provided an up-to-date review of the evidence about seasonality and health to over 120 of their clinicians.

Winter has an important influence on people’s risk of illness and death. Cold weather makes the blood thicken, and this can lead to a thrombosis (blood clot) which causes death from heart attack or stroke. Cold weather also lowers people’s resistance to chest infections, particularly influenza. Excess winter deaths are also strongly related to the spread of influenza in winter, and so it is not possible to fully reduce winter mortality by the provision of heating initiatives alone.

In the Cheshire East Council area alone there are around 221 excess deaths each winter, which represents an additional 19.7% risk of dying at this time of the year. The comparable figure for England is 17.6%, so Cheshire East experiences 12% more winter deaths than nationally. There are around 63 deaths each year in the two Area Partnership Boards covered by the Vale Royal Clinical Commissioning Group, but the risk of excess winter deaths in these two APB areas is lower than nationally.

Local Authority level data is published annually as part of the Local Authority Health Profiles. From these analyses, we know that winter mortality increases with age. In Cheshire East it is 26% higher amongst people over the age of 85 compared to 17.2% for those aged 65 to 84 and 9.8% for those aged under 65. The risk is also higher for people with certain chronic health conditions, for example it is 55.9% higher locally for respiratory disease and 22.3% higher for cardiovascular disease. Table Two shows that there are some geographical variations within the Local Area Partnerships (LAPs) of Cheshire East Council, but these are not statistically significant. Excess winter deaths represent an important threat to all communities.

Most excess winter deaths happen in people who are in reasonable health and who would not otherwise have died at that time. Their risk of death can be reduced by increasing the uptake of influenza vaccinations, by carefully targeting the provision of energy efficient housing, and by developing fuel poverty referral mechanisms in conjunction with the CCGs for those people who are clinically at greatest risk.

Seasonal flu vaccination takes place each year from October to January. This vaccination programme forms one of the largest co-ordinated prevention activities in this PCT, with 100,727 flu jabs given in this PCT in 2011/12. This included 70,955 jabs to people aged 65 and over, 44,880 to people in clinical risk groups, 1,856 jabs to pregnant women, and 1,638 to carers. Table Three shows that vaccine uptake is good in all areas except Wilmslow and Crewe.

Local general practices provide a very effective flu vaccination service, and there is excellent support from community pharmacists and maternity services. At the end of the 2011/12 seasonal flu vaccination programme, Central and Eastern Cheshire PCT had the fourth highest uptake of all the 151 Primary Care Trusts in England for people aged 65 years and over, the fifth highest for the clinical risk groups, and the ninth highest for pregnant women.

The Public Health Team gave presentations to the Eastern Cheshire Clinical Commissioning Group Winter Planning meeting in September 2011 and also at the South Cheshire and Vale Royal Winter Pressures Workshop later that month. We are extending the use of preventive opportunities within primary care seasonal planning, and also the development of new approaches to managing winter illnesses and emergency winter pressures. All three Commissioning Groups are aware of the need to target winter initiatives to those patients who are clinically at greatest risk.
Recommendations

- CCGs working with Public Health should look at further ways of increasing the uptake of influenza vaccinations, particularly in Wilmslow and Crewe
- further work needs to be undertaken to carefully target the provision of energy efficient housing
- further work needs to be undertaken to develop fuel poverty referral mechanisms in conjunction with the CCGs for those people who are clinically at greatest risk

Table Two: Average excess winter deaths each year in the six years from 2004/05 to 2009/10

<table>
<thead>
<tr>
<th></th>
<th>Annual excess winter deaths</th>
<th>Excess risk of winter death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congleton LAP</td>
<td>48</td>
<td>17.4%</td>
</tr>
<tr>
<td>Crewe LAP</td>
<td>44</td>
<td>17.8%</td>
</tr>
<tr>
<td>Knutsford LAP</td>
<td>16</td>
<td>19.1%</td>
</tr>
<tr>
<td>Macclesfield LAP</td>
<td>40</td>
<td>19.7%</td>
</tr>
<tr>
<td>Nantwich LAP</td>
<td>28</td>
<td>24.3%</td>
</tr>
<tr>
<td>Poynton LAP</td>
<td>18</td>
<td>21.5%</td>
</tr>
<tr>
<td>Wilmslow LAP</td>
<td>27</td>
<td>24.1%</td>
</tr>
<tr>
<td>Cheshire East</td>
<td>221</td>
<td>19.7%</td>
</tr>
<tr>
<td>Northwich and Rural North APB</td>
<td>33</td>
<td>16.0%</td>
</tr>
<tr>
<td>Winsford and Rural East APB</td>
<td>30</td>
<td>16.9%</td>
</tr>
<tr>
<td>England</td>
<td>221</td>
<td>17.6%</td>
</tr>
</tbody>
</table>

Source: CECPCT analysis of Death Registrations using the Public Health Mortality File

Table Three: Seasonal influenza vaccine uptake in 2011/12

<table>
<thead>
<tr>
<th></th>
<th>People aged 65 and over</th>
<th>Clinical risk groups</th>
<th>Pregnant women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congleton LAP</td>
<td>80.5%</td>
<td>59.6%</td>
<td>43.0%</td>
</tr>
<tr>
<td>Crewe LAP</td>
<td>77.6%</td>
<td>56.8%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Knutsford LAP</td>
<td>79.3%</td>
<td>57.4%</td>
<td>40.8%</td>
</tr>
<tr>
<td>Macclesfield LAP</td>
<td>80.1%</td>
<td>60.2%</td>
<td>41.1%</td>
</tr>
<tr>
<td>Nantwich LAP</td>
<td>79.2%</td>
<td>59.5%</td>
<td>41.5%</td>
</tr>
<tr>
<td>Poynton LAP</td>
<td>81.7%</td>
<td>61.1%</td>
<td>34.1%</td>
</tr>
<tr>
<td>Wilmslow LAP</td>
<td>77.6%</td>
<td>51.0%</td>
<td>34.7%</td>
</tr>
<tr>
<td>Cheshire East</td>
<td>79.4%</td>
<td>58.1%</td>
<td>39.4%</td>
</tr>
<tr>
<td>Northwich and Rural North APB</td>
<td>79.2%</td>
<td>60.0%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Winsford and Rural East APB</td>
<td>79.3%</td>
<td>60.4%</td>
<td>39.0%</td>
</tr>
<tr>
<td>CECPCT</td>
<td>79.4%</td>
<td>58.6%</td>
<td>40.8%</td>
</tr>
<tr>
<td>England</td>
<td>74.0%</td>
<td>51.6%</td>
<td>27.4%</td>
</tr>
</tbody>
</table>

Source: CECPCT analysis of influenza vaccine uptake at GP practice level, and the Department of Health
**Children with long-term conditions**

In this PCT there are around 4,600 children with one or more of the long-term health conditions outlined in Table Four. The three CCGs commission a range of health services for these children as well as for children with other long-term conditions including learning disability, mental health problems, physical disabilities, and sensory disabilities including hearing and vision loss.

Most children with heart disease or neurological disease are recognised prenatally or shortly after birth. Around 10-15 babies are newly diagnosed with neurological disease each year, and 40-50 with heart disease. Many of these babies require highly specialised diagnostics in tertiary centres, and the CCGs need to ensure that their care pathways are robust.

The CCGs should also ensure that plans are in place to deliver coordinated and effective packages of support according to the individual needs of the child. This is particularly important at key transition stages such as discharge from hospital to community care, starting school and then the transition into adult services.

Chronic respiratory disease is becoming increasingly common among children and young people. The origins of most chronic respiratory disease in childhood are caused by repeated exposure to environmental factors including cigarette smoke and recurrent respiratory infections.

The CCGs should work with the Councils to improve the environmental conditions of children who are at risk of respiratory disease, with the aim of reducing the overall number of children that develop chronic respiratory disease. There is also a need to update and improve the primary care clinical pathways for children with chronic respiratory disease, with the aim of managing most of these children in general practice rather than in hospital settings.

**Recommendations**

- CCGs should ensure that plans are in place to deliver coordinated and effective packages of support according to the individual needs of the child
- CCGs should work with others to improve the environmental conditions of children who are at risk of respiratory disease, with the aim of reducing the overall number of children that develop chronic respiratory disease
- CCGs should look to update and improve the primary care clinical pathways for children with chronic respiratory disease, with the aim of managing most of these children in general practice rather than in hospital settings

### Table Four: Children with selected long-term conditions, as at January 2012, ages 6 months to under 16 years

<table>
<thead>
<tr>
<th>Condition</th>
<th>Eastern Cheshire CCG</th>
<th>South Cheshire CCG</th>
<th>Vale Royal CCG</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic heart disease</td>
<td>282</td>
<td>312</td>
<td>198</td>
<td>792</td>
</tr>
<tr>
<td>Chronic respiratory disease</td>
<td>1,362</td>
<td>1,124</td>
<td>813</td>
<td>3,299</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>9</td>
<td>5</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>Chronic liver disease</td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Diabetes</td>
<td>72</td>
<td>49</td>
<td>43</td>
<td>164</td>
</tr>
<tr>
<td>Immunosuppression</td>
<td>32</td>
<td>26</td>
<td>20</td>
<td>78</td>
</tr>
<tr>
<td>Chronic neurological disease</td>
<td>107</td>
<td>128</td>
<td>80</td>
<td>315</td>
</tr>
</tbody>
</table>

Source: ImmForm Vaccination Monitoring System
Children in hospital

In Cheshire and Eastern Cheshire PCT there were 9,872 emergency hospital admissions by children and young people aged 0 to 19 during 2010/11. This is equivalent to over 9% of all the children living in the area, and is a major burden for families.

About a quarter of these emergency admissions occur in the first year of life, which is a time when the child lives in a highly passive environment and is totally dependent on the abilities of its parents. A further quarter of emergency admissions occur between the ages of one and three. It is during these first few years of life that we begin to see the health impacts of poor environments starting to affect the future lives of these children.

The Public Health team gave a presentation to the Vale Royal CCG priority setting event for children and young people in November 2011, involving partner agencies from health, local Councils and the voluntary sector.

Figure One: Vale Royal CCG children and young people aged 0 - 19 years emergency admissions to hospital 2010/11

In this CCG area there are high rates of childhood admissions in parts of Winsford and Northwich, which is partly influenced by high numbers of accident and emergency attendances from Northwich. This is illustrated in Figure One.

In the Cheshire East Council area, a fifth of all children and young people live in communities where the risk of being admitted to hospital as an emergency is 65% higher than for the Council as a whole. Many of these communities have high levels of child poverty and deprivation. Another fifth of children have a quite different experience, as they live in communities where the risk of being admitted is 53% lower than the Cheshire East average. Taken together, these represent an unacceptable level of variation which needs to be addressed through Council-led public health initiatives in partnership with the Eastern Cheshire and South Cheshire Clinical Commissioning Groups.

Source: CECPCT Information Team using hospital admission datasets
The geographical variation between high and low risk communities is illustrated in Figure Two, which also shows the boundaries of the local Children’s Centres. Table Five provides further data indicating Cheshire East children and young people aged 0 - 19 years emergency admissions to hospital 2010/11.

### Table Five: Cheshire East children and young people aged 0 - 19 years emergency admissions to hospital 2010/11

<table>
<thead>
<tr>
<th>Emergency admissions</th>
<th>Population age 0-19</th>
<th>% admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dark green</td>
<td>727</td>
<td>16,600</td>
</tr>
<tr>
<td>Medium green</td>
<td>1,220</td>
<td>17,200</td>
</tr>
<tr>
<td>Light green</td>
<td>1,471</td>
<td>16,600</td>
</tr>
<tr>
<td>Orange</td>
<td>1,726</td>
<td>15,900</td>
</tr>
<tr>
<td>Red</td>
<td>2,582</td>
<td>16,900</td>
</tr>
<tr>
<td>Cheshire East</td>
<td>7,726</td>
<td>83,200</td>
</tr>
</tbody>
</table>

Source: CECPCT Information Team using hospital admission datasets

![Figure Two: Cheshire East children and young people aged 0 - 19 years emergency admissions to hospital 2010/11](image_url)
Tobacco smoke causes respiratory disease. Children who breathe cigarette smoke have an increased risk of acute and long-term chest problems. Areas with high adult smoking rates are also those that have the highest rates of children being admitted with respiratory problems. Alongside the increasing burden of chronic respiratory disease in children, this makes tobacco control a priority for improving child health. We need to be able to track changes in adult smoking rates in local communities, and particularly those areas that are shaded on the map in orange or red.

A local example of good practice is that the South Cheshire Clinical Commissioning Group is planning to arrange for its primary care clinicians to be able to access the National Centre for Smoking Cessation and Training on-line training module for Very Brief Advice on Smoking in order to ensure that all smokers are fully aware of the health issues and know how to access stop smoking support.

Rotavirus is a very common gastrointestinal infection that mainly affects very young children. It produces diarrhoea that can be severe enough to cause dehydration and hospital admission. Outbreaks can easily occur in nurseries and other day care settings, although high levels of cleanliness and good toilet/nappy-changing hygiene can significantly reduce the risk of transmission in the home and in care settings. Breastfeeding also reduces the severity of the illness.

Other emergency admissions may occur because of insufficient parental understanding and lack of confidence to manage minor illnesses. A consistent finding across all the three CCGs is that the main reasons for admission are as follows:

During the first few years of life
- upper respiratory infections
- minor viral infections and fever
- gastroenteritis
- minor neonatal diagnoses
- lower respiratory infections

In older children and into the teenage years:
- asthma
- abdominal pain (and constipation)
- injuries (particularly head injury and limb fractures)
- tonsillitis
- upper respiratory infections

**Recommendations**

- CCGs working in partnership with others should aim to regularly measure changes in adult smoking rates in small areas
- CCGs should actively promote long-term breastfeeding, with the aim of reducing the number of severe gastrointestinal infections that are caused by rotavirus infection in very young children. This will have an impact on reducing the number of emergency hospital admissions
- CCGs should also ensure that all GPs have accessed the UNICEF GP breastfeeding training module (part of the Baby Friendly Stage 2 Accreditation) and remain up to date by working with local Community Infant Feeding Coordinator
- CCGs to ensure appropriate use of acute paediatric services and reduce numbers of inappropriate A&E attendances and admissions of children and young people
Premature deaths from cardiovascular disease

Cardiovascular disease (CVD) refers to problems of the circulatory system (heart and blood vessels). It includes coronary heart disease, stroke, transient ischaemic attacks and peripheral arterial disease.

CVD occurs when arteries become narrowed or blocked by fatty deposits and vessel damage (atherosclerosis and thrombosis). These conditions are also linked to conditions such as heart failure, chronic kidney disease and dementia.

There has been significant national progress in the reduction of CVD mortality rates in recent years; however CVD remains a major cause of premature death nationally and locally. Figure Three identifies that a quarter of all premature deaths in the Central and Eastern Cheshire area are caused by CVD/circulatory disease.

Figure Four identifies the variation in mortality caused by CVD/Circulatory Disease across the Central and Eastern Cheshire area. As CVD is the most important contributor to the inequalities in life expectancy between different parts of Central and Eastern Cheshire, tackling CVD continues to remain a priority.

Major modifiable risk factors for CVD are smoking, diet and physical inactivity. Excess alcohol also contributes to the risk. The risk of CVD is much greater in those with diabetes, hypertension or those who are overweight or obese. Effective primary preventive strategies are common to the range of vascular disorders, and many are also pertinent to prevention of the common cancers.

Figure Three: Main causes of premature death in Central and Eastern Cheshire, 2008-10

Figure Four: Mortality from circulatory disease, persons under 75, across Central and Eastern Cheshire, 2007-09

<table>
<thead>
<tr>
<th>Cause</th>
<th>Mortality Rate DSR per 100,000</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cancers</td>
<td>103.6 - 165.1</td>
<td>42%</td>
</tr>
<tr>
<td>Circulatory</td>
<td>71.0 - 103.5</td>
<td>25%</td>
</tr>
<tr>
<td>All Respiratory Diseases</td>
<td>57.1 - 71.7</td>
<td>10%</td>
</tr>
<tr>
<td>All Digestive Diseases</td>
<td>45.3 - 56.1</td>
<td>7%</td>
</tr>
<tr>
<td>All External Causes</td>
<td>&lt; 45.3</td>
<td>5%</td>
</tr>
<tr>
<td>All Infectious and Parasitic</td>
<td>1 - 10</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>10 - 19</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Public Health Mortality File
Population And Individual Level Efforts To Reduce Premature Mortality

A mixture of population and individual level approaches are needed to reduce risk factors for cardiovascular disease. Some actions are more appropriately commissioned and delivered at a wider national or regional footprint, whilst others are better considered locally (either through single or multiagency efforts). This will depend on the particular intervention, objectives and the evidence base of effectiveness.

Universal population based interventions aim to change the risks in the social, economic and environmental factors that affect an entire population (for example, achieved through legislation, subsidy, taxation and layout of physical spaces).

There is evidence that even small reductions in population prevalence of major risk factors can be effective in preventing more cases than focusing on a smaller number at high risk alone (Rose hypothesis\(^4^4\)). Indeed, epidemiological analyses indicate that reductions in premature mortality from cardiovascular disease in recent decades has mainly been associated with modest changes in population diet, smoking and blood pressure.\(^{4^5,4^6}\)

To complement these approaches, individual level activities may include primary prevention of risk factors and/or treatment options. The Health Inequalities National Support Team (HINST) data section in this chapter provides further insight into effective options to address these aspects.

What have recent reductions in CVD premature mortality been due to?

Latest evidence continues to support the complementary approach described above. A recent study of acute myocardial infarctions (MI) in England between 2002 and 2010 indicates that the decline in acute MI mortality comprised of a reduction in events, and an improvement in survival at 30 days. Just over half of the fall in deaths from acute MI during the decade was related to prevention of acute MI events, and just under half of the fall was associated with acute medical treatment of heart attacks.\(^4^7\) The longer term impact of the higher prevalence of population obesity compared to earlier decades is not yet known.

Recommendations

- local commissioners and service providers (in primary care, hospitals, community and others) need to work within this wider socio-economic context and consider how best to commission and/or directly deliver effective primary and secondary prevention

CVD indicators

For ease of reference a summary list of CVD indicators is shown in Table Six.
How much is spent on cardiovascular disease?

Programme budgeting data is nationally collated and shows spending by PCT for 23 programme categories. ‘Problems of circulation’ is described within this (budget programme 10). Unfortunately, at the present time, programme budgeting data are not yet available by CCG footprint, although the overall messages may still be useful.

‘Diseases of Circulation’, (budget programme area 10) is the highest spend area of the 23 categories.

This amounted to over £58 million in 2009/10 for the CECPCT population. (N.B. This does not include wider preventive activities or GMS/PMS, though it does include prescribing).

However, current PCT spend per 100,000 population on circulatory disease is less than its ONS peer cluster average though slightly more than England average, as shown in Table Seven.

Table Seven: Disease of circulation spend (£) per 100,000 weighted population 2009/10

<table>
<thead>
<tr>
<th>CECPCET (€millions/100,00)</th>
<th>ONS Cluster* average</th>
<th>Strategic Health Authority</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.9</td>
<td>14.4</td>
<td>14.7</td>
<td>13.8</td>
</tr>
</tbody>
</table>

Source: Spend and Outcome Tool (SPOT) data, DoH website, viewed 15.03.2011

Table Six: Summary list of cardiovascular disease indicators and values

<table>
<thead>
<tr>
<th>Note</th>
<th>Indicator</th>
<th>PCT value</th>
<th>England average</th>
<th>England best</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CVD mortality (under 75)</td>
<td>66.4</td>
<td>70.4</td>
<td>46.3</td>
</tr>
<tr>
<td>2</td>
<td>Change in CVD mortality (%)</td>
<td>50.4</td>
<td>50.1</td>
<td>59.9</td>
</tr>
<tr>
<td>3</td>
<td>AMI mortality (under 75)</td>
<td>15.6</td>
<td>16.3</td>
<td>6.6</td>
</tr>
<tr>
<td>4</td>
<td>Stroke mortality (under 75)</td>
<td>13.7</td>
<td>12.8</td>
<td>7.8</td>
</tr>
<tr>
<td>5</td>
<td>Estimated % smokers (16+)</td>
<td>17.6</td>
<td>22.2</td>
<td>12.0</td>
</tr>
<tr>
<td>6</td>
<td>4 week quitters per smokers</td>
<td>4.6</td>
<td>4.0</td>
<td>7.5</td>
</tr>
<tr>
<td>7</td>
<td>Estimated % obese (16+)</td>
<td>21.8</td>
<td>24.2</td>
<td>13.2</td>
</tr>
<tr>
<td>8</td>
<td>Obs/Exp CHD prevalence</td>
<td>0.66</td>
<td>0.61</td>
<td>0.84</td>
</tr>
<tr>
<td>9</td>
<td>Obs/Exp Hypertension</td>
<td>0.45</td>
<td>0.44</td>
<td>0.52</td>
</tr>
<tr>
<td>10</td>
<td>CHD emergency admissions</td>
<td>201.2</td>
<td>205.3</td>
<td>125.1</td>
</tr>
<tr>
<td>11</td>
<td>Primary angioplasty call median time</td>
<td>108.0</td>
<td>112.0</td>
<td>-</td>
</tr>
<tr>
<td>12</td>
<td>Stroke emergency admissions</td>
<td>86.0</td>
<td>104.2</td>
<td>67.1</td>
</tr>
<tr>
<td>13</td>
<td>Stroke patients discharged home (%)</td>
<td>77.5</td>
<td>78.5</td>
<td>97.5</td>
</tr>
<tr>
<td>14</td>
<td>% Smokers*</td>
<td>17.6</td>
<td>22.2</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>% Binge drinking*</td>
<td>22.0</td>
<td>20.1</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>% Adult obesity*</td>
<td>21.8</td>
<td>24.2</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>% Consuming less than 5 portions of fruit / vegetables per day*</td>
<td>68.5</td>
<td>71.3</td>
<td></td>
</tr>
</tbody>
</table>

Source: SEPHO data version 1.1, 2011, table compiled by PH Department, CECPCT.

Spending has decreased recently as a percentage of overall PCT budget. CVD spend decreased from 10.9% to 8.3% of PCT spend over 2006-10. The peer cluster average was 8.7% in 2009/10. PCT Clusters are Office of National Statistics (ONS) groupings according to key characteristics common to the populations in that grouping. These groupings, known as clusters, are based on census data.

CVD expenditure vs outcomes

- spend and outcomes data (SPOT data) from the Department of Health indicates that CECPCT spends less and achieves worse outcomes compared to the ONS peer average as shown in Figure Six. This suggests that opportunities for optimising cost-effectiveness probably lie within care pathways rather in reducing the overall budget.
Table Nine: Central and Eastern Cheshire Primary Care Trust % total spend on circulatory disease, 2010/11

<table>
<thead>
<tr>
<th>Category</th>
<th>% of total spend on circulatory disease (2010/11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention and health promotion*</td>
<td>0.2</td>
</tr>
<tr>
<td>Primary care (includes primary care prescribing mainly, GMS PMS not included)</td>
<td>26.3</td>
</tr>
<tr>
<td>Secondary care (includes inpatient non-elective, inpatient elective and day cases, outpatients, other)</td>
<td>60.8</td>
</tr>
<tr>
<td>Urgent care (Ambulance and A&amp;E**)</td>
<td>2.4</td>
</tr>
<tr>
<td>Community care</td>
<td>4.0</td>
</tr>
<tr>
<td>Health and social care in other setting</td>
<td>-</td>
</tr>
<tr>
<td>Non health/social care</td>
<td>2.8</td>
</tr>
</tbody>
</table>


Notes: * Comprises immunisation and screening. **A&E component is derived from apportioning the total A&E expenditure across the 23 programme budget categories.
One of the outcomes used to calculate this is premature mortality from circulatory diseases for which the CECPCT outcome appears worse than its ONS peer average but which is slightly better than national average as shown in Table Eight. Higher rates indicate worse premature mortality.

### Table Eight: Directly standardised mortality rates for Circulatory disease

<table>
<thead>
<tr>
<th>DSR per 100,000 population</th>
<th>CECPCT</th>
<th>Cluster average</th>
<th>SHA average</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67</td>
<td>59</td>
<td>86</td>
<td>70</td>
</tr>
</tbody>
</table>

Source: Spend and Outcome Tool (SPOT) data, DoH website, viewed 15.03.2011

The overall programme budgeting data estimates in Table Nine show that the bulk of healthcare spending for circulatory conditions is related to the secondary care setting.

**Effective interventions to reduce premature mortality in the short to intermediate term:**

1. **Health Inequalities National Support Team data**
   
   The Health Inequalities National Support Team have described effective interventions to help reduce premature deaths in the short to medium term (thereby reducing health inequalities).

   Many of these effective interventions are related to cardiovascular disease. Some of these are ‘upstream’ primary preventive measures and some are ‘downstream’ treatment. All are individual level interventions. They are directly relevant for health service commissioners to consider.

   Using national prevalence estimates, Tables Ten, Eleven and Twelve show potential gains by individual CCG footprint for a range of effective interventions. Estimates are based on optimal levels, in practice commissioners may need to set improvement targets at pragmatic levels.

2. **Numbers Needed to Treat**
   
   The ‘Numbers Needed to Treat’ (NNT) is given within the following tables. The NNT is an indication of how many people need to be treated to postpone one death. Interventions with lower NNT numbers are more efficient at achieving greater population life expectancy gain for the same number treated than interventions with higher NNTs.

   Examples of lower NNTs are secondary prevention of CVD, anti-coagulant therapy for patients over 65 with AF, CVD risk in patients with COPD. Some interventions with higher NNT value can also lead to relatively significant life expectancy gain for the population because they prevent very early deaths, for example, eliminating smoking in pregnancy.

### Recommendations

- any investment should aim to improve effectiveness and efficiency through an evidence based approach. Consider HINST options when considering the local approach to addressing NHS and Public Health outcomes. Estimate costs of supporting some of the ‘HINST’ interventions
- the local commissioning challenge is to strike a balance between increased levels of different effective interventions (preventive and treatment), thus securing optimum health gain from limited resources. To achieve this, commissioners, providers including clinicians and patients need to work together to make difficult choices about how funding should be used
- for a coherent system wide approach to CVD, each CCG and other commissioning organisations to consider what their roles are:
  - as a Commissioner,
  - as a Professional link to delivery of primary care services which contribute to the wider health agenda,
  - in co-ordination with others where appropriate
  - as an advocate of issues to be tackled (i.e. in support of other organisations which have the duty to commission)
Table Ten: Numbers needed to treat and potential gains for Eastern Cheshire Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Assumed treatment coverage of eligible population (%)</th>
<th>Intervention</th>
<th>Potential postponed deaths in one year (based on 2006-08 data)</th>
<th>Estimated population eligible for treatment</th>
<th>Number Needed to Treat (NNT) to postpone one death</th>
<th>Life expectancy gain (for CCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Persons</td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td></td>
<td>Ratio</td>
<td>Ratio</td>
<td>Ratio</td>
<td>Ratio</td>
<td>Ratio</td>
</tr>
<tr>
<td>Cardiovascular disease: Secondary prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four treatments (beta blocker, aspirin, ACE inhibitor, statin) for all patients with previous CVD event</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently untreated</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD deaths averted</td>
<td>8</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Stroke deaths averted</td>
<td>0.06</td>
<td>0.04</td>
<td>0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently partially treated</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD deaths averted</td>
<td>9</td>
<td>5</td>
<td>15</td>
<td>15</td>
<td>24</td>
</tr>
<tr>
<td>Stroke deaths averted</td>
<td>0.13</td>
<td>0.06</td>
<td>0.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional treatment for hypertensives with no previous CVD event</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional hypertensive therapy</td>
<td>21</td>
<td>10</td>
<td>30</td>
<td>30</td>
<td>51</td>
</tr>
<tr>
<td>Statin treatment for hypertensives with high CVD risk</td>
<td>0.34</td>
<td>0.16</td>
<td>0.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment for heart attack</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary angioplasty (PCI) for heart attack</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>307</td>
</tr>
<tr>
<td>Anticoagulant therapy (Warfarin) for all patients over 65 with a trail fibrillation</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke deaths averted</td>
<td>6</td>
<td>13</td>
<td>20</td>
<td>6</td>
<td>391</td>
</tr>
<tr>
<td>Diabetes</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing blood sugars (HbA1c) over 7.5 by one unit</td>
<td>9</td>
<td>3</td>
<td>12</td>
<td>9</td>
<td>2,229</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment with inhaled corticosteroids for eligible patients Statins to address CVD risk among COPD patients</td>
<td>40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>12</td>
<td>33</td>
<td>927</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td>Reducing smoking in pregnancy</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eliminating smoking in pregnancy (infant deaths averted)</td>
<td>0.2</td>
<td>0.3</td>
<td>0.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Harmful alcohol consumption</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief intervention for 10% of harmful drinkers</td>
<td>0.9</td>
<td>0.4</td>
<td>1.2</td>
<td>343</td>
<td>216</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing rates of early presentation</td>
<td>1.0</td>
<td>0.8</td>
<td>1.9</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Smoking cessation clinics (setting a quit date)</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results shows deaths postponed in short term (1-2 years)**</td>
<td>0.7</td>
<td>0.7</td>
<td>1.4</td>
<td>856</td>
<td>933</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>123</td>
<td>222</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: HINST, Modelling Mortality Reductions, v6.1, December 2010

Note: Totals may not sum due to rounding
* Eligible population and NNT figures will be provide in a later version of this model after further consideration of the evidence.
** Reductions in smoking rates would result in a much greater number of postponed deaths over a longer time period.
**Table Eleven: Numbers needed to treat and potential gains for South Cheshire Health Clinical Commissioning Group**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Assumed treatment coverage of eligible population (%)</th>
<th>Potential postponed deaths in one year (based on 2006-08 data)</th>
<th>Estimated population eligible for treatment</th>
<th>Number Needed to Treat (NNT) to postpone one death</th>
<th>Life expectancy gain (for CCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Persons</td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td><strong>Cardiovascular disease: Secondary prevention</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four treatments (beta blocker, aspirin, ACE inhibitor, statin) for all patients with previous CVD event</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Currently untreated</strong></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD deaths averted</td>
<td>7</td>
<td>3</td>
<td>14</td>
<td>743</td>
<td>732</td>
</tr>
<tr>
<td>Stroke deaths averted</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Currently partially treated</strong></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD deaths averted</td>
<td>8</td>
<td>4</td>
<td>22</td>
<td>5,648</td>
<td>3,922</td>
</tr>
<tr>
<td>Stroke deaths averted</td>
<td>4</td>
<td>12</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional treatment for hypertensives with no previous CVD event</strong></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional hypertensive therapy</td>
<td>19</td>
<td>9</td>
<td>25</td>
<td>14,298</td>
<td>33,168</td>
</tr>
<tr>
<td>Statin treatment for hypertensives with high CVD risk</td>
<td>9</td>
<td>25</td>
<td>11</td>
<td>18,870</td>
<td>14,298</td>
</tr>
<tr>
<td><strong>Treatment for heart attack</strong></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary angioplasty (PCI) for heart attack</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>279</td>
<td>107</td>
</tr>
<tr>
<td><strong>Anticoagulant therapy (Warfarin) for all patients over 65 with a trail fibrillation</strong></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke deaths averted</td>
<td>4</td>
<td>9</td>
<td>13</td>
<td>314</td>
<td>274</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing blood sugars (HbA1c) over 7.5 by one unit</td>
<td>8</td>
<td>3</td>
<td>10</td>
<td>1,896</td>
<td>899</td>
</tr>
<tr>
<td><strong>Chronic obstructive pulmonary disease (COPD)</strong></td>
<td>40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment with inhaled corticosteroids for eligible patients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Statins to address CVD risk among COPD patients</td>
<td>0</td>
<td>11</td>
<td>32</td>
<td>894</td>
<td>546</td>
</tr>
<tr>
<td><strong>Reducing smoking in pregnancy</strong></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eliminating smoking in pregnancy (infant deaths averted)</td>
<td>0.3</td>
<td>0.2</td>
<td>0.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Harmful alcohol consumption</strong></td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief intervention for 10% of harmful drinkers</td>
<td>0.9</td>
<td>0.3</td>
<td>1.2</td>
<td>320</td>
<td>197</td>
</tr>
<tr>
<td><strong>Lung cancer</strong></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing rates of early presentation</td>
<td>0.9</td>
<td>0.7</td>
<td>1.6</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Smoking cessation clinics (setting a quit date)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results shows deaths postponed in short term (1-2 years)**</td>
<td>0.6</td>
<td>0.7</td>
<td>1.3</td>
<td>769</td>
<td>839</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: HINST, Modelling Mortality Reductions, v6.1, December 2010

Note: Totals may not sum due to rounding

* Eligible population and NNT figures will be provide in a later version of this model after further consideration of the evidence.

** Reductions in smoking rates would result in a much greater number of postponed deaths over a longer time period.
# Table Twelve: Numbers needed to treat and potential gains for Vale Royal Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Assumed treatment coverage of eligible population (%)</th>
<th>Intervention</th>
<th>Potential postponed deaths in one year (based on 2006-08 data)</th>
<th>Estimated population eligible for treatment</th>
<th>Number Needed to Treat (NNT) to postpone one death</th>
<th>Life expectancy gain (for CCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>Females</td>
<td>Persons</td>
<td>Males</td>
<td>Females</td>
<td>Persons</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>--------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Cardiovascular disease: Secondary prevention</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four treatments (beta blocker, aspirin, ACE inhibitor, statin) for all patients with previous CVD event</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>CHD deaths averted</td>
<td>5</td>
<td>5</td>
<td>9</td>
<td>441</td>
</tr>
<tr>
<td></td>
<td>Stroke deaths averted</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td><strong>Currently partially treated</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>CHD deaths averted</td>
<td>6</td>
<td>9</td>
<td>15</td>
<td>3,350</td>
</tr>
<tr>
<td></td>
<td>Stroke deaths averted</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>Additional treatment for hypertensives with no previous CVD event</strong></td>
<td>100%</td>
<td>Additional hypertensive therapy</td>
<td>12</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Statin treatment for hypertensives with high CVD risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Treatment for heart attack</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>Primary angioplasty (PCI) for heart attack</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Anticoagulant therapy (Warfarin) for all patients over 65 with a trail fibrillation</strong></td>
<td>100%</td>
<td>Stroke deaths averted</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>Reducing blood sugars (HbA1c) over 7.5 by one unit</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>1,136</td>
</tr>
<tr>
<td><strong>Chronic obstructive pulmonary disease (COPD)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40%</td>
<td>Treatment with inhaled corticosteroids for eligible patients</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Statins to address CVD risk among COPD patients</td>
<td>12</td>
<td>7</td>
<td>18</td>
<td>536</td>
</tr>
<tr>
<td><strong>Reducing smoking in pregnancy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>Eliminating smoking in pregnancy (infant deaths averted)</td>
<td>0.3</td>
<td>0.1</td>
<td>0.4</td>
<td>-</td>
</tr>
<tr>
<td><strong>Harmful alcohol consumption</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td>Brief intervention for 10% of harmful drinkers</td>
<td>0.5</td>
<td>0.2</td>
<td>0.9</td>
<td>213</td>
</tr>
<tr>
<td><strong>Lung cancer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>Increasing rates of early presentation</td>
<td>0.5</td>
<td>0.4</td>
<td>0.9</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Smoking cessation clinics (setting a quit date)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td>Results shows deaths postponed in short term (1-2 years)**</td>
<td>0.4</td>
<td>0.4</td>
<td>0.8</td>
<td>483</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>64</td>
<td>119</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: HINST, Modelling Mortality Reductions, v6.1, December 2010

Note: Totals may not sum due to rounding

* Eligible population and NNT figures will be provide in a later version of this model after further consideration of the evidence.

** Reductions in smoking rates would result in a much greater number of postponed deaths over a longer time period.
Chapter One


15. Liverpool Primary Care Trust. The Workplace Wellbeing Charter. www.wellbeingcharter.org.uk/


Chapter Two


Chapter Three


## Domain One: Improving the wider determinants of health

### Objective
Improvement against wider factors that affect health and wellbeing and health inequalities

### Indicator
1. Children in poverty  
2. School readiness  
3. Pupil absence  
4. First time entrants to the youth justice system  
5. 16-18 year olds not in education, employment or training  
6. People with mental illness and or disability in settled accommodation**  
7. People in prison who have a mental illness or significant mental illness  
8. Employment for those with a long-term health condition including those with a learning difficulty / disability or mental illness*, **  
9. Sickness absence rate  
10. Killed and seriously injured casualties on England’s roads  
11. Domestic abuse **  
12. Violent crime (included sexual violence)  
13. Reoffending  
14. The percentage of the population affected by noise  
15. Statutory homeless  
16. Utilisation of green space for exercise/health  
17. Fuel poverty  
18. Social connectedness  
19. Older people’s perception of community safety **

## Domain Two: Health Improvement

### Objective
People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

### Indicator
20. Low birth weight of term babies  
21. Breastfeeding  
22. Smoking status at time of delivery  
23. Under 18 conceptions  
24. Child development at 2 - 2.5 years  
25. Excess weight in 4-5 and 10-11 year olds  
26. Hospital admissions caused by unintentional and deliberate injuries to under 18 year olds  
27. Emotional wellbeing of looked after children  
28. Smoking prevalence - 15 year olds  
29. Hospital admissions as a result of self harm  
30. Diet  
31. Excess weight in adults  
32. Proportion of physically active and inactive adults  
33. Smoking prevalence in adults (over 18)  
34. Successful completion of drug treatment  
35. People entering prison with substance dependence issues who are previously not known to community treatment  
36. Recorded diabetes  
37. Alcohol related hospital admission  
38. Cancer diagnosed at stage 1 and 2  
39. Cancer screening coverage  
40. Access to non-cancer screening programmes  
41. Take up of the NHS Health Check programme - by those eligible  
42. Self reported wellbeing  
43. Falls and injuries in the over 65s

## Domain Three: Health Protection

### Objective
The populations health is protected from major incidents and other threats, while reducing health inequalities

### Indicator
44. Air pollution  
45. Chlamydia diagnoses (15-24 year olds)  
46. Population vaccination coverage  
47. People presenting with HIV at a late stage of infection  
48. Treatment completion for TB  
49. Public sector organisations with board-approved sustainable development management plans  
50. Comprehensive, agreed inter-agency plans for responding to public health incidents

## Domain Four: Healthcare public health and preventing premature mortality

### Objective
Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

### Indicator
51. Infant mortality rate*  
52. Tooth decay in children aged five  
53. Mortality from causes considered preventable  
54. Mortality from all cardiovascular diseases (including heart disease and stroke)  
55. Mortality from cancer  
56. Mortality from liver disease  
57. Mortality from respiratory disease  
58. Mortality from communicable diseases  
59. Excess under 75 mortality in adults with serious mental illness  
60. Suicide  
61. Emergency readmissions to hospital within 30 days of discharge***  
62. Preventable sight loss  
63. Health related quality of life for older people  
64. Hip fractures in over 65s  
65. Excess winter deaths  
66. Dementia and its impact
Targeted health improvement in areas of inequality in Central and Eastern Cheshire

Appendix 2
Framework for commissioning for health gain

Appendix 3

Health Improvement

Health Protection

Commissioned via LA or ‘PHE’

Health and Wellbeing Board

Link to wider Public Health Team work

Public Health offer to GP Consortia and other commissioning organisations

Link to wider population level commissioning.

Health Services/Healthcare Public Health

Strategic Vision
of commissioning organisation

Eg. GP Consortium, PCT Cluster
- Strategic priorities for health

Tactical Commissioning input/intelligence

Eg.
- Population perspective to investment/disinvestment decisions
- Population perspective to information on efficiency and variations in care eg. QIPP, ‘Healthcare Sustainability’ agenda
- Population perspective to commissioning policy development

‘Operational’
PH inputs to pathways & their commissioning cycle

- Transitional, ‘day to day’ inputs to commissioning cycle (needs, effectiveness, contracts/pathways/quality)
- Can be large or small tasks
- Includes inputs to 1, 2, 3 services or specialised services dependent on relevant care pathway
- Uses PH skills in commissioning cycle; eg. evidence-based approach; population perspective to population and clinical data, effective preventive opportunities, a focus on inequities in access and outcomes

Very important strategically

‘Right Direction’

Very important for optimising health gain form given resources

‘Right Choices’

Commissioning cycle actions to deliver strategic vision

‘Right Actions’

- May be delivered from commissioning or provider organisations (e.g. Consortia, PCT clusters, Trusts etc)
- Inputs not necessarily delivered by PH, some elements may be delivered by wider multi-disciplinary colleagues with guidance/steer from PH

Source: Julie Tin © February 2011
Public Health Dept, CEGPCT
The following action points and recommendations were made as part of the Annual Report of the Director of Public Health 2010. The progress column shows the activity which has taken place since the recommendation or action was made.

<table>
<thead>
<tr>
<th>APHR 2010 Page no.</th>
<th>Action Point / Recommendation</th>
<th>Response / Progress / Comment</th>
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<tbody>
<tr>
<td>26</td>
<td>CECPCT will work with local organisations to progress towards achieving Baby Friendly Accreditation</td>
<td>CECPCT coordinates a Breastfeeding Project Group that has a membership from the three local NHS organisations pursuing UNICEF Baby Friendly Accreditation. East Cheshire NHS Trust maternity service achieved Stage Two in December 2010. East Cheshire NHS Trust Health Visitors achieved Stage Two in July 2011. Both are now working towards the final stage, Stage 3. Mid Cheshire Hospitals NHS Foundation Trust achieved Stage One in May 2011</td>
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| 28                 | Teenage Pregnancy services will be reviewed and improved | **Cheshire East:** Work has been completed from the Teenage Pregnancy plan targeting the High Schools in the geographical areas with most hotspot wards. A multi-agency steering group looked at Sex and Relationship education, the provision of sexual health services and work to raise the self esteem and aspiration of young women. Work is planned to use a risk factor toolkit with year 7 to identify young people most at risk of developing risky behaviours including risky sexual behaviour and plan early interventions to mitigate risk.  
**Cheshire West and Chester:** CECPCT has been involved in developing a Teenage Pregnancy Strategy for Cheshire West and Chester. An Action Plan for the Strategy has been developed which has several recommendations for the Vale Royal area of Central and Eastern Cheshire area. Key ones are developing a Sexual Health Outreach Nurse capability and the development of a Family Nurse Partnership for teen mums |
<p>| 29                 | The PCT is developing local plans and achievement targets for each area and practice based on their specific immunisation uptake rates, involving all those with a role in immunisation advice, administration and recording. Expert advice and support will be focused where significant issues are identified | The PCT has seen an overall improvement in the immunisation uptake rates for the primary immunisation course by age 1 and of booster doses received by age 5 since 2010. Systems have been put in place to identify and reduce waiting lists that may be preventing children being called at the correct times. Work has also been done with a small number of practices to ensure that information about childrens’ immunisation status is recorded correctly on the child health system, which particularly affects those children who move into our area |</p>
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<tr>
<td>30</td>
<td>All health professionals have a role in helping people quit</td>
<td>Brief intervention training to raise awareness of the health risks of smoking and onward referral to stop smoking services has been delivered to a number of health professionals. This has included District Nurses, Dentists, School Nurses, Practice Nurses, Healthcare Assistants, Respiratory Nurse Specialists, Community Matrons, Community Champions (18-24 year olds) at Pathways CIC and Midwives. This will be continued in future years</td>
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<td>30</td>
<td>The PCT will work with partners to implement the smokefree strategy</td>
<td>CECPCT coordinates the Cheshire East Tobacco Alliance which has a broad membership across the NHS, local authority and other public sector organisations. A number of projects are in place - Smokefree Homes, Illicit Tobacco campaign, Stop Smoking Service, support the Cheshire Charter, Smokefree website and Global Youth Tobacco Survey</td>
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<td>30</td>
<td>Stop smoking service to target hard to reach groups</td>
<td>The local Stop Smoking Service provides a universal service but targets groups with high smoking rates - in particular Routine and Manual Groups, pregnant women and the Polish migrant population in Crewe.</td>
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<td>31</td>
<td>CECPCT has set a target for achieving a 2% year-on-year reduction of alcohol-related admission rates</td>
<td>In order to achieve our target a Hospital Alcohol Liaison Team was established at Leighton Hospital in April 2011. The team, which includes an alcohol nurse and two project workers, works with colleagues within the hospital to identify and treat people who have been admitted to hospital as a result of their drinking, or whose alcohol misuse risks compromising their care. The team is able to offer advice and treatment to patients and are also training staff to screen patients for alcohol problems and to offer appropriate advice and interventions</td>
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<tr>
<td>34</td>
<td>CECPCT will, when prioritising to address CVD, use a whole care pathway approach in identifying evidence-based and cost-effective preventative opportunities</td>
<td>We commission GP practices to provide the service through the locally enhanced quality and outcomes framework</td>
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<td>35</td>
<td>CECPCT cancer commissioning group will work towards implementing the recommendations of the National Cancer Strategy</td>
<td>The CECPCT cancer commissioning group grew into the cancer and End of Life Programme Board. This was to ‘join up’ the complete agenda and ensure all stakeholders were engaged. It also assured governance and accountability within the changing PCT</td>
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<td>44</td>
<td>Public health to initiate, inform and support the development of the strategic health improvement partnerships</td>
<td>Public Health continues to provide representatives in attendance to a number of the area partnership boards in Cheshire East and Cheshire West and Chester Council areas. Public Health consultants also work closely with the newly formed Clinical Commissioning Groups to provide public health advice and support with engaging with community groups and other strategic partnerships. Recently GP practice locality groups within Eastern Cheshire Clinical Commissioning Group have been formed with a remit to work more closely at a local level with their area partnerships boards and have begun to nominate GP representatives to attend the area partnership boards management groups. Local GPs are also members of the areas partnership boards in Winsford and in Northwich</td>
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<td><strong>Page no.</strong></td>
<td><strong>228</strong> CECPCT will continue to deliver, as the lead Primary Care Trust for the Department of Work and Pensions North West, the Employment Advisory Support Service</td>
<td>North West Employment Advisory pilot ended December 2010 and achieved its target of 540 people retained in employment who had common mental health problems. Evaluation shows the service was valued by GPs, patients and therapists, with the vast majority of people presenting with mental health conditions as a consequence of the outcomes of poor work and the manifestation of the psycho-social risks of the workplace. CECPCT is now the lead PCT for the Employment Support Service across the North West Region and has disseminated the learning across all Improving Access to Psychological Therapies sites across the North West. The importance of employment as part of the recovery is mainstreamed within IAPT Services. In addition during April 2011-March 2012 the service has supported 940 people to find/be retained in employment where specialist vocational rehabilitation support has been required. This support has enabled PCTs to achieve their employment targets of the IAPT criteria linked to the outcomes framework and ensure equity of services.</td>
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<td><strong>229</strong> Raise awareness of the negative impact of alcohol consumption on young people through the Young Persons Health Partnership</td>
<td>119 young people have been employed through the FJF by Pathways CIC and have received support to understand the importance of alcohol awareness. Individual action plans were put in place to ensure the staff were aware of how much they drank, the reasons why they drank, the impact on their personal health and identification of appropriate support strategies. These staff as part of their six months employment provided alcohol awareness support at community events throughout Central and Eastern Cheshire, including schools.</td>
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<td><strong>229</strong> Support the development of the Work for Skills programme for Young Offenders</td>
<td>The Work Programme was introduced in July 2011. The Work Programme provides tailored support for claimants of all age groups who need more help to undertake active and effective job seeking. This work has been mainstreamed through the Work Programme which allows providers greater freedom to tailor the right support to the individual needs of each claimant of all age ranges.</td>
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<td><strong>231</strong> Further investigation is needed to identify if there is a pattern of increased incidences of suicide by gender, social group, and area in those local areas experiencing high incidences of worklessness</td>
<td>Data on the incidence of suicide across Cheshire East Council and Cheshire West and Chester Council can be viewed via the Joint Strategic Needs Assessments for both areas: <strong>Cheshire East Council:</strong> <a href="http://www.doriconline.org.uk/ViewPage1.aspx?C=ResourceandResourceID=335">http://www.doriconline.org.uk/ViewPage1.aspx?C=ResourceandResourceID=335</a> <strong>Cheshire West and Chester Council:</strong> <a href="http://www.wcheshirepct.nhs.uk/default.asp?page=Joint_Strategic_Needs_Assessment/6_Suicide_Audit.asp">http://www.wcheshirepct.nhs.uk/default.asp?page=Joint_Strategic_Needs_Assessment/6_Suicide_Audit.asp</a></td>
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CECPCT will continue to aspire to become an exemplar public sector employer

CECPCT actively encourages and promotes staff involvement at all levels of activity. A number of formal and informal forums and committees are in place to ensure this happens. Commitment to working in partnership with our staff side colleagues is formally through the Partnership Forum. A Staff Forum has also been developed for commissioning staff based at Universal House where there is limited staff side representation.

CECPCT has scored well in the sections relating to management and supervision, appraisal, and health and well being. 92% of staff surveyed reported having an appraisal in the previous twelve months and 94% of staff believing that the Trust provides equal opportunities for career progression. Staff also reported that their Health and Wellbeing did not impact on their ability to perform work or daily activities.

In line with recommendations set out by the Boorman review CECPCT has lowered its sickness absence target to 3.5%. The Human Resources Business Partner teams and the HR Consultancy continue to support line managers in the management of sickness absence within the workforce.

Targeted Health and Wellbeing interventions have been delivered in line with the Health and Wellbeing Strategy including mini health checks for staff provided by Cheshire Occupational Health Service and managing your money sessions provided by the financial services authority, and promotion of national health campaigns.

Transforming Community Services (TCS)

Community services provide essential care to many people, families and communities, from health promotion to end of life care. This care is provided in many settings, at critical points in people’s lives, and often to those in vulnerable situations.

The TCS programme was established in July 2008 as a two year programme to support the development of community services, through separating commissioning of services from provision by April 2011. As part of this programme work has been ongoing to support the transfer of Cheshire East Community Health staff to East Cheshire NHS Trust.

The Strategic Human Resource Team has supported; consultations with staff and unions, the exchange of liability information, the Electronic Staff Record (ESR) de-merge supporting establishment of integrated organisation, and the validation of information held on personal files and in ESR through the data cleanse project.

This work has helped to ensure a smooth transition for staff with no disruption to the services provided for patients.

CECPCT will continue to promote sign-up to the MINDFUL Employer charter by all of its working partner organisations

CECPCT has recently completed a review of its commitment and progress towards being a MINDFUL Employer, with view to continuing to be a signatory for a further two years.

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