

**ANNUAL REPORT
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DIRECTOR OF PUBLIC HEALTH**

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Editorial Group

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Chapter One: Introduction

Real improvements in health and well-being only happen when everyone – individuals, communities, services, researchers, government – work together.

Chapter Two gives an overview of how I have defined the big health issues for the PCT, and the variety of ways in which these issues can be tackled.

Chapter Three describes the big health issues, gives a flavour of the work that has been done, and makes recommendations for what still needs to be done.

Today the opportunity for a long and healthy life is still linked to your social circumstances and your characteristics: where you live, what job you do, your race and your gender. The difference in life expectancy of 9.7 years across the wards of the PCT is unacceptable. Joint working is crucial to address the wider actions needed, which go beyond what NHS organisations on their own can do.

In Section 3.1, I describe how improvements to life expectancy have not been matched equally by advances in healthy life expectancy. We are spending longer periods in poor health at the end of our lives. This burden is unequally distributed.

The 'Staying Healthy' strand of the PCT Strategy aims to tackle just this, and help to advance healthy life expectancy through major investments in:

- smoking cessation and tobacco control
- adult obesity
- childhood obesity
- improving life expectancy (cardiovascular disease screening programme)
- alcohol misuse
- children and families.

Inequalities are relevant at all stages of care, not just in relation to staying healthy. Deprivation is associated with a poorer outcome for bowel cancer because people seek help later, making treatment more difficult. People with mental health problems experience 'downward social drift' as they are increasingly disabled before they are in contact with services. Health equity audit is one tool that can be used to assess rates compared with prevalence figures as shown in the joint strategic needs assessment.

Prevention is undoubtedly better than cure. Smoking is the single greatest cause of preventable disease and premature death in the UK. We need to take a different approach to encouraging the people of North Staffordshire not to start smoking and to helping them to stop smoking. We are planning significant investments in improving the access to, and range of, smoking cessation services.

Obesity continues to be a growing problem, especially in children. Again, in taking the PCT'S strategy forward, we are planning to make considerable investments to tackle this.

High blood pressure, despite progress in prevention, detection, treatment and control, remains an important public health problem for the PCT. We need to promote awareness of the condition, and the relevant lifestyle changes, such as reducing salt intake and increasing physical activity.

The increasing problem of alcohol misuse has resulted in dramatic increases in the rates of alcohol-related hospital admissions. Helping people to stop binge drinking is important, but we must not lose sight of the dependent drinkers, many of whose lives would benefit from intensive help. But this is not just about treatment, it's about availability and awareness.

Six long-term conditions have been highlighted, with a clear focus on cardiovascular disease.

Coronary heart disease, diabetes, chronic kidney disease and stroke between them cause a huge amount of ill health and premature death. These diseases manifest themselves in very different ways, but they share the same risk factors: high blood pressure, smoking, obesity, poor diet, and lack of physical activity. Moreover, these diseases often serve as risk factors for each other. Our understanding of the most effective approaches to prevention, risk assessment and management of cardiovascular disease has developed considerably in recent years and we now need to turn our knowledge into action.

An update on the topics highlighted in the previous annual reports is given in Chapter Four. Good progress has been made in many areas, but more needs to be done.

Chapter Five looks at key public health indicators: ways in which we can track the changes in people's experience of health and improvements in health outcomes. I hope that colleagues who work in areas aligned with the local authorities boundaries, and colleagues in practice-based commissioning, find this information useful.

Throughout the report, I have given examples of what we have been doing to improve health and well-being – but with the clear recognition that more needs to be done. I am grateful for the support and commitment of the many colleagues who have worked with us over the last year, and look forward to building on this in the coming year.

Dr Judith Bell
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North Staffordshire PCT

Chapter Two: Defining the Big Health Issues for North Staffordshire PCT

In this Chapter, I outline how I have identified the big health issues for the people of North Staffordshire PCT. I then give an overview of the ways in which I work with others to tackle these issues.

In Chapter Three, I describe each of the big health issues, and make recommendations for what the NHS and partner organisations need to do.

How do we improve the health and well-being of the people of North Staffordshire PCT? By preventing disease, prolonging life and actively promoting health and well-being.

My role as Director of Public Health is to provide public health leadership in partnership with others to ensure that the needs of the local people are assessed – and addressed – through public health programmes. In order to do this, we need an understanding of the population's health, its wider determinants and a clear focus on identifying and tackling inequalities in health.

2.1 How do we define the big health issues and what are they?

Four specific criteria can be used to identify the big health issues in North Staffordshire PCT:

- the health issue places a large burden on society
- the health issue is distributed unfairly across the population (i.e. it does not affect all people in the same way, but affects minorities and disadvantaged individuals to a greater extent)
- there is evidence that preventative strategies could substantially reduce the burden of the health issue
- there is a strong evidence-base for high quality care for the health issue (which is not being consistently practiced).

Based on these criteria, there are three major health issues.

Health inequalities

While overall levels of health match the UK average, this conceals huge gaps in health experience within our population: the difference in life expectancy across the PCT is almost 10 years. The difference between us and more deprived PCTs is in the proportions of people at the lower end of the scale.

The stark differences in health experience represent **the** big health issue for North Staffordshire PCT. Tackling entrenched and enduring inequalities in health is a daunting challenge. Health inequalities are widening, and will continue to do so unless we do things differently.

Preventing disease

We need a strong emphasis on prevention and early intervention if we are to improve people's health. Prevention of ill-health begins by building good health and a healthy lifestyle from the beginning of an individual's life. This means addressing not only the short-term consequences of avoidable ill-health, but also the longer-term causes.

We need to target the areas where there is strong evidence that we can have an impact and prevent disease development.

The big health issues (in terms of risk factors) for North Staffordshire PCT are:

- smoking
- obesity
- high blood pressure
- alcohol consumption.

Improving the quality of life for those with long-term conditions

The PCT also has large numbers of patients with long-term conditions. The big health issues (in terms of high burden of disease, for which there is a strong evidence base for prevention of disease, and improving quality of life) are:

- asthma / chronic obstructive pulmonary disease
- diabetes

- coronary heart disease
- chronic kidney disease
- stroke and transient ischaemic attack.

2.2 How do we tackle the big health issues?

There are a variety of ways in which we need to approach this: strategically, operationally, and in partnership with other agencies.

The main methods for delivering improvements in health and well-being are:

- commissioning
- developing our health improvement function
- working in partnership
- national and local health agendas and associated targets.

2.2.1 Commissioning to improve health and well-being

Proficient local commissioning will help people to stay healthy and independent, and tackle health inequalities. The *Commissioning framework for health and well-being* identifies eight steps to more effective commissioning:

- 1 Putting people at the centre of commissioning
- 2 Understanding the needs of populations and individuals
- 3 Sharing and using information more effectively
- 4 Assuring high-quality providers for all services
- 5 Recognising the interdependence between work, health and well-being
- 6 Developing incentives for commissioning for health and well-being
- 7 Local accountability
- 8 Capability and leadership

Good commissioning depends on good information: information about communities that will help commissioners and providers target health improvement resources to those who will most benefit from them.

A key focus has been the production and promotion of joint strategic needs assessments (JSNAs). Two JSNAs have been produced for Staffordshire: one of adults and one for children. Both JSNAs were developed in collaboration with Staffordshire County Council, commissioning colleagues, and other relevant partners.

I took the lead on the production of the JSNA for children, and the Director of Public Health for South Staffordshire PCT took the lead on the production of the JSNA for adults.

Both of these reports have been actively promoted to commissioning colleagues within the PCT.

Fundamental to the development of the JSNA for children was the work undertaken by the Children's Trust Commissioner for Staffordshire, in making sure that children and young people were able to have their say.

Work, health and well-being

Public health also has a duty to ensure that the wider determinants of health are better understood and inform commissioning decisions. There is a need to improve the health and well-being of people in employment, and to help individuals improve their well-being through employment.

The NHS, as one of the world's largest public bodies, has a considerable opportunity to promote positive change. It can set an example as a responsible employer by supporting staff who want to stop smoking, ensuring that on-site catering promotes healthy food and drink choices, and by promoting physical activity in the work place.

North Staffordshire PCT is the host organisation for the Staffordshire Condition Management Programme, providing both corporate and clinical accountability. It is a valuable opportunity for NHS organisations to offer added value to the care and treatment of patients of working age with long-term health conditions. During the first year of service delivery, the programme has evidenced improvements in all areas for service users.

Commissioning services from the voluntary sector

The Local Strategic Partnership (LSP) project officer works closely with commissioning colleagues in the PCT to develop and support commissioning from the voluntary sector. Services are commissioned taking into account the wider determinants of health, with a particular emphasis on the inequalities within the PCT.

We also need to continue to support and develop the voluntary sector as service providers, to encourage the development of innovative services especially for hard to reach groups.

Equity and access

We need to develop – and respond to – health equity audits.

We need to work closely with our commissioners, and service providers, to continue to improve access and the quality of services for disadvantaged groups – particularly in relation to preventative services.

We also need to ensure local community involvement continues to be an integral part of initiatives to tackle health inequalities, to have a greater chance of having a long-term and sustainable impact.

2.2.2 Developing our health improvement function

The new health improvement function is fully integrated within the Public Health Directorate with its strong emphasis on reducing health inequalities, preventing disease and promoting health.

The structure has been based on a number of principles, including:

- the health improvement team should work closely with other staff in the PCT, particularly the commissioning teams, developing matrix type working to establish health improvement as an integrated element of the PCT function
- senior staff will need to have well developed influencing and partnership skills as well as ability to access and evaluate evidence (they will need to become key players in local partnership developments and in the delivery of the Local Area Agreement outcomes and Local Strategic Partnership delivery plans).

2.2.3 Working in partnership

Improving health and well-being is everyone's responsibility: individuals, communities, health services, social services, and local and national government. Working in partnership is crucial, based on a co-ordinated approach that addresses all the factors determining the public's health.

Examples include:

Staffordshire Strategic Partnership

Newcastle-under-Lyme Local Strategic Partnership

Staffordshire Moorlands Local Strategic Partnership

Community and Voluntary Services

Overview and Scrutiny Committees

Staffordshire Children's Trust Board

Staffordshire Safeguarding Children's Board

Newcastle Borough Children's Trust Board

Staffordshire Moorlands District Children's Trust Board

Staffordshire Healthy Schools Strategic Partnership Group

Staffordshire Teenage Pregnancy Partnership

Staffordshire Drug and Alcohol Action Team Partnership

Staffordshire Joint Commissioning Unit

Health Protection Agency

Northern Staffordshire Health Economy Pandemic Flu Planning Group

North Staffordshire Tuberculosis Network

Greater Midlands Cancer Network

University Hospital of North Staffordshire Clinical Interface Group

Darwin Training Consortium

Comprehensive Local Research Network Board

West Midlands Deanery, Postgraduate School of Public Health Board (Training Executive Committee)

2.2.4 National and local health agendas and associated targets

There are many national and local policy drivers that are used to concentrate and co-ordinate activities to improve health and well-being.

The government has identified national priorities for improving health. *The NHS Improvement Plan* set out the Public Service Agreement (PSA) targets agreed between the Department of Health and the Treasury, which include challenging public health targets.

The PSA targets from the NHS Operating Framework 2007/08 were based on four priority areas:

- improving the health of the population
- supporting people with long-term conditions
- access to services

- patient/user experience.

A full list of the PSA targets is on the PCT's website.

The NHS Operating Framework for 2008/09 describes the priorities for the coming year. These targets set out are in the form of 'vital signs', broken down into three tiers:

- national requirements
(as set out in vital signs A targets, such as VSA14 which focuses on improving the quality of stroke care)
- national priorities for local delivery
(as set out in vital sign B targets, such as VSB05 which focuses on reducing the number of smokers)
- local priorities
(as set out in vital sign C targets, such as VSC26 which focuses on reducing hospital admissions for alcohol-related harm).

A full list of the vital signs targets is on the PCT's website.

In order to identify local priorities, the PCT involved members of the Professional Executive Committee, the Patient Public involvement Forum, members of the Practice Based Commissioning clusters and both the Newcastle-under-Lyme and Staffordshire Moorlands LSPs along with input from the Public Health Directorate.

In setting local priorities for action, the PCT will also be concentrating its efforts on long-term conditions that I have identified as the big health issues for the PCT, namely:

- asthma / chronic obstructive pulmonary disease
- diabetes
- coronary heart disease
- chronic kidney disease
- stroke and transient ischaemic attack.

Setting explicit local targets will help us to monitor our progress in improving the health and quality of life of people with these conditions.

In addition to the local vital sign C targets, there are the Local Area Agreement (LAA) targets which are set and monitored by Staffordshire Strategic Partnership.

Chapter Three: What are the Big Health Issues for North Staffordshire PCT?

3.1 Health inequalities

What are the health inequalities in North Staffordshire PCT?

The opportunity for a long and healthy life is linked to your characteristics (your gender and race) and your social circumstances (where you live and the job that you do).

Differences in health experience are illustrated by the patterns in life expectancy and premature death.

By 2010, increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women (PSA Priority I: targets PSA01 to PSA11)

By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth (PSA Priority I: targets PSA06 and PSA07)

3.1.1 Life expectancy

People have been living longer over the past 20 years, but the extra years have not necessarily been lived in good health. Life expectancy – and healthy life expectancy – both increased between 1981 and 2001, but with life expectancy increasing at a faster rate than healthy life expectancy.

The difference in life expectancy across the wards in North Staffordshire PCT is 9.7 years. The difference in healthy life expectancy across the wards in North Staffordshire PCT is 18.7 years.

So we are living longer, but the time that we spend in less good health is getting longer too.

Variation in life expectancy and healthy life expectancy by ward

	Lowest		Highest	
Life expectancy				
males	68.5	Town	80.5	Cellarhead
females	75.7	Bradwell	85.1	Westlands
persons	73.4	Leek North	83.1	Dane
Healthy life expectancy				
males	60.3	Holditch	80.1	Westlands
females	66.5	Holditch	77.4	Westlands
persons	63.3	Holditch	76.7	Alton

Note: Healthy life expectancy estimates are not calculated for wards with the 2001 population estimates less than 1,000, and therefore separate estimates for males and females have not been calculated for eight wards: Alton, Biddulph Moor, Biddulph South, Dane, Hamps Valley, Horton, Ipstones, and Manifold.

Source: *Life expectancy and healthy life expectancy at birth for males, females, and persons, 1999 to 2003 (experimental statistics)*, ONS, 2007 <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=12964>

Nationally, three key interventions have been identified as having the potential to make the greatest contribution to closing the life expectancy gap:

- reducing smoking in manual social groups
- preventing and managing other risks for coronary heart disease and cancer, such as poor diet and obesity, physical inactivity and high blood pressure through effective primary care (especially targeting the over-50s)
- improving housing quality by tackling cold and dampness, and reducing accidents at home and on the road.

The particular impact that improving housing quality and reducing accidents will have on the life expectancy of our population is unclear. Locally, the most restrictive wider determinants of health are employment and educational attainment.

3.1.2 Premature death

Saving Lives, Our Healthier Nation is the current comprehensive government plan focused on the main killers: cancer, coronary heart disease and stroke, accidents, mental illness. It is an action plan to reduce deaths from preventable illnesses, focussing on improving the health of those worst off. The four targets are:

By the year 2010

- **cancer:** to reduce the death rate in people under 75 **by at least a fifth**
- **coronary heart disease and stroke:** to reduce the death rate in people under 75 **by at least two fifths**
- **accidents:** to reduce the death rate by **at least a fifth** and serious injury **by at least a tenth**
- **mental illness:** to reduce the death rate from suicide and undetermined injury **by at least a fifth.**

Statistics are produced separately for the PCT and local authority areas. The geography of North Staffordshire PCT does not match exactly to the local authority areas of Newcastle-under-Lyme and Staffordshire Moorlands, making direct monitoring of trends over time for the PCT problematic. However, it is possible to compare recent death rates (2004 –2006 pooled) of the PCT with those of England as a whole. This are summarised in the table next page.

At a local level, the very small numbers of infant deaths make it difficult to make any conclusive judgements about this data.

Nationally, the following key short-term interventions have been identified as having the potential to make the greatest contribution to closing the gap in infant mortality:

- improving the quality and accessibility of antenatal care and early years support in disadvantaged areas
- reducing smoking and improving nutrition in pregnancy and early years
- preventing teenage pregnancy and supporting teenage parents
- improving housing conditions for children in disadvantaged areas.

Premature death rates (directly standardised rate, 2004-06, pooled per 100,000 population)

	PCT	England	
All causes (<75 years)	315.4	309.6	not significantly different
Cancer (<75 years)	114.6	117.1	not significantly different
Circulatory disease (<75 years)	84.4	84.2	not significantly different
Accidents (all ages)	19.7	15.9	PCT significantly higher
Suicide and injury undetermined (all ages)	5.8	8.3	PCT rate significantly lower

Source: NCHOD

Premature death rate (rate per 1,000 population, January 2003-December 2005)

	Newcastle-under-Lyme BC	Staffordshire Moorlands DC	England	
Infant mortality	5.6	3.1	5.1	not significantly different

Source: ONS

The premature death data appears to give a relatively positive picture of health in the PCT – in direct conflict to the life expectancy and healthy life expectancy data. The premature death rates represent the average for the PCT as a whole, and therefore hide the variation in health experience.

Clearly life expectancy and mortality are long-term outcomes, and we need ‘interim outcome measures’ that can be tracked over shorter time periods to monitor progress (e.g. breast feeding, smoking in pregnancy). However, we also need to be clear about measuring things that matter, and not just what can be measured.

3.1.3 Deprivation

Deprivation in its widest sense lies at the heart of health inequalities. Although deprivation is classically associated with larger towns and cities, the latest deprivation indices reveal pockets of severe deprivation within Newcastle-under-Lyme.

Deprivation is relative, and the usual way to look at it is to focus on the top 10% most affected areas. Areas are assessed against the following domains, which are combined to give an overall score:

- income
- employment

- health and disability
- education, skills and training
- barriers to housing and services
- crime
- living environment.

In terms of overall deprivation, three super output areas (SOAs)* in the PCT are in England's 10% most deprived. These are in three wards: Cross Health, Knutton and Silverdale, and Chesterton.

The issues across the PCT differ substantially: in Newcastle-under-Lyme key issues are education, skills, and training, and health and disability, and in the more rural Staffordshire Moorlands the challenges mainly relate to barriers to housing and services.

When we look at the seven individual domains that make up the overall deprivation score, a further 16 wards have SOAs that are in England's 10% most derived. The most common domain is education, skills and training group, affecting 10 of the 48 wards in the PCT.

From 2004 to 2007, there have been increases in deprivation in terms of education, skills and training (with three new areas being identified) and barriers to housing and services (two new areas). The biggest improvement was seen in a reduction in deprivation in terms of crime (a decrease of two areas, both within Biddulph East).

Six wards contain SOAs which experience high levels of deprivation as measured by the barriers to housing and services domain. These are in the rural wards of Dane, Hamps Valley, Horton, Ipstones, Manifold, and Horton, and Loggerheads and Whitmore. This reflects the sparsely-populated nature of these areas.

What are we doing?

- Reducing health inequalities is a fundamental ambition within the PCT Strategy, identified as being key to driving the delivery of improvements in health and well-being. The focus is on reducing unacceptable differences in life expectancy. We also need to concentrate on adding life to years as well as adding years to life.
- Actively promoting inequalities issues, and sharing data on life expectancy, healthy life expectancy and deprivation data widely: from Board papers to formal and informal presentations. This information is used to inform planning and commissioning decisions.
- Commissioning effective, accessible healthcare and working in partnership are the two fundamental levers. The LAA, Staffordshire Children's Trust, Newcastle-under-Lyme LSP and Staffordshire Moorlands LSP play a key role.

* SOAs are a new way to measure geographical areas. SOAs avoid the problems caused by the inconsistent and unstable electoral ward geography, and are more consistent in terms of the numbers of people who live in the area.

What more needs to be done?

What more can the NHS do?

- Continue to work in partnership.
- Carry out further needs assessments where appropriate to identify the most important issues for our population.
- Ensure that commissioning decisions are made with a clear emphasis on reducing health inequalities.
- Promote fair access to care.
- Be a good corporate citizen and employer.

What more can our partners do?

- Continue to work to improve the wider determinants of health (housing, benefits, fuel poverty, transport, crime, employment).
- Ensure that commissioning decisions are made with a clear emphasis on reducing health inequalities.
- Promote fair access to services.
- Be a good corporate citizen and employer.

3.2 Prevention of disease

3.2.1 Smoking

Why is stopping smoking still important?

Smoking kills. It is the single greatest cause of preventable illness and premature death in the UK. Smoking, more than any other identifiable factor, contributes to the gap in healthy life expectancy between those most in need and those most advantaged.

Many children experiment with smoking, believing they will be able to stop when they want to. But smoking is highly addictive and many will find themselves unable to give up. The younger people start to smoke, the more likely they are to smoke for longer and to die from smoking.

National trends show a decrease in the numbers of smokers, although it is estimated that a quarter of the population still smoke.

According to the General Household Survey in 2005, smoking prevalence in the West Midlands was 22%, just below the national prevalence of 24%. The table below gives synthetic estimates for smoking prevalences across the West Midlands.

Smoking prevalence estimates by PCT in the West Midlands (1998-2001)

Shropshire and Staffordshire SHA	27%
South Western Staffordshire	23%
East Staffordshire	25%
Shropshire County	25%
Staffordshire Moorlands	25%
Burntwood, Lichfield and Tamworth	27%
Newcastle-under-Lyme	28%
Cannock Chase	29%
Telford and Wrekin	29%
South Stoke	31%
North Stoke	34%

Source: West Midlands Key Health Data 2006/07

Can we intervene effectively?

Yes. Without help, between 4-5% of people will successfully quit smoking. Using NHS Stop Smoking services quadruples a smoker's chance of successfully quitting.

The most recent NHS Stop Smoking services success rate data (April to December 2007) show that 49% of people using our service had successfully quit at 4 weeks. Only one PCT in the West Midlands achieved a 4-week quit rate of over 50%.

So we need to look at increasing access to the service, and new ways of improving the 4-week quit rate.

What are we doing?

- Helping people to stop smoking. North Staffordshire Stop Smoking Service was established in 1999, and consists of a number of integrated cessation schemes delivered in a wide range of settings across both Stoke-on-Trent and North Staffordshire PCTs.
- Applying social marketing techniques to improve our smoking cessation services. This recognises the diversity within the target groups, and identifies the most appropriate way to communicate health messages to different populations.
- In taking the PCT's Strategy forward, we are planning additional significant investments in improving the access to, and range of, smoking cessation services.

What more needs to be done?

What more can the NHS do?

- Support people who want to stop smoking (including helping employees who want to stop smoking).
- Ensure that our stop smoking services are as effective as possible.
- Target manual workers, pregnant women, young people as well as our disadvantaged communities to encourage smokers to stop.
- Ensure diversity in service provision (providing a range of services in a variety of settings).
- Train all front line staff to offer consistent brief advice on stopping smoking.
- Support smokefree homes (young children as especially vulnerable to passive smoking in homes).

What more can our partners do?

- Support employees who want to stop smoking.
- Continue to reduce the number of under-age smokers by identifying and prosecuting retailers who sell to children under 16 (and maximise the use of media by the publication of warnings, successful prosecutions and health information where appropriate).
- Continue to act on information concerning the location of cigarette vending machines on premises where children have access.
- Promote initiatives that tackle tobacco smuggling.
- Provide support to small- and medium-sized businesses to help them address the measures of the smokefree legislation.

What can the individual do?

- Give up smoking - contact the PCT's Stop Smoking Service.

3.2.2 Obesity

Data from North Staffordshire PCT GP disease registers (for patients aged 16 and older) shows that as at 31 March 2007, 10.0% of patients were obese compared with 9.1% in England as a whole.

Why does obesity matter?

Being overweight or obese can have a severe impact on an individual's health, both are associated with an increasing risk of diabetes, cancer, and heart and liver disease.

And the risks get worse the more overweight you become.

In recent years Britain has become a nation where overweight is the norm. The increase in overweight and obesity, in both children and adults, is remarkable. By 2050, it is estimated that 60% of adult men, 50% of adult women and about 25% of all children under 16 could be obese.

Childhood obesity is closely linked with early onset of preventable disease, including diabetes. But the consequences of obesity in childhood go further and include social stigma, discrimination and prejudice linked to low self-image, low self-esteem and depression. Moreover, overweight adolescents have a 70% chance of becoming overweight or obese adults.

During 2006/07, obesity in childhood was measured in two school years:

Reception Year (children aged 4 to 5) PCT obesity rate = 12.4%, England obesity rate = 9.9%

Year Six (children aged 10 to 11) PCT obesity rate = 18.8%, England obesity rate = 17.5%

Can we intervene effectively?

The current prevalence of obesity in the population has been at least 30 years in the making. This will take time to reverse and it will be a considerable number of years before reductions in the prevalence of obesity – and its associated diseases – are seen.

The evidence is very clear that policies aimed solely at individuals will be inadequate and that significant effective action to prevent obesity at a population level is required.

What are we doing?

- Working in partnership, through the LAA.
- Monitoring the impact: the PCT has a well-established information system for monitoring school children's height and weight.
- Encouraging local schools to join up to the National Healthy Schools Programme, which includes action on physical activity and food.
- Exploring the potential of other organisations, such as 'Sure Start', to address the issue of childhood obesity.
- Proactively promoting the PCT's exercise-on-prescription programme, 'Go5'.
- Running a range of initiatives, including 'Walk to Water' and promoting free swimming during the school holidays, aimed at helping people to become more active.

What more needs to be done?

What more can the NHS do?

- Set an example as a responsible employer by ensuring that on-site catering promotes healthy food and drink choices, and by promoting physical activity in the work place.
- Increase access to exercise and healthy eating opportunities that fit easily into people's everyday lives, and support people's circumstances and preferences.
- Promote healthy infant feeding, including targeted provision of 'positive parenting' advice and classes, and supporting families with family-based interventions.
- Promote and monitor use of the NICE guidelines for preventing overweight and obesity.

What more can our partners do?

- Local authorities can also set an example as employers, and should ensure that on-site catering promotes healthy food and drink choices, and promote physical activity in the work place.
- Improve access to well-maintained, safe, affordable, and convenient leisure and sports facilities.
- Through the LSPs, work to remove barriers to healthy eating by improving availability and access. Encourage local shops and supermarkets to promote healthy food and drink choices.
- Increase the range of healthy food choices (and make it more difficult to make unhealthy food choices) in schools. Increase the opportunity for physical exercise in schools. Encourage active travel to and from school.

What can the individual do?

- Eat healthily (reduce fat intake, increase intake of fruit and vegetables) and exercise regularly (at least 30 minutes a day on five or more days a week).

3.2.3 High blood pressure

Data from North Staffordshire PCT GP disease registers (for all patients) shows that as at 31 March 2007, 15.1% of patients had high blood pressure compared with 12.5% in England as a whole.

Why does high blood pressure matter?

High blood pressure is the most important modifiable risk factor for stroke, plays a major role in coronary heart disease, and is a key risk factor in diabetes and chronic kidney disease.

According to the World Health Organisation, the burden of disease attributable to a systolic blood pressure of 115mgHg or above is:

- 20% of all deaths in men and 24% of all deaths in women
- 62% of strokes and 49% of coronary heart disease, and
- 11% of disability adjusted life years.

Can we intervene effectively?

Yes. There are effective interventions to treat and control high blood pressure, but many people with high blood pressure are not treated or receive inadequate treatment.

There are a number of lifestyle interventions that have been shown to be effective for primary prevention of high blood pressure. These are:

- maintaining a normal body weight
- reducing salt intake
- taking regular physical exercise
- limiting daily alcohol consumption
- maintaining an adequate intake of dietary potassium
- having a diet rich in fruits and vegetables, and in low-fat dairy products with a reduced content of saturated and total fat.

Primary care management of hypertension varies across the PCT. This can be seen clearly in the differences between GP practices in achieving the quality indicators for people with high blood pressure.

Summary of achievement across the QOF hypertension quality indicators

QOF Indicator	Lowest to highest GP practice achievement	Achievement across the PCT as a whole
The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months	75.8% to 98.0%	93.2%
The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less	46.3% to 92.7%	76.2%

Source: QMAS data as at 31 March 2007

Several other quality indicators relate to the measurement and control of high blood pressure in specific groups of patients. Again, there are significant variations between GP practices in the proportions of eligible patients in whom blood pressure is regularly monitored and adequately controlled.

We need to better understand what this quality indicator data is telling us, and work with low-achieving GP practices to improve care for people with high blood pressure.

Summary of achievement across the QOF quality indicators related to the management of hypertension

QOF Indicator	Lowest to highest GP practice achievement	Achievement across the PCT as a whole
The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	89.5% to 100%	98.7%
The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	45.2% to 96.6%	76.0%
The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	93.3% to 100%	98.1%
The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	65.2% to 97.2%	86.8%
The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months	90.3*% to 100%	98.1%
The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less	59.6*% to 100%	81.0%
The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months	85.2% to 100%	97.2%
The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	57.3% to 100%	84.7%

* excluding practices with less than 30 eligible patients

Source: QMAS data as at 31 March 2007

What are we doing?

- As part of the primary care performance monitoring, QOF visits are made to outlier GP practices with low scores.

What more needs to be done?

What more can the NHS do?

- Increase access to exercise and healthy eating opportunities to help prevent high blood pressure in high-risk groups (people with blood pressure in the range 130-139/80-89mgHg i.e. those most likely to go on to develop high blood pressure, and those people who already have cardiovascular disease, diabetes, chronic kidney disease, or retinal disease).
- Improve the early identification of people with high blood pressure in high-risk groups (those patients at high overall risk of cardiovascular disease, or those with signs or symptoms of target organ damage that may be due to high blood pressure).
- Increase access to effective treatments to lower blood pressure, and promote patient adherence.
- Ensure better monitoring to help control high blood pressure, using a systematic method.
- Implement workplace health initiatives.

What more needs to be done? (continued)

What more can our partners do?

- Provide convenient facilities for a wide range of exercise opportunities (with a focus on men aged over 35 years of age).
- Increase the opportunities for physical activity in schools and increase the range of healthy food choices (particularly with regard to reduced salt intake) in schools. Encourage active travel to and from school.
- Implement workplace health initiatives.

What can the individual do?

- Eat healthily (reduce salt intake, increase fruit and vegetable intake), increase physical activity (at least 30 minutes a day on five or more days a week), drink alcohol sensibly.

3.2.4 Alcohol

Why does alcohol consumption matter?

Excessive alcohol consumption is known to lead to a range of health problems, including chronic liver disease, alcoholic poisoning, alcohol-induced pancreatitis, and stomach cancer.

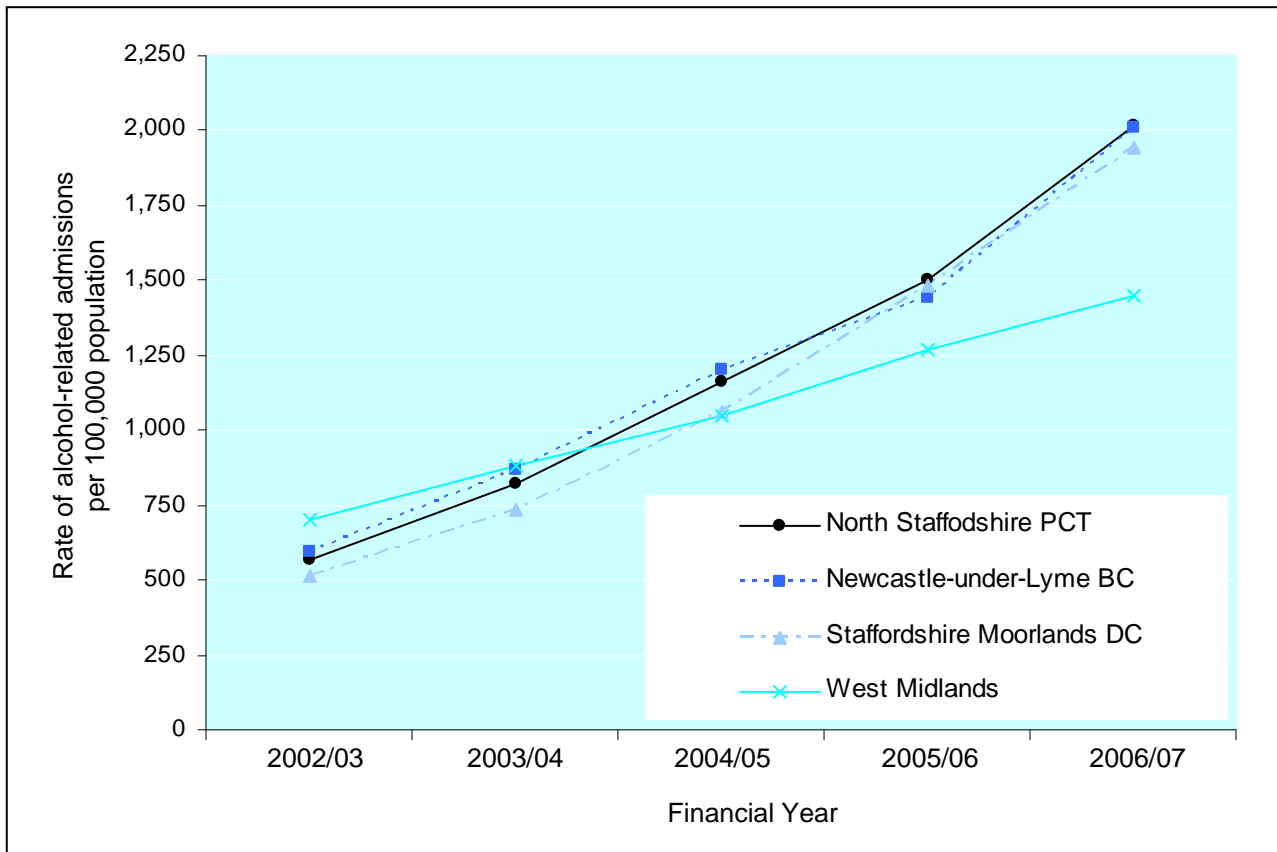
But it's not just about the direct disease effects. Excessive alcohol consumption also has a negative effect on communities. This can be seen in increasing anti-social behaviour, acts of violence, accidents, crime, risky sexual activity (potentially leading to teenage pregnancies and sexually transmitted infections), and truancy from school.

Over recent years, there has been a dramatic increase in the number of alcohol-related admissions.

What are we doing?

- Commissioning community addiction services provided by Alcohol and Drug Services in Staffordshire (ADSiS) to support those people with less severe alcohol dependency to be managed in a home setting.
- Providing a new 'brief intervention' service, aimed at people who misuse alcohol who are admitted to University Hospital North Staffordshire (specifically, the Accident and Emergency Department, the Primary Care Urgent Care Unit, the Acute Assessment Unit, the Minor Injuries Unit, the Short Stay Unit and the Surgical Assessment Unit.) This service has been commissioned jointly with Stoke-on-Trent PCT, and will be provided by ADSiS. 'Brief interventions' services have been shown to be effective across a wide range of alcohol problems. They help individuals with hazardous and harmful drinking, bridging the gap between primary prevention efforts and more intensive treatment for persons with serious alcohol use disorders. The service will also provide an invaluable opportunity to identify and refer severe cases of alcohol dependence to specialized treatment.
- Through the LAA, a project has shown promising results in reducing reported drinking levels in school-age children.

Trend in the rate of alcohol-related admissions to hospital



Source: North West Public Health Observatory / The Information Centre for health and social care

What more needs to be done?

What more can the NHS do?

- Closely monitor the brief interventions service at the University Hospital of North Staffordshire.
- Work with GPs to enhance the current screening and service provision for alcohol misuse.
- Incorporate the lessons learned from a county-wide council project which successfully reduced reported drinking levels in school-age children into local PCT plans.
- Work with partners to support a wider campaign of education and awareness of the possible negative consequences of alcohol misuse (including promoting sensible alcohol consumption aimed at younger people).
- Continue to work closely with the local Crime and Disorder Reduction Partnerships and Staffordshire Drug and Alcohol Action Team to ensure an integrated approach to tackling alcohol-related violence.

What more needs to be done? (continued)

What more can our partners do?

- Continue to reduce the number of under-age drinkers by identifying and prosecuting retailers who sell to children under 18 (and maximise the use of media by the publication of warnings, successful prosecutions and health information where appropriate).
- Continue to implement responsible licensing (including revoking the licences of problem premises).
- Work in schools to promote primary prevention measures.
- Strengthen partnership working to make drinker venues, and local communities, safer.
- Businesses that produce, promote and sell alcoholic drinks need to go beyond compliance with legal responsibilities, and should promote and encourage a wider social responsibility.
- Promote good practice in product development, advertising and packaging (including not targeting under-age drinkers, providing clear information about unit content, using safer materials).

What can the individual do?

- Drink alcohol responsibly.
 - Men – no more than 21 units per week (and no more than 4 units in any one day).
 - Women – no more than 14 units per week (and no more than 3 units in any one day).
 - Pregnant women or women trying to conceive – should avoid drinking alcohol. (If you do choose to drink, to minimise the risk to the baby, you should not drink more than 1 to 2 units of alcohol once or twice a week and should not get drunk.)

3.3 Improving the quality of life for people with long-term conditions

3.3.1 Asthma

According to GP disease registers, asthma is the most common long-term condition in the PCT. Data (for all patients) shows that as at 31 March 2007, 6.4% of patients were diagnosed as having asthma compared with 5.8% in England as a whole.

People should have their asthma regularly reviewed to ensure that symptoms remain under control. There is enormous variability between GP practices in the PCT in achieving the QOF review quality indicator: the percentage of people with asthma who have had an asthma review in the previous 15 months varies from 22.6% to 96.2%.

Experiencing an asthma attack that requires hospital treatment is frightening and distressing. Improved primary care can reduce the need for emergency hospital care (it is estimated that 75% of emergency admissions for asthma could be avoided).

In 2004, hospital admission rates for asthma showed considerable differences across the PCTs in England. The England average rate was 100, and both the predecessor PCTs had rates below this (Newcastle-under-Lyme = 98, Staffordshire Moorlands = 87).

Can we intervene effectively?

Yes. High quality routine care can make a real difference to the lives of people with asthma. National guidelines state that people with asthma should expect:

- their condition to be adequately controlled by medication
- to have good symptom control
- not to need emergency treatment if appropriate routine care is given.

What are we doing?

- Including of the care of patients with asthma as a key local priority in the PCT's operational plan 2008/09.

What more needs to be done?

What more can the NHS do?

- Support people who want to stop smoking (including helping employees who want to stop smoking).
- Improve careful diagnosis, for adults and children (especially children, due to the long-term implications for both the child and health services).
- Reduce variation in access to high quality primary care to decrease unnecessary hospital admissions.
- Ensure that people with asthma are offered a written personal asthma plan.

What more can our partners do?

- Support employees who want to stop smoking.
- Continue to improve the quality of housing by tackling cold and dampness.

What more needs to be done? (continued)

What can the individual do?

- Make sure that they have a written personal asthma plan.
- Visit the GP or asthma nurse for regular reviews.

3.3.2 Chronic Obstructive Pulmonary Disease (COPD)

Data (for all patients) shows that as at 31 March 2007, 1.7% of patients were diagnosed as having COPD compared with 1.4% in England as a whole.

COPD is very common, and it's getting more common, especially among women. It's possible to have COPD without knowing you have it.

Nine out of ten people who have COPD are – or used to be – heavy smokers. Second-hand smoke can also cause COPD. Giving up smoking reduces your risk of developing COPD. But even after about 10 years of not smoking, 1 in 10 people who used to smoke will develop COPD.

Experiencing an acute exacerbation of COPD requiring hospital treatment is frightening and distressing. For the patient, it may signal the beginning of the terminal phase of the illness. There is increasing evidence that non-pharmacological interventions may prevent hospital admissions.

The premature death rate (pooled for 2004-06) for the PCT is similar to that for England as a whole, but the rate in Newcastle-under-Lyme Borough Council (15.2 per 100,000 population) is significantly higher than that for Staffordshire Moorlands District Council (8.7 per 100,000 population).

Can we intervene effectively?

Yes. High quality routine care can make a real difference to the lives of people with COPD. There are national guidelines for the diagnosis and care of people with COPD.

Smoking cessation is the single most effective – and cost effective – intervention in most people to reduce the risk of developing COPD.

Primary care management varies significantly across the PCT. There are marked differences between GP practices in achieving the COPD quality indicators.

What are we doing?

- Helping people to stop smoking.
- Working with Stoke-on-Trent PCT and the University Hospital of North Staffordshire to develop an evidence-based local care pathway for people with COPD.
- Including the care of patients with COPD as a key local priority in the PCT's operational plan 2008/09.

Summary of achievement across the QOF COPD quality indicators

QOF Indicator	Lowest to highest GP practice achievement	Achievement across the PCT as a whole
The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing	53.6*% to 100%	91.7%
The percentage of patients with COPD with a record of FeV1 in the previous 15 months	25.0*% to 97.5*%	77.4%
The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the previous 15 months	29.7% to 100%	89.1%
The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	70.7*% to 100%	91.6%

* excluding practices with less than 30 eligible patients

Source: QMAS data as at 31 March 2007

What more needs to be done?

What more can the NHS do?

- Support people who want to stop smoking.
- Work with GPs to ensure that COPD is recognised and diagnosed: it has been estimated that only 1 in 4 people with COPD are diagnosed.
- Improve access to spirometry.
- Improve the primary care of patients with COPD: reduce variation in inhaler technique checks and lung function monitoring across the GP practices within the PCT.
- Encourage the use of written personalised self-management plans.
- Review the requirements of implementing the new COPD care pathway. What services do we already have in place to support this? What services need to be developed? Which service gaps need to be filled first? How will we know that it's happening in practice (audit and monitoring)?

What more can our partners do?

- Support employees who want to stop smoking.
- Ensure that workplaces where exposure to harmful substances routine, or highly likely, provide employees with appropriate safety information, protective clothing and equipment.

What can the individual do?

- Give up smoking - contact the PCT's Stop Smoking Service.
- If you work in an industry where you could be exposed to harmful substances, be certain to follow safety advice to protect your lungs.
- Take regular exercise.

3.3.3 Diabetes

According to GP disease registers, diabetes is the second most common long-term condition in the PCT. Data (for patients aged 17 and older) shows that as at 31 March 2007, 5.4% of patients were diagnosed as having diabetes compared with 4.5% in England as a whole.

Diabetes causes significant illness and premature death, which can be reduced by effective treatment and preventative measures. Over time, poorly controlled diabetes has widespread adverse health effects:

- eye disease, leading to impaired vision and blindness
- kidney damage
- nerve damage, leading to loss of bladder and bowel control, loss of sensation in the feet (hence the likelihood of ulcers and amputation).

Nationally, the number of people developing Type 2 diabetes is rising. Of concern is the number of young people being diagnosed with Type 2 diabetes – a condition previously associated with those aged over 40 years of age.

There is significant variability between GP practices in the PCT in achieving the diabetes quality indicators, most notably in inconsistency in achieving HbA1c control and blood pressure control.

Summary of achievement across the QOF diabetes quality indicators

QOF Indicator	Lowest to highest GP practice achievement	Achievement across the PCT as a whole
The percentage of patients with diabetes whose notes record BMI in the previous 15 months	71.8% to 100%	94.7%
The percentage of diabetic patients who have a record of HbA1c or equivalent in the previous 15 months	83.5% to 100%	97.1%
The percentage of patients with diabetes in whom the last HbA1c is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	53.8% to 89.3%	68.8%
The percentage of patients with diabetes in whom the last HbA1c is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	82.1% to 97.1%	93.1%
The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	62.2% to 100%	87.3%
The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	23.0% to 99.8%	91.2%
The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	22.1% to 100%	90.8%
The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	89.5% to 100%	98.7%
The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	45.2% to 96.6%	76.0%

Summary of achievement across the QOF diabetes quality indicators (continued)

QOF Indicator	Lowest to highest GP practice achievement	Achievement across the PCT as a whole
The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	39.2% to 96.6%	86.5%
The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months	82.4% to 100%	96.9%
The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	76.3*% to 100%	90.1%
The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	78.8% to 100%	96.1%
The percentage of patients with diabetes whose last measured total cholesterol within previous 15 months is 5 mmol/l or less	64.9% to 93.3%	82.0%
The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	75.4% to 100%	90.6%

* excluding practices with less than 30 eligible patients

Source: QMAS data as at 31 March 2007

The premature death rate (pooled for 2004-06) for the PCT is similar to that for England as a whole. However, 75% of deaths in people with diabetes are caused by cardiovascular disease.

Can we intervene effectively?

Yes. High quality routine care can make a real difference to the lives of people with diabetes. The National Service Framework for Diabetes has clear standards for prevention of Type 2 diabetes, early identification of diabetes, and empowering people with diabetes.

There is clear evidence that the majority (two thirds) of Type 2 diabetes can be prevented by lifestyle and diet interventions.

What are we doing?

- Working with Stoke-on-Trent PCT and the University Hospital of North Staffordshire to develop an evidence-based local care pathway for people with diabetes.
- Planning a cardiovascular disease screening programme (described in section 3.3.4).
- Proactively promoting the PCT's exercise-on-prescription programme, 'Go5'.
- Including the care of patients with diabetes as a key local priority in the PCT's operational plan 2008/09.

What more needs to be done?

What more can the NHS do?

- Support people who want to stop smoking (including helping employees who want to stop smoking).
- Improve early diagnosis and treatment.
- Improve early identification of people at risk (to intervene to prevent the development of diabetes).
- Review the requirements of implementing the new diabetes care pathway. What services do we already have in place to support this? What services need to be developed? Which service gaps need to be filled first? How will we know that it's happening in practice (audit and monitoring)?

What more can our partners do?

- Support employees who want to stop smoking.
- Improve access to well-maintained, safe, affordable, and convenient leisure and sports facilities.
- Increase the range of healthy food choices (and make it more difficult to make unhealthy food choices) in schools. Increase the opportunity for physical exercise in schools. Encourage active travel to and from school.

What can the individual do?

- Give up smoking - contact the PCT's Stop Smoking Service.
- Eat healthily (reduce fat intake, eat at least two portions of fish per week - one of which should be an oily fish, increase intake of fruit and vegetables).
- Exercise regularly (at least 30 minutes a day on five or more days a week).
- Drink alcohol sensibly (within the recommended limits).

3.3.4 Coronary Heart Disease (CHD)

According to GP disease registers, CHD is the third most common long-term condition in the PCT. Data (for all patients) shows that as at 31 March 2007, 4.4% of patients were diagnosed as having CHD compared with 3.5% in England as a whole.

CHD is the most common cause of premature death in the UK. It is a key public health priority because it is common, frequently fatal, and largely preventable.

Primary care management varies across the PCT. There are significant differences between GP practices in the PCT in achieving the CHD quality of care indicators, notably control of cholesterol levels and blood pressure, and use of beta blockers for secondary prevention.

Can we intervene effectively?

Yes. High quality routine care can make a real difference to the lives of people with CHD. The National Service Framework for CHD has clear standards for improved prevention, diagnosis, treatment and rehabilitation, and goals to secure fair access to high quality services.

Summary of achievement across the QOF CHD quality indicators

QOF Indicator	Lowest to highest GP practice achievement	Achievement across the PCT as a whole
The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	93.3% to 100%	98.1%
The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	65.2% to 97.2%	86.8%
The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months	57.0% to 100%	94.9%
The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	44.6% to 94.2%	82.6%
The percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	75.9% to 99.6*%	94.8%
The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)	49.4% to 97.3*%	76.3%
The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or Angiotensin II antagonist	82.5*% to 100%	90.4%
The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	61.5% to 99.1%	92.0%

* excluding practices with less than 30 eligible patients

Source: QMAS data as at 31 March 2007

What are we doing?

- We are in the process of commissioning a cardiovascular disease screening programme. The broad scope of the programme is:
 - primary prevention (reduction of risk factors for cardiovascular disease in the population)
 - identification of those at high risk of CHD, chronic kidney disease, stroke, transient ischaemic attack, or diabetes (so that interventions can be made to prevent disease development)
 - identification of those already with CHD, chronic kidney disease, stroke, transient ischaemic attack, or diabetes (so that these conditions can be managed appropriately).
- Including the care of patients with CHD as a key local priority in the PCT's operational plan 2008/09.

What more needs to be done?

What more can the NHS do?

- Support people who want to stop smoking (including helping employees who want to stop smoking).
- Set an example as a responsible employer by ensuring that on-site catering promotes healthy food and drink choices, and by promoting physical activity in the work place.
- Improve early diagnosis and treatment.
- Improve the primary care of people with CHD: reduce variability in the management and control of risk factors, and in the prescribing of medication for secondary prevention.
- Improve early identification of people at risk (to intervene to prevent the development of CHD).

What more can our partners do?

- Support employees who want to stop smoking.
- Local authorities can also set an example as employers, and should ensure that on-site catering promotes healthy food and drink choices, and promote physical activity in the work place.
- Improve access to well-maintained, safe, affordable, and convenient leisure and sports facilities.

What can the individual do?

- Give up smoking - contact the PCT's Stop Smoking Service.
- Eat healthily (reduce fat intake, eat at least two portions of fish per week - one of which should be an oily fish, increase intake of fruit and vegetables).
- Exercise regularly (at least 30 minutes a day on five or more days a week).
- Drink alcohol sensibly (within the recommended limits)

3.3.5 Chronic Kidney Disease (CKD)

According to GP disease registers, CKD is the fourth most common long-term condition in the PCT. Data (for patients aged 18 and older) shows that as at 31 March 2007, 3.9% of patients were diagnosed as having diabetes compared with 3.0% in England as a whole.

CKD is the broad term for all types of kidney disease that slowly destroys the kidneys over months or years. If not treated, early CKD can progress to more severe forms of the disease, including renal failure. The numbers of people requiring dialysis or transplantation is rising rapidly, and is not expected to reach a steady state for another 25 years.

There is considerable variability between GP practices in the PCT in achieving the CKD quality indicators, notably in the management of high blood pressure. Practices have been working hard to establish CKD registers - which in most cases have more than doubled in size this year. So although the percentage figures may appear low, more patients overall have been assessed.

Summary of achievement across the QOF CKD quality indicators

QOF Indicator	Lowest to highest GP practice achievement	Achievement across the PCT as a whole
The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months	90.3*% to 100%	98.1%
The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less	59.6*% to 100%	81.0%
The percentage of patients on the CKD register with hypertension who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	61.9*% to 100%	84.7%

* excluding practices with less than 30 eligible patients

Source: QMAS data as at 31 March 2007

The premature death rate (pooled for 2004-06) for the PCT is similar to that for England as a whole. However, CKD patients have an increased risk of cardiovascular disease that accounts for 40-50% of all deaths in CKD.

Can we intervene effectively?

Yes. High quality routine care can make a real difference to the lives of people with CKD. The National Service Framework for Renal Services has clear standards to raise the quality of care provided for people with kidney disease, increase their choice, and minimise the impact of their disease.

What are we doing?

- Planning a cardiovascular disease screening programme (described in section 3.3.4).
- Including of the care of patients with CKD as a key local priority in the PCT's operational plan 2008/09.

What more needs to be done?

What more can the NHS do?

- Support people who want to stop smoking (including helping employees who want to stop smoking).
- Set an example as a responsible employer by ensuring that on-site catering promotes healthy food and drink choices, and by promoting physical activity in the work place.
- Increase early identification of people with CKD to maximise the opportunity to prevent or slow disease progression.
- Improve the primary care of patients with CKD: reduce the variation in blood pressure management.

What more needs to be done? (continued)

What more can our partners do?

- Support employees who want to stop smoking.
- Local authorities can also set an example as employers, and should ensure that on-site catering promotes healthy food and drink choices, and promote physical activity in the work place.
- Improve access to well-maintained, safe, affordable, and convenient leisure and sports facilities.

What can the individual do?

- Give up smoking – contact the PCT's Stop Smoking Service.
- Eat healthily (reduce fat intake, eat at least two portions of fish per week – one of which should be an oily fish, increase intake of fruit and vegetables).
- Exercise regularly (at least 30 minutes a day on five or more days a week).
- Drink alcohol sensibly (within the recommended limits)

3.3.6 Stroke and transient ischaemic attack (TIA)

According to GP disease registers, stroke and TIA are the sixth most common long-term condition in the PCT. Data (for all patients) shows that as at 31 March 2007, 2.2% of patients were diagnosed as having had a stroke or TIA compared with 1.6% in England as a whole.

Stroke, the brain equivalent of heart attack, is one of the top three causes of death in England – and the leading cause of adult disability. Because the brain controls everything that we do, feel, think and remember, damage to the brain affects these abilities.

The most important treatable conditions linked to stroke are: high blood pressure, smoking, heart disease, diabetes, and TIA. In the four weeks following a TIA ('mini stroke') the risk of a stroke is around 20%.

Public awareness of the symptoms and impact of stroke – and how strokes can be prevented – is very low.

There is significant variability between GP practices in the PCT in achieving the stroke quality indicators, notably in the management of cholesterol levels and high blood pressure.

Summary of achievement across the QOF stroke quality indicators

QOF Indicator	Lowest to highest GP practice achievement	Achievement across the PCT as a whole
The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months	85.2% to 100%	97.2%
The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	57.3% to 96.4*%	84.7%

Summary of achievement across the QOF stroke quality indicators (continued)

QOF Indicator	Lowest to highest GP practice achievement	Achievement across the PCT as a whole
The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	50.0% to 100%	92.3%
The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	40.5% to 90.7%	77.2%
The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	87.7% to 100%	94.5%
The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	67.4% to 100%	89.3%

* excluding practices with less than 30 eligible patients

Source: QMAS data as at 31 March 2007

The premature death rate (pooled for 2004-06) for the PCT is similar to that for England as a whole.

Can we intervene effectively?

Yes. Many strokes are preventable and developments over the last ten years have shown that fast and effective acute treatment of stroke, along with high quality rehabilitation, can significantly reduce death and disability.

What are we doing?

- The PCT supports a health economy-wide local stroke register which is a key resource in monitoring local health outcomes.
- Planning a cardiovascular disease screening programme (described in section 3.3.4).
- Including of the care of patients with stroke and TIA as a key local priority in the PCT's operational plan 2008/09.

What more needs to be done?

What more can the NHS do?

- Improve public awareness
- Primary prevention: work with primary care to ensure that the identification and management of high blood pressure is a priority.
- Support people who want to stop smoking (including helping employees who want to stop smoking).
- Set an example as a responsible employer by ensuring that on-site catering promotes healthy food and drink choices, and by promoting physical activity in the work place.
- Improve the primary care of stroke and TIA patients: reduce variations in the management of cholesterol levels and high blood pressure.
- Ensure high quality rehabilitation and co-ordinated post-acute support for patients and carers.
- Implement the National Stroke Strategy.

What more can our partners do?

- Support employees who want to stop smoking.
- Local authorities can also set an example as employers, and should ensure that on-site catering promotes healthy food and drink choices, and promote physical activity in the work place.
- Improve access to well-maintained, safe, affordable, and convenient leisure and sports facilities.
- Improve support to stroke survivors and carers.

What can the individual do?

- Know what your blood pressure should be, and get your blood pressure checked regularly.
- Give up smoking - contact the PCT's Stop Smoking Service.
- Eat healthily (reduce fat intake, eat at least two portions of fish per week - one of which should be an oily fish, increase intake of fruit and vegetables).
- Exercise regularly (at least 30 minutes a day on five or more days a week).
- Drink alcohol sensibly (within the recommended limits)
- Don't ignore a TIA – see your doctor as soon as possible.

Chapter Four: Progress with Last Year's Priorities

In this Chapter, I give an update on the key issues highlighted in previous annual reports.

	<i>What are we doing?</i>	<i>What more needs to be done?</i>
Health inequalities	<i>described in Chapter Three</i>	<i>described in Chapter Three</i>
Smoking, chronic obstructive pulmonary disease and lung cancer	<p>Smoking and chronic obstructive pulmonary disease: <i>described in Chapter Three</i></p> <p>Lung cancer:</p> <ul style="list-style-type: none"> ▪ Helping people to stop smoking. ▪ Working closely with the University Hospital of North Staffordshire to improve access to cancer services in order to meet the national waiting times targets. The lung cancer pathway was a particular problem, and work was undertaken to speed up access to diagnostics prior to attending the clinic. ▪ Working with the Greater Midlands Cancer Network and the University Hospital of North Staffordshire, to improve treatment outcomes. 	<p>Smoking and chronic obstructive pulmonary disease: <i>described in Chapter Three</i></p> <p>Lung and other cancers:</p> <ul style="list-style-type: none"> ▪ Working with researchers at Keele University to get a better understanding of why people with symptoms of cancer wait before going to their GP, and what can be done to encourage people to act earlier.
Obesity	<i>described in Chapter Three</i>	<i>described in Chapter Three</i>
Alcohol consumption	<i>described in Chapter Three</i>	<i>described in Chapter Three</i>

	<i>What are we doing?</i>	<i>What more needs to be done?</i>
Infant feeding	<ul style="list-style-type: none"> ▪ Employing dedicated Infant Feeding Co-ordinators: have had a significant impact on the number of mums continuing to breastfeed at 6 weeks and 3 months. ▪ Implementing an Infant Feeding Policy, and a number of supportive projects such as Breast Feeding Cafés. 	<ul style="list-style-type: none"> ▪ Promote antenatal education and support. ▪ Set up maternity services which allow for the time needed to encourage new mums to breastfeed by truly informing them of the benefits <i>and risks</i> associated with the various feeding options, and supporting them through the first weeks of their child's life. Maternity services can play a pivotal role on educating, preparing and supporting women. ▪ Ensure that there is sufficient ongoing support, and learn from the Infant Feeding Co-ordinators' successes. ▪ Better data collection systems.
Sexual health	<ul style="list-style-type: none"> ▪ Working closely with the University Hospital of North Staffordshire and Stoke-on-Trent PCT to improve the services at the GUM Clinic. These improvements have included the re-organisation of opening hours, reducing unnecessary activity, increasing user involvement, and the subsequent move to open access. ▪ Working with Staffordshire Teenage Pregnancy Partnership Board. ▪ The Teenage Pregnancy Team for North Staffordshire: a programme of activities and actions in place that are developed in partnership with young people, their parents and carers that covers both prevention and support. Projects include 'Clinic-in-a-box', and 'Sexplain' (a website with the information on sexual health and HIV, contraception, pregnancy and sexuality). 	<ul style="list-style-type: none"> ▪ Provide more sexual health services in the community (this will be achieved as part of the implementation of our local sexual health plan). ▪ Continue raising public awareness about the seriousness of sexual health issues.

	<i>What are we doing?</i>	<i>What more needs to be done?</i>
Admission avoidance and proactive case management	<ul style="list-style-type: none"> ▪ Developing of a Primary Care Urgent Care Unit, with Stoke-on-Trent PCT, initially on a weekend only basis. ▪ Including of emergency admissions as a key local priority in the PCT's operational plan 2008/09. 	<ul style="list-style-type: none"> ▪ Find new ways to improve the quality of life of people with long-term conditions (including reducing emergency admissions) ▪ Implement the most appropriate local model of care to implement, by formally evaluating the current proactive care and the interventionist approach models. ▪ Planned extension of the Primary Care Urgent Care Unit to seven days a week.
Pharmaceutical public health	<ul style="list-style-type: none"> ▪ All pharmacies within North Staffordshire PCT provide essential services to support public health. ▪ Five pharmacies form part of the North Staffordshire Stop Smoking Service. 	<ul style="list-style-type: none"> ▪ Explore further ways in which community pharmacies can support the 'Staying Healthy' strand of the PCT Strategy.
Global warming	<ul style="list-style-type: none"> ▪ North Staffordshire NHS Estates Agency have developed proposals to reduce the level of primary care energy consumption and improve energy efficiency performance. 	<ul style="list-style-type: none"> ▪ Seek external advice regarding additional steps that the PCT can take to make a positive difference and reduce its carbon footprint and focus on the wider picture beyond that of estates (for example, the development of green travel plans). ▪ Consider signing up to the Climate Change Declaration for Staffordshire, led by the County Council.

Chapter Five: Key Public Health Indicators

Good quality data and information is needed to inform priorities and commissioning. We also need robust indicators to monitor progress with improving health and well-being. This Chapter gives an overview of the key public health indicators available on the PCT's website.

The indicators summarised in the table below is available on the PCT's website. However, if you have any problems accessing the data, please contact the Public Health Directorate and we will be happy to provide a paper copy.

Wherever possible, the data is presented in a number of ways, in order to increase the usefulness of this information for colleagues who work in areas aligned with the local authorities boundaries, and colleagues in practice-based commissioning.

Please note that the geographical boundary of North Staffordshire PCT does not exactly match the combined areas of Newcastle-under-Lyme Borough Council and Staffordshire Moorlands District Council. Three wards within Staffordshire Moorlands District Council (Bagnall & Stanley, Brown Edge & Endon, and Caverswall) are the responsibility of Stoke-on-Trent PCT.

	PCT	Local authority	Commissioning cluster
Demographics (age, gender, ethnicity)	✓	✓	✓ (not all indicators)
Risk factors and lifestyle behaviours (smoking prevalence, obesity, high blood pressure, alcohol indicators, teenage pregnancy, breastfeeding initiation)	✓	✓ (not all indicators)	✓ (not all indicators)
Disease prevalence (asthma, atrial fibrillation, cancer, coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, dementia, diabetes, heart failure, hypothyroidism, epilepsy, mental health (psychotic disorders), stroke and transient ischaemic attack)	✓	✓	✓
Life expectancy	✓	✓	✓
Healthy life expectancy	✓	✓	✓
Premature death (all causes, accidents, cancer, circulatory disease, suicide and undetermined injury, infant deaths)	✓	✓	✗
Deprivation	✓	✓	✓

Glossary

Children's Trusts	<p>Children's Trusts are organisational arrangements which bring together strategic planners from relevant sectors to identify where children and young people need outcomes to be improved in a local area and plan services accordingly.</p> <p>The PCT is a strategic partner on Staffordshire Children's Trust Board, Newcastle Borough Children's Trust Board, and Staffordshire Moorlands District Children's Trust Board.</p>
Commissioning	<p>Commissioning is the process of securing and managing appropriate healthcare services for relevant populations at value for money for taxpayers. It is composed of three phases:</p> <ol style="list-style-type: none">1) Understanding, segmenting and anticipating the needs of local communities and individual patients, and planning and prioritising accordingly.2) Defining services to meet these and contracting them from the most appropriate providers.3) Monitoring provision and managing contracts, to continuously improve outcomes for patients and local communities.
Healthy Schools programme	<p>A programme, overseen by the Department of Health and the Department for Education and Skills, which encourages schools to contribute to the improvement of children's health and well-being. To become a Healthy School, schools must meet certain criteria in four core areas: personal, social and health education, healthy eating, physical activity and emotional health and well-being.</p>
Joint Strategic Needs Assessment (JSNA)	<p>JSNA describes a process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness.</p>
Local Area Agreements (LAAs)	<p>The LAA is an agreement that sets out the priorities for a local area in certain policy fields as agreed between central government (represented by the Government Office), and a local area, represented by the local authority and Local Strategic Partnership and other partners at local level. The agreement is made up of outcomes, indicators and targets aimed at delivering a better quality of life for people through improving performance on a range of national and local priorities.</p>
Local Strategic Partnerships (LSPs)	<p>A Local Strategic Partnership is a body made up of organisations from across a specific area, working together to improve the quality of life for local people in the area. An LSP involves people from local authorities, the emergency services, the health service, education, social care, community groups, local businesses and voluntary organisations. The aim of an LSP is to ensure that the partner organisations work effectively together across all of their activities to bring about improvements in local communities.</p>
Long-term conditions	<p>Conditions (for example, diabetes and asthma) that cannot, at present, be cured but whose progress can be managed and influenced by medication and other therapies.</p>

National Institute for Health and Clinical Excellence (NICE)	The independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill-health.
Primary prevention	Primary prevention aims to avoid the development of a disease or condition.
Public Service Agreement (PSA)	An agreement between each government department and HM Treasury which specifies how public funds will be used to ensure value for money.
Quality and Outcomes Framework (QOF)	<p>The QOF is part of the contract PCTs have with GPs. It is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results.</p> <p>The QOF contains four main components, known as domains. Each domain consists of a set of measures of achievement, known as indicators, against which practices score points according to their level of achievement.</p>
Secondary prevention	Secondary prevention aims to limit the progression and effect of a disease at as early a stage as possible. It includes further primary prevention.