Public Health

South Staffordshire NHS
Primary Care Trust

Mind the Gap

A five year public health plan to address Health Inequalities in South Staffordshire

Produced by SSPCT
Public Health Department

This document is the public health strategy for closing the health gap and tackling health inequalities

The subsequent sections on lifestyle interventions are HOW WE ARE GOING TO DELIVER THE STRATEGIC PLAN

Introduction

Over the last 18 months the Public Health Directorate has quantified the health status of the population of South Staffordshire. It has produced a number of reports for the PCT Board and commissioners culminating in the two most recent reports on health inequalities with a focus on infant mortality and life expectancy.

The PCT Board recognises the imperative to reduce health inequalities within South Staffordshire and has requested the Health and Well-Being Service Improvement Board to develop a strategy to reduce the gap in health over the next five years.

As well as a focus on reducing the health gap, this strategic plan supports the commitment of the PCT to invest in health improvement and prevention, and to improve the health and well-being of the population we serve as a whole.

This document follows the reports to the Board and sets out the evidence of need to support the proposed investment along with action plans for key interventions which will deliver the improvements needed.

The purpose of this document is to provide the PCT with an action plan for health improvement, and commissioners with information to allow local prioritisation and implementation. The plan brings together a number of public health interventions, each will be developed in its own implementation plan.

This plan builds on the PCT “Staying Healthy Strategy”. Some observers may notice variance in costings between the two papers, which is because the “Staying Healthy Strategy” focuses on primary prevention and does not include comprehensive service provision costs.

This plan also makes considerable financial sense. Currently South Staffordshire spends approximately £25m on hospital admissions for circulatory disease. This is expected to increase to approximately £29m by 2013 along with a steady increase in respiratory and diabetes hospital admissions.

With an increasing elderly population, demands on health services will increase and investing in prevention of ill-health is a legitimate means of managing demand on health services.

Meeting Corporate Targets and Objectives

This Strategic Public Health Plan is the contribution of the Public Health Directorate to addressing the following corporate objectives and targets.

1) PCT Strategic Themes

- Improving child health
- Increasing life expectancy
- Quicker high quality healthcare
- Improving care for patients with long-term conditions
- Patients in control of their health
- Working with partners

2) Corporate Objective

- CP4 Reduce Inequalities in Health Outcome by 10%

3) Vital Signs

- VSB05 Smoking prevalence
- VSB09 Childhood obesity
- VSB11 Prevalence of breastfeeding (6 - 8 weeks)
- VCS27 Patients with diabetes
- VSC23 Practices with CVD registers
- VSC26 Rates of admission for alcohol related harms

4) Local Area Agreement Targets (LAA)

- NI8 Adult participation in sport
- NI56 Obesity in primary school children (year 6)
- NI39 Alcohol related admission
- NI121 Mortality rate from all circulatory diseases below the age of 75
- NI123 Smoking prevalence age 16+

The Plan

South Staffordshire PCT will reduce the health inequality gap within the PCT and improve the overall health of the population by concentrating efforts on reducing the risks of developing cardiovascular disease (CVD). Many of these risks are associated with modifiable lifestyle issues, which, as well as reducing the mortality and morbidity associated with CVD, have also been demonstrated to have beneficial effects on the incidence of cancers.

CVD includes coronary heart disease, stroke, diabetes and kidney disease. It accounts for the largest contribution to differences in life expectancy. In addition South Staffordshire PCT will reduce the level of infant mortality in East Staffordshire to the same as for the rest of the PCT – a reduction of 25%. Many of the factors associated with infant mortality overlap with the risk factors associated with CVD. This plan will focus on lifestyle interventions and prevention of CVD. The Long Term Conditions Service Improvement Board will take forward the other elements of the CVD clinical pathways, which will include appropriate access to treatment for patients with a persistent CVD risk of >20% in accordance with NICE guidance.

Infant mortality is small in numbers but has a significant impact on reduced life expectancy as so many years of life are lost. High levels of infant mortality are also an indicator for poor health across a community and to tackle infant mortality we need to improve health in general.

In the final section of this plan, we consider other Public Health challenges that the PCT will need to address in the next five years. This recognises that whilst CVD prevention will have the single largest impact on the health of the population, other areas including sexual health, primary mental health and oral health also need addressing.

The impact of the plan will be to ensure both CVD and infant mortality are reducing beyond national targets as well as closing the health in equalities gap within South Staffordshire.

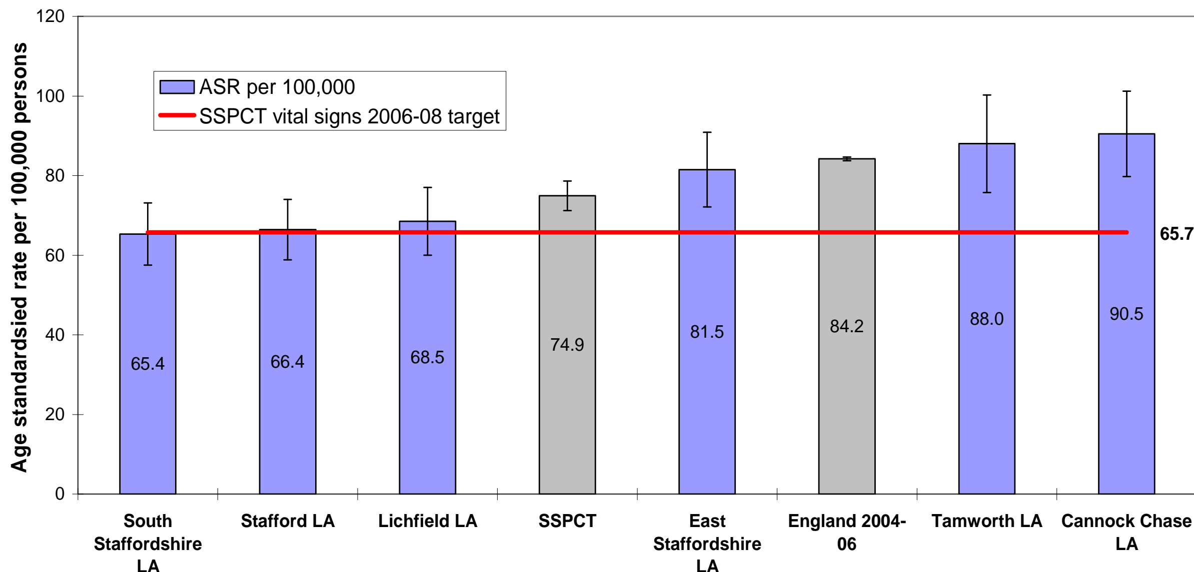
Developing an Ethos of Self Care

Self care was highlighted in the NHS Plan as one of the key building blocks for a patient-centred health service. More recently self care featured as a key component of the model for Supporting People with Long Term Conditions. Research shows that supporting self care can improve health outcomes, increase patient satisfaction and help in deploying the biggest collaborative resource available to the NHS and social care - patients and the public. Helping people care for themselves presents an exciting opportunity and challenge for the NHS and social care services to empower patients to take more control over their lives.

In recognising a model whereby the population adopt healthier lifestyles, the contribution that patients themselves can make should not be underestimated. Social marketing programmes delivering healthcare messages have been shown to bring about lifestyle change. Furthermore investing in “healthcare marketing” and support is a cost-effective means of bringing about change in people to become well-motivated, culminating in reduced need for health and social services.

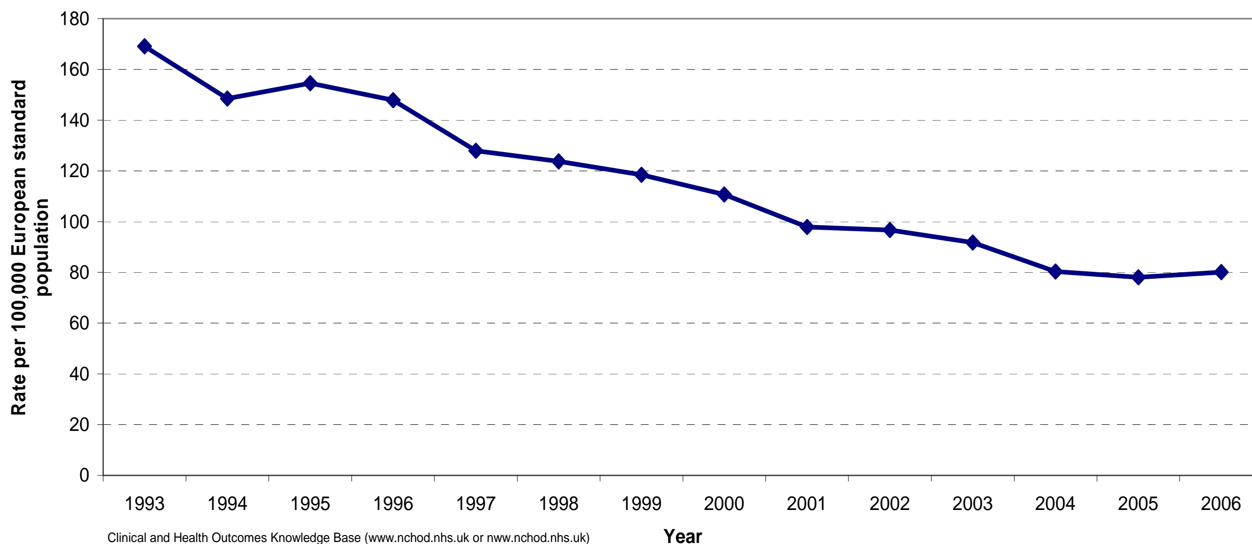
The following sections of the Public Health Plan involve the development of information and support to empower the population of South Staffordshire to maximise their own contribution to their health and well-being. This will be achieved by ensuring that patients have access to a wide range of services to meet their needs in key areas. Investment will be needed in some areas to ensure that services meet the required standards.

Why CVD and Infant Mortality?



The table above clearly demonstrates that current levels of premature death relating to CVD are significantly above the target for South Staffordshire. Particular emphasis will need to be placed on reducing CVD prevalence in East Staffordshire, Tamworth and Cannock localities.

The graph below also identifies that the rate of fall in CVD mortality within South Staffordshire appears to have plateaued, with a small rise between 2005 and 2006.



For infant mortality, there are key factors which overlap significantly with CVD lifestyle modification including smoking in pregnancy and obesity in pregnancy. In addition reducing conception rates in the under 18s age group is also a key target and a PCT "vital sign" (VSB08).

When effectively targeted, interventions that focus on CVD and infant mortality reduction will also impact on Chronic Obstructive Pulmonary Disease (COPD), cancer and other factors in reducing life expectancy.

Understanding the link between lifestyle and CVD risk

The key determinants of cardiovascular risk are:

- Smoking
- Hypertension
- Cholesterol levels
- Diabetes
- Alcohol

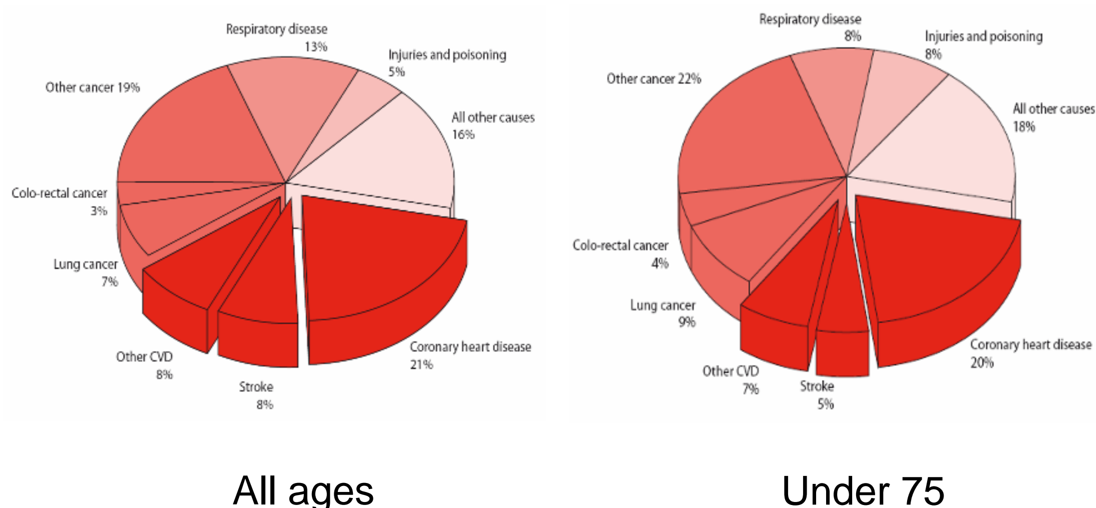
Smoking is a wholly modifiable risk factor. Stopping smoking can reduce cardiovascular risk by more than 30%.

High blood pressure increases cardiovascular risk in direct proportion to the elevation from normal. Men who drink more than eight units a day are four times more likely to suffer from hypertension and have a doubled risk of having a stroke.

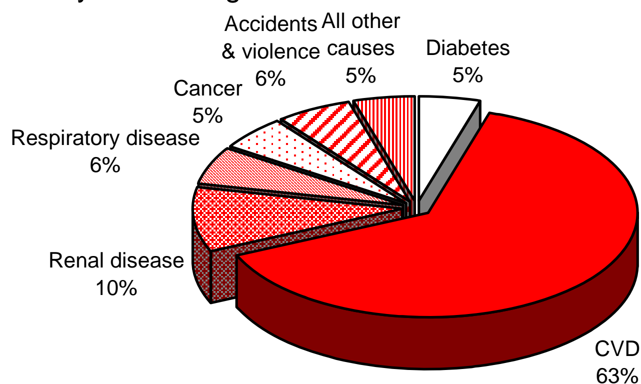
Sensible drinking, diet and exercise have all been shown to reduce blood pressure, and small changes in blood pressure can have a dramatic benefit. A 2mmHG reduction in systolic blood pressure is estimated to reduce the incidence of stroke by 7% and mortality by 10%. So small changes deliver dramatic benefits.

People who are obese are more than 12 times more likely to develop type II diabetes. In addition to the burden of diabetic complications, the presence of type II diabetes can increase cardiovascular risk by over 30%. The single biggest cause of death for patients with type II diabetes is cardiovascular disease. The diagrams below clearly identify the impact of CVD in patients suffering from diabetes. Preventing diabetes through weight management and other lifestyle improvements will therefore reduce cardiovascular deaths as well as reducing the burden of treating diabetes.

Causes of death in men 2005



All ages Under 75



The pie charts above show that in men under the age of 75 CVD accounts for around 32% of deaths, in men with diabetes this increases to 63%, the pattern is similar for women.

Risk factors compound and diabetic, obese smokers are at highest risk of a cardiovascular event.

In a follow-up from the Framingham study conducted between 1948 and 1990, it was identified that a 40 year old obese smoker would lose in excess of 13 years of life expectancy compared to a non-smoking 40 year old of normal weight.

In the UK CHD deaths reduced by 68,230 between 1981 and 2000; 58% of this reduction was due to a change in lifestyle risk factors. It should be recognised that as these risk factors are additive and not providing a comprehensive lifestyle service may only partially address the issues.

What needs to be done?

We cannot delay action if we are to have an impact in five years. We need to focus the interventions where they will be most effective and take forward the strands of work simultaneously (see scarf tables Appendix 1). In particular we need to challenge ourselves by setting a number of PCT aspirational targets. Key actions include:

1) Implement a cardiovascular risk management programme to identify those most at risk and provide comprehensive services to reduce that risk.

2) Carry out a CVD health equity audit to determine access to services including appropriate pharmacotherapy for patients with CVD risk above 20% and maximise uptake of secondary prevention.

3) Take steps to reduce the levels of infant mortality in East Staffordshire.

4) Commission services that will have a significant and enduring impact on smoking, physical activity, obesity, alcohol and under 18 conceptions.

5) Engage with the population to develop an ethos of self care. This will need to address primary mental health issues so people are able to make healthy lifestyle choices including the uptake of immunisation and screening opportunities offered to them.

6) Utilise all health and social care practitioners as public health advocates, providing brief interventions and signposting of services at every opportunity.

7) Work with all partners across the Local Area Agreement (LAA) to tackle the wider determinants of health inequalities including education, housing and employment in those areas with the widest health gap.

The following sections of this document consider the individual elements of the public health plan that will need to be delivered in unison to deliver the aspirations of the plan

Cardiovascular Risk Assessment Programme

Vision

Through our primary care services we have a unique opportunity to keep people well. A comprehensive standardised risk assessment of people's lifestyle and current health status with a wide range of lifestyle services to refer into will radically change the way we approach CVD. It will become a disease to be prevented rather than just treated.

Key Points
• To address modifiable lifestyle risk factors at an individual patient level, and to ensure appropriate treatment of patients identified with a persistent CVD risk of >20%, the PCT needs to identify and implement a risk assessment programme that meets the needs of the population. • Current evidence suggests that assessment of CVD risk is poor and inconsistent in some practices, resulting in some patients being under treated whilst others are treated inappropriately. • CVD risk assessment is not new and some activity will already be in place. • There is a DH plan to assess all patients aged 40 - 74 for cardiovascular risk, this equates to 270,000 patients in South Staffordshire PCT, which will require an innovative approach to delivery. • Once high-risk patients are identified, there will be a need to increase capacity within the lifestyle modification services to deliver the changes needed. (Eg smoking cessation, weight management, physical activity and alcohol). • Active case seeking and subsequent treatment in accordance with national guidance will increase prescribing costs. Current expenditure in South Staffordshire PCT on "statins" is 9% below the national average.

5 Year Stretch Targets

- By 2013 all patients over the age of 40 should have been offered a cardiovascular risk assessment.
- By 2013 80% of patients over the age of 40 should have a documented cardiovascular risk assessment.
- By 2013 all patients with modifiable risk factors should have received a documented brief intervention on lifestyle advice and change.
- By 2013 patients requiring support to bring about lifestyle change will have access to a range of services to meet their needs.

What Needs To Be Done?

- Agree a framework for CVD risk assessment. There are models based on Framingham which are widely available, however all models relate to specific populations and no one model is generally applicable.
- Specific consideration needs to be given to ethnicity, family history of premature death and patients with enduring mental health problems.
- Provide training to healthcare professionals on the CVD risk assessment process to ensure quality and consistency.
- Commission services to deliver robust and high quality risk management services, with emphasis on ensuring that the specific areas of health inequality are prioritised.
- Develop an ongoing programme of audit to ensure quality and effectiveness of commissioned programmes.
- Develop patient care pathways incorporating lifestyle services to reduce cardiovascular risk and improve overall health of the population.

CVD Health Equity Audit

Cardiovascular disease has been identified as the major cause of premature death in South Staffordshire, accounting for around a third of deaths. We need to undertake a health equity audit to ensure that services and interventions are targeted at areas of greatest need and impact.

The National Institute for Health and Clinical Excellence has produced public health guidance*, Identifying and supporting people most at risk of dying prematurely.*

What is a health equity audit?

Health equity audit (HEA) is a process which utilises the audit cycle to identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas.

Health equity and reducing health inequalities

The purpose of undertaking a HEA is to provide information to help narrow the health inequalities gap by taking positive decisions on investment, service planning, commissioning and delivery. Health equity audits focus on how fairly resources are distributed in relation to the health needs of different groups. This may include resources such as services, facilities, and the determinants of health such as employment and education. The overall aim is not to distribute resources equally, but rather in relation to need.

Therefore the audit cycle is not complete until something changes to reduce inequalities, for example, changes in resource allocation, commissioning, service provision or care outcomes.

A local HEA will inform future commissioning proposals for changes in investment and services with the aim of reducing avoidable health inequalities and promoting equal opportunity to the determinants of good health, access to health and other services.

Why is a CVD health equity audit needed?

In men, coronary heart disease makes up on average 55% of all South Staffordshire PCT circulatory disease deaths and stroke 23%. In women, only 41% of all circulatory disease deaths are due to coronary heart disease, with 35% due to stroke. (Source: National Statistics 2004-06)

These figures highlight important differences in our population and the need to address prevention and management of all vascular disease, and stroke in particular, and not just CHD if we are to reduce all circulatory disease mortality. A local CVD health equity audit is needed to ascertain the equity of provision of services received by the different sections of the population and different localities in the PCT across the whole care pathway, from primary and secondary prevention to cardiac rehabilitation and other tertiary services.

A CVD health equity audit for South Staffordshire

A local South Staffordshire PCT CVD HEA would include the following conditions and risk factors:

- CHD
- Stroke
- Diabetes
- Chronic kidney disease
- Risk factors – the above conditions share the same modifiable risk factors, for example:
    - Smoking
    - Hypertension
    - Obesity
    - Lipid abnormalities

It is proposed to carry out the audit in two phases, following a model used by Cambridgeshire and Peterborough PCTs.

- Phase 1 to address differences in services received in each of the localities in the PCT and consider any differences between the populations serviced by different secondary care providers.
- Phase 2 will be to look in more detail at levels of inequality between smaller areas, and for specific vulnerable groups, for example, black and minority ethnic groups.

Smoking & Tobacco Control

Vision

Smoking is such a significant risk factor to CVD, COPD and cancer that the PCT needs to make every effort to stop people starting and to give them support to quit. A comprehensive high quality programme could bring about those real changes in the population's health and the PCT needs to be aspirational.

Key Points
• Quitting at any age provides both immediate and long-term health benefits. Smokers who quit before the age of 35 years have a similar life expectancy to someone who has never smoked. • Smoking costs the NHS in South Staffordshire approximately £20.2m per year. Smoking costs the South Staffordshire economy over £140m each year (RDPH 2006). Tackling smoking therefore has benefits not only to the individual, and the NHS, but the wider economy. • Smoking is the most significant lifestyle factor for health inequalities. Reducing smoking is the most effective lifestyle intervention to reduce CVD. • Smoking is estimated to cost the NHS £1.5bn each year and is the single greatest cause of preventable illness and premature death in the UK. • Synthetic estimates suggest that across South Staffordshire there are 114,000 adult smokers (23%), it is further estimated that over 3,200 children aged 11 - 15 smoke regularly. • Overall smoking prevalence is higher in Cannock Chase and Tamworth localities, including higher smoking in pregnancy rates.

5 Year Stretch Targets

- To record patient smoking status in at least 80% of registered population by 2010 and 100% by 2013.
- To reduce adult smoking prevalence in South Staffordshire from 23% to below 18% by 2013.
- To reduce adult smoking prevalence in Cannock Chase and Tamworth to below 23% by 2010 and to below 21% by 2013.
- To reduce the percentage of mothers smoking at delivery by 2% each year for the next five years.
- To reduce the number of 11 - 15 years olds who regularly smoke by 30% by 2013.

What needs to be done?

- Commissioners will need to recognise that these challenging targets may need novel and innovative models of service delivery.
- Full implementation of the National Smoking Support Team's 10 point strategy for tobacco control, which includes an integrated approach to stopping smoking, and preventing people starting to smoke.
- Double capacity and delivery of quit rates in the areas of highest smoking prevalence.
- Target services at health inequality groups, including pregnant women, patients with chronic ill-health and enduring mental illness.

Physical Activity

Vision

Being more active brings great mental and physical health rewards. It brings protection from disease as well as core stability. It energises and improves self confidence and mental health. A more active South Staffordshire will mean a more positive, healthier community.

Key Points
• In 2006 South Staffordshire PCT 12% of men and 11% of women achieved the recommended levels of physical activity, with 47% of men and 54% of women doing no physical activity during the week. • Physical inactivity costs South Staffordshire PCT £100m per annum (excluding costs of obesity). • Regular physical activity can help to prevent cases of hypertension, diabetes, coronary heart disease and obesity. It can also improve numerous physiological conditions, improve well-being and reduce anxiety and depression. • Regular physical activity can reduce the risk of developing type II diabetes by up to 64% independent of weight loss. • 11% of hypertension is estimated to be due to low levels of physical activity. • 9% of coronary heart disease could be avoided if all those who are sedentary or lightly active became moderately active. • The estimated number of patients in South Staffordshire who are obese due to low levels of physical activity is 26,500. • If levels of adult physical activity were increased South Staffordshire PCT could: o Prevent 5,254 cases of diabetes per annum and save £2.9m on drug costs o Prevent 16,500 cases of hypertension per annum and save £1.4m on drug costs o Prevent between 3,300 - 5,500 cases of CHD and save between £6.6 – £11m per annum o Save £4m per annum by preventing obesity through increased physical activity

5 Year Stretch Targets

- To increase the number of physically active adults by 10% over the next five years; this equates to 44,780 more people participating in physical activity each year.
- Increase participation of specific target groups (those with a disability, BME, women, older people, long-term limiting illness).
- Increase activity in those areas with the worst health – Cannock Chase, Tamworth and East Staffordshire – to the percentage achieved within the rest of South Staffordshire.
- Increase activity in those with diabetes/hypertension/CHD and those with significant risk factors.

What needs to be done?

- Produce and implement a PCT wide strategy and action plan with clear targets and achievable outcomes on physical activity which covers the NHS health economy.
- Target interventions in the workplaces across South Staffordshire.
- Maximise the use of open spaces and leisure centres.
- Equip all NHS staff in primary and secondary care with skills and knowledge to deliver brief interventions and give out messages to patients about recommended levels of physical activity.
- Develop a population marketing and communications campaign.
- Commission physical activity interventions for key groups and ensure that physical activity is included within all lifestyle programmes in the NHS and local authority.

Reducing Adult and Childhood Obesity and Improving Nutritional Status

Vision

Our vision for reducing obesity and increasing healthy eating includes ensuring children have a healthy growth and weight; that healthier food choices are widely available and promoted and that individuals can get the support they need to change their eating habits. We need to develop a generation who understands food, can cook and finds it easy to make healthy lifestyle choices.

Key Points
• In South Staffordshire PCT in 2008 28% of adults are obese. • Currently South Staffordshire PCT spends £143.7m on treating diseases related to overweight and obesity. This will rise to £159.5m in 2015. • People who gain weight during adulthood are up to 12 times more likely to develop type II diabetes, which confers a significant increase in cardiovascular risk and burden on healthcare resources. • Incidence of type II diabetes is directly proportional to the incidence of obesity, being responsible for 55% of type II diabetes; 21% of heart disease, 10% of non-smoking related cancers. • Children who are obese are more likely to continue to be obese into adulthood. • Obesity during pregnancy may result in lower birth-weight and increased infant mortality. • Breastfeeding reduces the incidence of childhood obesity. • People from lower socio-economic groups are less likely to eat well, and this contributes to the gap in health inequalities with obesity related illness leading to 9,000 premature deaths each year in the UK and reducing life expectancy by an average of nine years. • Diet and nutrition are fundamental to health throughout life. A good diet helps to maintain a healthy bodyweight, improve general physical and mental health and reduce ill-health. • Healthy eating, in conjunction with physical activity, can be used to reduce obesity as well as prevent future weight gain.

5 Year Stretch Targets

- To increase the percentage of mothers breastfeeding at 6 - 8 weeks by 2% year on year to 36% in 2013.
- To increase the percentage of mothers who initiate breastfeeding by 2% year on year for five years.
- To reduce the incidence of adult obesity by 2% by 2013 from 28% to 26%.
- To halt the year on year increase in obesity in reception and year 6 children by 2010/11. (LAA, Vital Sign)
- To reduce the proportion of overweight and obese children to 2000 levels by 2013.

What needs to be done?

- Develop an understanding of the prevalence of obesity and lifestyle behaviours of our population.
- Define PCT priority areas for evidence based interventions.
- Develop obesity and weight management pathways.
- Offer personalised support for overweight and obese individuals.
- Further support the “Food in Schools programme” to implement a whole school approach to food education and healthy eating.
- Promote the national school fruit and vegetable scheme.
- All health professionals are trained in brief intervention on weight management.
- Ensure lifestyle interventions are being driven through mainstream health services, eg school nursing, health visiting, primary care.
- Ensure PBC addresses BME issues with regard to diet and nutritional education.
- Ensure all partners are clear as to their role in promoting the benefits of a healthy diet.

Alcohol

Vision

Our vision for the prevention and treatment of alcohol misuse in South Staffordshire over the next five years is to create an integrated service provision to reduce the negative impact of alcohol on individuals, families and the community in which they live. The impact of alcohol on people's physical and mental health is not well understood by the public and we need to ensure people can make healthy decisions about how they use alcohol.

Key Points
• Excessive alcohol consumption is implicated in social disorder and anti-social behaviour as well as having a significant impact on health. • Alcohol costs the South Staffordshire NHS £20m a year. • 25% of adults in South Staffordshire drink at a harmful level. • Excessive alcohol consumption in men doubles the risk of stroke and increases the risk of coronary heart disease by 70%. • It is estimated that around 500 women in South Staffordshire PCT drink harmfully during pregnancy. • 80 deaths each year in South Staffordshire are attributed to alcohol misuse. • Approximately 30% of 11 - 15 year olds in South Staffordshire consumed alcohol in the previous week. Levels of drinking among all young people is significantly higher than England. • Alcohol misuse is associated with 150,000 hospital admissions in the UK each year. • 50% of A&E attendances for assault happen at weekends.

5 Year Stretch Targets

- To reduce the percentage of the public who perceive drink and rowdy behaviour as a problem in their area.
- To reduce the number of alcohol related presentations at A&E by at least 1% each year.
- To reduce chronic and acute ill-health caused by alcohol, resulting in fewer alcohol related hospital admissions.

What needs to be done?

- Identify the current level of local provision for alcohol related harm and harm reduction and identify any gaps.
- Understand and agree an integrated model of provision across the whole prevention and care pathway, ensuring it addresses the five strategic themes identified from the alcohol needs assessment. These being to (i) improve and increase the provision of alcohol services; (ii) to target families and children in most need; (iii) to provide awareness, education and prevention services; (iv) to tackle alcohol related crime and disorder; (v) build a stronger community response to alcohol.
- Become more outcome focused in the commissioning of alcohol services.
- Ensure arrangements are in place for implementation, monitoring and evaluation.
- Build an evidence base of effective interventions to support the PCT strategy.

Reducing Health Inequalities in Infant Mortality

Vision

The death of a baby is devastating for any family and we would aim to reduce preventable death significantly. We want mothers to be able to make healthy lifestyle choices, to link up with antenatal services early and be offered high quality care for themselves and their baby.

Key Points

- Although infant mortality has fallen in South Staffordshire from 6.3 per 1,000 live births in 1999 - 2001 to 5.6 in 2004 – 2006, unacceptable differences still exist. Babies from certain population groups (routine and manual socio-economic groups, students, unemployed and lone mothers) are more likely to die before their first birthday. Also infant mortality in East Staffordshire appears to be on an upward trend since 2000 - 2002, and in 2004 - 2006 was statistically higher than England as a whole at 8.4 per 1,000 live births.

- The main cause of deaths in the first week of life between 2003 - 2005 in East Staffordshire was immaturity related conditions (43%). Congenital anomalies accounted for 19%. Unusually however the number of deaths in the first week of life in East Staffordshire exceeds the number of stillbirths (deaths from 24 weeks of gestation to birth).

- Although the mortality rate is falling for routine and manual workers, the mortality rate is falling faster in the population as a whole and additional efforts need to be made to narrow the health gap by at least 10% (ie reduce the relative gap from 13% in 1997 - 1999 to 12% in 2009 - 2011).

- Avoidable deaths can be prevented through the provision of high quality pre-conception, maternity and neonatal care and we must focus our interventions particularly on high-risk groups.

- Infant mortality rates have long been a reliable marker of the health of populations and reflect both population risk and the effectiveness of services. They also form the tip of an iceberg in measuring wider health issues such as nutrition, smoking, breastfeeding.

- It remains a key national target reflected in the National Operating Framework 2008/09 and will be part of the Comprehensive Strategy on Inequalities which is due for release in 2008. Reducing inequalities in infant mortality impacts on the health and well-being of children and contributes to the aim of reducing inequalities in life expectancy.

5 Year Stretch Targets

- The National Infant PSA objective is to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole, starting with children under one year, by 2010.
- The South Staffordshire PCT aspirational target is to reduce the upward growth of infant mortality in East Staffordshire currently at 8.4 per 1,000 live births and reduce it to the South Staffordshire PCT rate of 5.6 per 1,000 live births.
- To stop the increase in under 18 conception rates and to meet the national target for South Staffordshire.
- Infant mortality will be reduced if we meet our targets for obesity, alcohol and smoking.

What needs to be done?

- Avoidable deaths can be prevented through the provision of high quality pre-conception, maternity and neonatal care and we must focus our interventions particularly on high-risk groups.
- Provision for breastfeeding co-ordinators, and increased provision for smoking cessation services and weight management have been identified elsewhere in this strategy and their implementation will have an impact on infant mortality.
- We need to do a significant piece of work to determine the reasons for the current position in East Staffordshire and commissioners will need to recognise that these challenging targets may need novel and innovative models of service delivery.
- Although the target is about the gap between the population as a whole and routine and manual groups, the highest infant mortality rates occur in the "other" group, that is students, never worked, long-term unemployed or occupation inadequately described and sole registrations where births are registered by the mother alone. Any actions to address infant mortality should include these groups as well as the target group.
- Social deprivation and housing are also key determinants of infant mortality, healthcare services should work with other agencies to address this.
- Implementation of an effective teenage pregnancy strategy.
- The focus should be on pre-conception preparedness and maternal health, including nutrition, alcohol and smoking status. Additional support will also be provided for women already pregnant who may be overweight or smoke.
- Post-natally all new mothers should be encouraged and supported to breastfeed.

Supplementary Public Health Challenges

In addressing the health inequalities and targets previously described, health and social care professionals will also have opportunities to provide public health messages and further contribute to closing the health inequalities gap.

Vision

As well as managing the major modifiable threats to health, we need people to consider other ways they can take responsibility for their health including sexual health, mental health, oral health and uptake of screening.

Key Points
• Sexual health is key in preventing unplanned pregnancy and sexually transmitted infections. • Primary mental health services are a major challenge. • The least well off in society are least likely to take up childhood and adult immunisation and screening opportunities. • The rates of screening vary across localities. • Health inequalities in oral health also exist within South Staffordshire. • Developing the workforce as Public Health Advocates will maximise the delivery of brief interventions. • Working with partners from allied organisations will maximise impact of campaigns and “normalise” healthier lifestyle activity.

5 Year Stretch Targets

Specific Targets are included under each section, but will include:

- Increase childhood immunisation uptake in the lowest performing localities, with an aspiration to achieve immunisation levels equivalent to the best locality.
- Delivering on sexual health targets including teenage pregnancy, GUM access and Chlamydia screening.
- Improve uptake rates for cervical and breast screening in low-uptake groups.
- Consider ways of reducing oral health inequalities, including extension of existing water fluoridation schemes.
- Improve impact of oral health services through ensuring that oral health improvement is at the core of commissioning and provision, in line with “Delivering Better Oral Health” (see Oral Health Strategy).

Sexual Health

Vision

In South Staffordshire we will provide a comprehensive sexual health prevention and treatment programme to meet the needs of our residents. Services will be easily accessible, appropriate to different sections of the community and support individuals to make healthy sexual choices.

Key Points
• High rates of teenage pregnancy contribute to health inequalities and infant mortality. • Promotion of "Safe Sex" messages can reduce conception rates and reduce incidence of sexually transmitted infections. • A sexual health needs assessment may identify gaps in service provision which will need to be addressed. • Chlamydia is a known cause of female infertility, failing to screen and treat may result in increased future demands for costly infertility services such as IVF.

5 Year Stretch Targets

- To increase the percentage of patients offered an appointment to be seen within 48 hours of contacting GUM to achieve 100% by 2008.
- Demonstrate the reduction in the number of new diagnosis of Gonorrhoea per 100,000 population.
- To screen 50% of the sexually active population aged 15 - 24 annually for Chlamydia.
- To reduce the under 18 conception rate by 50% by 2010, defined as the number of conceptions to under 18 year olds in a calendar year per 1,000 females aged between 15 – 17.
- Improve the health and social care for people living with HIV and reduce the stigma associated with HIV and STIs.

The above are monitored targets, but there is also a requirement to provide open access to contraceptive, termination, GUM and HIV services.

What needs to be done?

- Commission a comprehensive sexual health service, following a sexual health needs assessment.
- Develop sexual health service networks within the PCT.
- Promote information and education of sexual health through a comprehensive health promotion programme.
- Empower and involve people who use services ensuring services meet the sexual needs of all residents.
- Ensure prompt access to services and information.
- Detect and manage sexually transmitted infections with prompt access to diagnostic services.
- Improve access to contraceptive advice and provision.
- Provide termination as early as possible in pregnancy.
- Develop community gynaecology services.

Mental Health

Vision

There is no health without mental health! The vision for the five year public health plan for mental health is for professionals and the public to recognise that mental health and well-being frequently underpin risk-taking behaviours, poor physical health and lack of social well-being and that strategies to promote protective factors and address risk factors are key to improving health and reducing health inequalities in general.

Also, at the end of five years, clinical pathways and interventions from a range of providers are in place that enable 'intervention downstream' to promote positive mental health and to intervene earlier before problems escalate.

Key Points
• There is no health without mental health. Mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families and communities. Good mental health enables people to experience life as meaningful and for them to become creative and active citizens. • Mental health promotion aims to increase the factors that promote positive mental health and reduce those that undermine it. • Smoking, drug and alcohol abuse, unwanted pregnancy and poor diet all contribute to poor mental health. • Good mental health protects physical health and improves health outcomes and recovery rates, notably for CHD, stroke and diabetes. Poor mental health significantly increases the risk of poor physical health and is associated with poor self management of chronic illness. There is a link between feelings of anger, despair, frustration, hopelessness, low self worth and higher cholesterol levels, blood pressure and susceptibility to infection. As risk factors for heart disease, psychological factors are on a par with smoking, high blood pressure, obesity and cholesterol problems. • Many people have symptoms of mental distress that do not reach clinical levels but which would benefit from mental health promotion intervention. For both clinical and non-clinical populations, even small improvements in mental health can contribute to improvements in physical health, productivity and improved quality of life. • The skills and attributes associated with positive mental health not only lead to improved physical health and better quality of life, but also reduced crime, higher educational attainment, economic well-being and personal dignity. • Local mental health needs assessments and research shows that mental health promotion and prevention services are underdeveloped and that services that do exist are patchy.

What needs to be done?

- Agree and implement a model for mental health promotion locally which places mental health and well-being at the centre of improving physical and social well-being.
- Address risk factors and promote protective factors.
- All partner organisations create mental health promoting policy and supportive environments.
- Raise awareness and promote positive mental health through health and well-being programmes.
- Map existing provision and develop service specifications for a more comprehensive range of mental health interventions, including working with partners on the wider determinants of mental health.

Screening Programmes

It is recognised that screening programmes are taken up by the better off in society more than the least well off and this leads to increased health inequalities.

1. Antenatal and Childhood Programmes

Issues and Challenges

Antenatal screening programmes aim to offer informed reproductive choice and for some such as antenatal haemoglobinopathy screening it needs to be offered as early in the pregnancy as possible. Women from disadvantaged backgrounds, ethnic minority groups and teenage mothers tend to present later in pregnancy for antenatal care with therefore less opportunity for choice. HIV screening is also more likely to be declined by those more likely to have the disease. The aim of newborn and childhood screening programmes is to detect and manage problems early.

Coverage of the newborn bloodspot screening programme is high as it is done by community midwifery in the home. However, the newborn hearing screening test, which is done in hospitals for about half of our children, can get missed if mothers leave hospital early and do not attend for community follow up. Screening programmes for vision in older children have lower coverage when offered appointments in community clinics rather than school based sessions.

Informed consent is an essential part of the screening process and for women whose language is not English or who do not read well information may be less available.

Geographical access to both maternity and children's services can also be a problem for families without cars.

New programmes and standards are being introduced.

There is not a well established QA System.

What needs to be done?

- Introduce the new haemoglobinopathy screening programme for all pregnant women by 2010.
- Move to combined Downs Syndrome test in first trimester by 2011.
- Ensure equity of childhood vision screening across the PCT by 2012.
- Implement Quality Assurance for all screening programmes with regular reporting by 2011 and commission to agreed standards.
- Carry out equity audits for screening programmes.

2. Adult Screening Programmes

Issues and Challenges

There are several challenges associated with the implementation of screening programmes. While most of these issues are common to all screening programmes, others are specific to particular programmes.

The coverage and uptake of screening services remains an important determinant of its effectiveness in the population. While the PCT has worked to increase the coverage of these services across its population, it is recognised that uptake varies between subgroups within the population. Uptake tends to be better among the better off (socioeconomic inequality), and in certain age groups (age inequality) in society than the others.

The fact that screening tests may sometimes wrongly identify some people as suffering from a disease or condition when they are in fact healthy (false positives), or may give a false reassurance to some others who do in fact have the disease or condition (false negatives) – means that good quality assurance mechanisms need to be in place.

Informed consent is an essential part of the screening process and for all those eligible whose language is not English or who do not read well, information may be more difficult.

While geographical access to both breast and cervical screening services are well established in the PCT, access to bowel cancer screening services remains a challenge to some parts of the PCT's geographical area.

2.1 Cancer Screening

Cancer remains a major cause of health inequalities in the population – and the national screening programmes are implemented as part of the interventions to reduce these inequalities.

Although there are several cancer screening programmes – the basic rationale for each programme remains the same. Screening is applied to apparently healthy people in order that a small number with the potential to develop disease might then be diagnosed and receive effective treatment early.

2.2 Abdominal Aortic Aneurysm (AAA) Screening

AAA is associated with high mortality and morbidity. It is present in about 5 - 10% of men aged 65 - 74 years, and the prevalence is about six times less common in women. Rupture occurs in about 1 - 3% of men aged 65 and above – and 70 - 95% of whom die.

The Department of Health have recommended the implementation of a population-based AAA screening programme throughout England and PCTs are encouraged to start putting together an implementation plan for their population although final details on the programme are yet to be confirmed.

2.3 Bowel Cancer Screening

As the third most common cancer in the UK, and the second leading cause of cancer deaths each year, regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.

Delays in the regional roll out plan have led to partial coverage of the eligible population in the PCT – creating a potential inequity across the PCT.

2.4 Breast Cancer Screening

Previously, women aged 50 - 70 were invited for breast screening once every three years – with every woman receiving an invitation to breast screening before her 53rd birthday.

With the newly published Cancer Reform Strategy, all women aged between 47 and 73 should now be invited for breast screening once every three years. This requirement meant that there are an additional nine screening rounds, with an average of 27% increase in eligible population – which will potentially affect coverage and uptake of the programme.

2.5 Cervical Cancer Screening

Cervical screening aims to detect and treat early abnormalities which, if left untreated, could lead to cancer. Early detection and treatment can prevent 75% of cancers developing. All women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years.

Although the coverage in the PCT is above the national average of 80%, it is however falling in all age cohorts, especially among those aged 25 - 39.

What needs to be done?

- Implement the bowel screening programme across the whole of the PCT by 2009.
- Implement the extended breast screening programme and introduce digital mammography by 2010-2012.
- Address variations in uptake of cervical screening by 2011.
- Offer AAA screening to all eligible men across the PCT within the DH timescales.
- Implement Quality Assurance for all programmes and commission to an agreed standard.
- Assure equitable uptake of screening across the PCT.

Oral Health Action Plan 2008 – 2010

Vision

This plan sets out how South Staffordshire Primary Care Trust will continuously improve the oral health of its population over the next five years, and should be read in conjunction with the Oral Health Improvement and Dental Commissioning Strategy.

What needs to be done?

- Reduce inequalities in oral health through targeted commissioning of services in areas of greatest need.
- Increase access, choice and convenience to NHS dental services in areas where it is apparent there is insufficient capacity and greatest need.
- Improve oral health through commissioning effective services to help patients reduce their risk of oral disease eg tobacco control.
- Scope the practicability of extending water fluoridation schemes to reduce inequalities in dental caries experience in partnership with other Primary Care Trusts and West Midlands Strategic Health Authority.
- Develop oral health promotion schemes in prisons and the community.
- Continue to improve performance management and governance arrangements.
- Work across primary and secondary care to redesign services for orthodontics and minor oral surgery.
- Assess the PCT's dental commissioning against world class commissioning competencies and assurance framework.
- Develop the health promotion role of primary care dental teams.
- Commission additional dental services to reduce health inequalities and improve access in areas of low access rates.
- Review arrangements for Looked After Children (2008-9) and disabled groups (2009-10).
- Develop local plans for service continuity during an outbreak of pandemic flu (2008).

Developing the Health and Social Care Workforce as Public Health Advocates

Vision

We want to aim high and develop a culture shift in the local community infrastructure so that we create an "opt out approach" for health and well-being rather than the "opt in" model which we currently have. We need to make it easier for people to aspire and attain health.

To deliver the vision over the next five years we need to invest in new primary prevention services focused on health outcomes. This can be done through primary care, pharmacy, in targeted settings and in the community, such as in the workplace, and through clinicians in the acute sector.

We have an army of frontline staff in the NHS and other sectors that can deliver key messages on public health and support behaviour change. We need to train the NHS workforce in brief intervention, motivational interviewing and in basic information about benefits of lifestyle change.

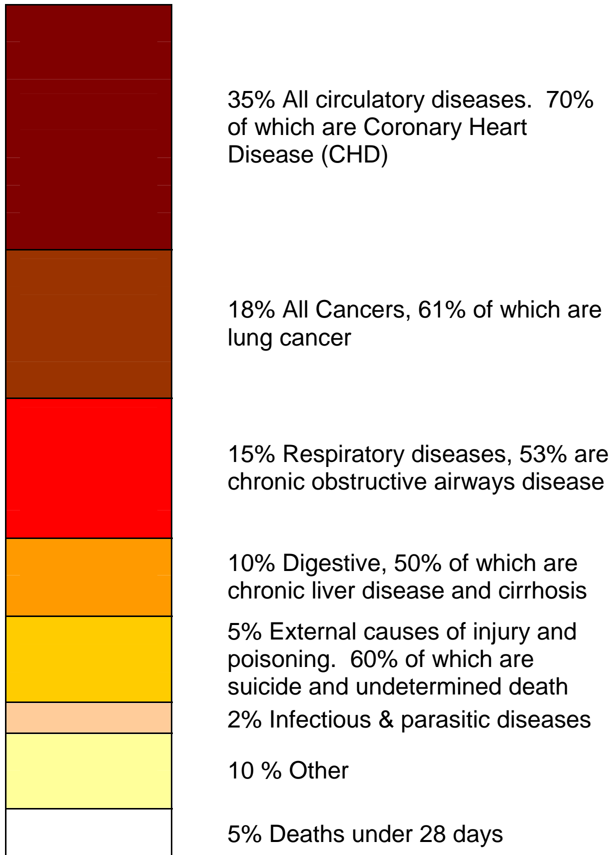
Key Points
• A major cultural shift amongst the NHS workforce is required so that health promotion is an integral part of everyday contact with patients and the public. • The health and social care workforce is substantial and there are other workforces in the local authority and voluntary sector who, with appropriate training and development, can deliver a large element of the primary prevention agenda. • We need to maximise all opportunities to give out key messages in public health across all patient pathways throughout prevention to treatment and care, so that each clinical one to one contact promotes individual and community health and well-being. • The public health competency framework provides a clear structure on the skills and knowledge needed for all areas of health improvement. We need to ensure this is systematically applied across the workforce.

What needs to be done?

- Inclusion of health promotion messages in all clinical interactions with patients across the health economy.
- Map the current public health workforce and identify gaps in knowledge and skills to deliver comprehensive lifestyle services.
- A workforce trained in brief interventions and motivational interviewing (smoking, alcohol, physical activity).
- Ensure prevention is included in all clinical pathways.
- Ensure consistent messages on staying healthy are delivered to the public through all providers.

Diseases which account for the gap in life expectancy between Spearheads and England alongside national modelling of interventions to reduce the gap by 2010

The Gap - for males



Contribution to Life Expectancy Gap in Males

The Interventions

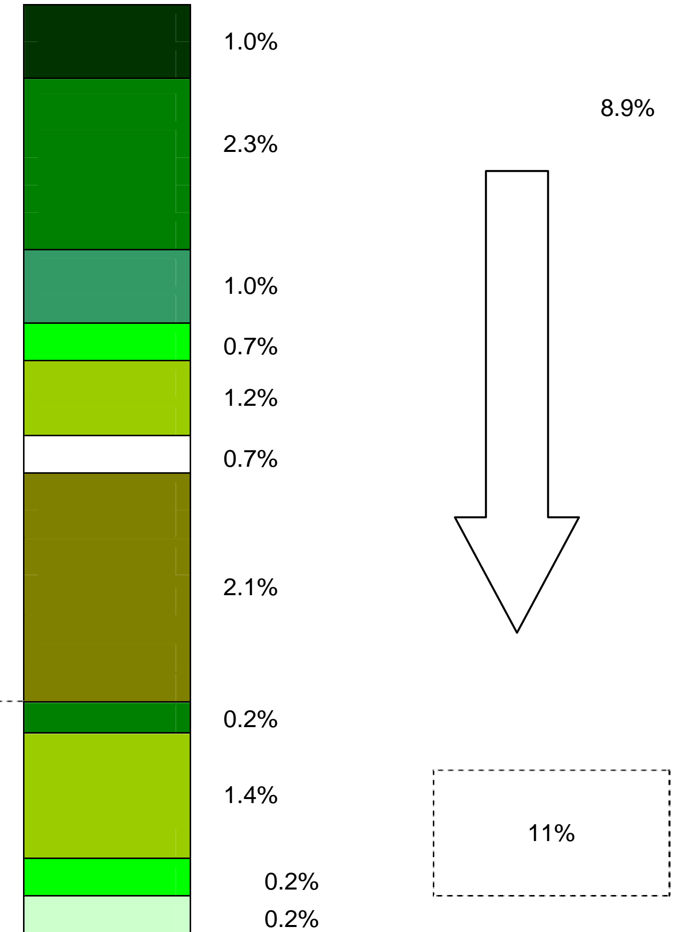
Targeted:

- Smoking cessation clinics: double capacity in Spearhead areas for 2 years
- Secondary prevention of CVD: additional 15% coverage of effective therapies in Spearhead areas 35-74 yrs
- Primary prevention of CVD in hypertensives under 75 yrs:
  - 40% coverage antihypertensives
  - statin therapy
- Primary prevention of CVD in hypertensives 75 yrs +:
  - 40% coverage antihypertensives
  - statin therapy
- Other* including
  Early detection of cancer
  Respiratory diseases
  Alcohol related diseases
  Infant mortality

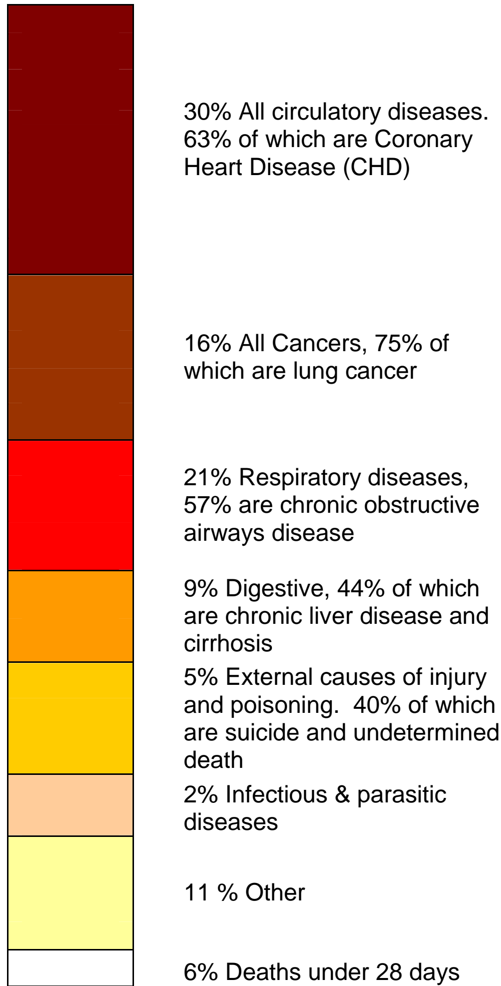
Universalist:

- Smoking reduction in clinics - as at present
- Secondary prevention of CVD:75% coverage of 35-74 yrs
- Primary prevention of CVD in hypertensives under 75yrs
- 20% coverage antihypertensive statin therapy

The Impact - for males



The Gap - for females



Contribution to Life Expectancy Gap in Females. Breakdown by disease, 2003.

The Interventions

Targeted:

- Smoking cessation clinics: double capacity in Spearhead areas for 2 years
- Secondary prevention of CVD: additional 15% coverage of effective therapies in Spearhead areas 35-74 yrs
- Primary prevention of CVD in hypertensives under 75 yrs:
  - 40% coverage antihypertensives
  - statin therapy
- Primary prevention of CVD in hypertensives 75 yrs +:
  - 40% coverage antihypertensives
  - statin therapy
- Other* including

  Early detection of cancer

  Respiratory diseases

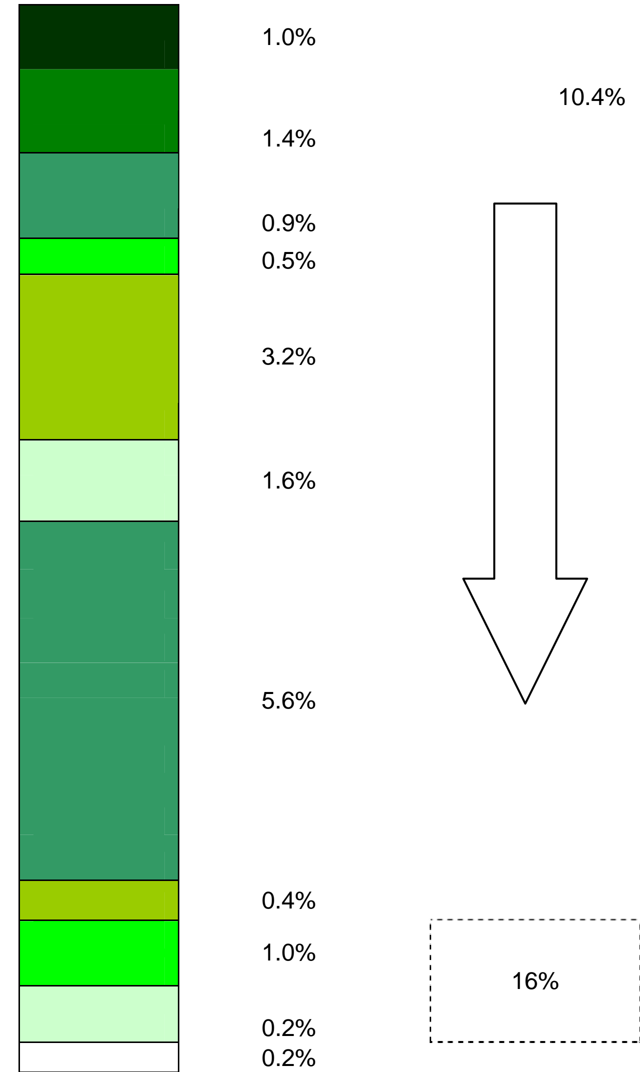
  Alcohol related diseases

  Infant mortality

Universalist:

- Smoking reduction in clinics - as at present
- Secondary prevention of CVD:75% coverage of 35-74 yrs
- Primary prevention of CVD in hypertensives under 75yrs
- 20% coverage antihypertensive statin therapy

The Impact - for females



Source- Tackling Health Inequalities: 2004-06 data and policy update for 2010 target. Dept of Health Dec 20