DRAFT REPORT OF THE

HEALTH SCRUTINY

TOPIC TEAM

ON CHOOSING HEALTH IN HALTON

Executive Summary

In recognition of the health issues prevalent in Halton, the Healthy Halton Policy and Performance Board requested a scrutiny review be conducted of Choosing Health initiatives. These initiatives arose from a government funded programme detailed in a White Paper titled 'Choosing Health Making Healthy Choices Easier'; published in 2004. The essence of this Department of Health document was to drive forward a 21st century approach to prevention and public health. The government identified the following overarching priorities:

- Reducing the numbers of people who smoke.
- Reducing obesity and improving diet.
- Increasing exercise.
- Encouraging and supporting sensible drinking.
- Improving sexual health.
- Improving mental health.

The Choosing Health initiatives reviewed in this report comprise of Halton & ST Helens Primary Care Trust's response to this White Paper. The purpose of this report is to detail the findings of this scrutiny topic which examines the contributions Choosing Health initiatives have made towards improving the health of people in Halton. A review of this nature was felt to be important given that it is believed the targeting of more deprived areas will be key to closing the gap health inequalities within Halton.

The analysis of the results found that 60% of the uptake of initiatives occurred in the top 50% of all Super Output Areas (SOAs) for all interventions. Furthermore, activity for specialist weight management is over 70% uptake and even higher for Health Trainers. In contrast, uptake of complementary therapies was more evenly distributed across all SOAs. This more even distribution can be largely explained by the latter relying on GP referrals, which can come from practices not necessarily found in the most deprived areas. An important consideration to bear in mind when reviewing these figures, is that it was never the intention for Choosing Health initiatives to be targeted at the most deprived communities.

In recognition of the best way to secure lasting improvements, is to place health inequalities within the mainstream of service delivery, thus ensuring that resources are targeted at disadvantaged areas and groups, this scrutiny topic has made the following recommendations:

Recommendation1: That SMT note the findings of the CH scrutiny review and progress to date.

Recommendation 2: That the report be submitted to Halton health Partnership

Recommendation 3: That the Healthy Halton Special Strategic Partnership be responsible for monitoring and evaluating progress to achieving the above recommendations. The SSP may wish to ask the performance sub-group to ensure these actions continue to be addressed in future commissioning.

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AND

EVIDENCE

1 Purpose

The purpose of this report is to set out the findings of a scrutiny topic that examines the effectiveness and contribution 'Choosing Health' (CH) initiatives towards improving the health of people in Halton. CH is a Government funded initiative that supports projects designed to improve the overall health of the population.

2 Introduction

The Strategic Director, Health & Community reported to the Healthy Halton Policy & Performance Board (HHPPB) on the 13th September 2005 and secured agreement that "Choosing Health" should be selected as a scrutiny topic. The report noted the relevance of this topic given the fact Halton is a spearhead area where the gap in health inequalities within the borough, is disproportionately high.

Choosing Health finances have been protected by the PCT, and invested against the Choosing Health investment plan that has previously been shared with HBC. This funding supports a range of projects designed to meet the objectives set out in the plan. Where projects were delayed in starting, any potential underspend has been identified and reinvested in activities and programmes that contribute to Choosing Health outcomes. By focusing on Choosing Health the scrutiny process will be able to evaluate the impact of the Delivery Plan and significant funding for health promotion activities in Halton within the priority targets areas.

The delay mentioned above has also had a knock-on effect with respect to this scrutiny report. In essence, the relevant data has only been collected by the PCT from April 2007. Given at least six months of data was needed to make this scrutiny review viable, the process could only begin in earnest from October 2007.

3 What is health scrutiny?

The Health and Social Care Act 2001 introduced a new power for local authorities to review and scrutinise health issues and services in their area and make reports and recommendations to local NHS bodies on these matters. This new power came into effect on 1st January 2003.

Health scrutiny is part of Halton B C's overall overview and scrutiny (O&S) function the primary purpose of which is to hold the Council's decision-making Executive and certain key partners to account, and to review and develop policy – including carrying out Topic reviews such as this one. The ultimate aim of O&S is to bring about improvements for local people.

A PPB's work programme can be divided into 2 main categories:

- Regular, recurring business that takes place primarily at meetings of the PPB
- Topic-based overview and scrutiny more often progressed through task groups or "Topic teams".

4 Why we chose this area for review?

Improving Health is a key strategic priority for the Council. As a reflection of the challenges ahead, Halton has been offered an opportunity to improve the health of residents by being selected as a Spearhead Area to implement "Choosing Health". A review of the impact of "Choosing Health" in Halton provides a focus on meeting this priority.

Funding from the NHS has been identified to support this government initiative. Choosing Health was published as a White Paper late in 2004 and a Delivery Plan published in March 2005. Government documents place an emphasis on the NHS being responsible for health improvement as well as the treatment of illness.
National and international research demonstrates a significant relationship between these preventable illnesses and diseases with where people live and/or their socio-economic circumstances. This pattern of relationships highlights deprived communities being disproportionately affected. Given resources are scarce there is a strong case for interventions to be directed to areas most likely to address the high incidence of mortality and morbidity (i.e. deprived communities). Whilst the focus for this scrutiny review is the Choosing Health programme, it is not the explicit aim of this programme to target or reduce inequalities in health. The main aim of Choosing Health initiatives is to improve the health of the whole population through personalised approaches, informed choice and working together. As a consequence, it is not clear what impact this will have on decreasing health inequalities. Given that reducing inequalities is a key aim of the Local Area Agreement (LAA) it was felt to be an important area for analysis and review. Hence this report will serve to enhance the linkages between Choosing Health and the LAA and ensure lessons learned from Choosing Health are carried forward.

A number of meetings where held between December 2006 and March 2007. The first of these set the parameters for this scrutiny review and subsequent meetings highlighted areas of concern and key issues as well as receiving a presentation from the Director of Public Health, Halton & St Helens PCT. As a key witness to the Choosing Health scrutiny programme, members had the opportunity to discuss and question the PCT on progress in implementing Choosing Health. The information gathered at these meetings and the issues raised form the basis for this report.

5 Parameters for this scrutiny review

Aim of review

The focus for this review will be to assess the extent to which Choosing Health initiatives and projects have targeted areas of deprivation in Halton.

Scope

The parameters for evaluating Choosing Health initiatives will be as follows:

a) The extent to which Choosing Health monies have had a beneficial effect on the most marginalised and excluded groups and areas.
b) The extent to which initiatives have alleviated barriers and constraints to healthy choices and thus enhanced motivation, opportunities and support available to the individual.

c) To assess whether the projects are partnership based and hence make health everybody's business in order to facilitate health improvement initiatives are treated as part of a whole system.

6 National Context of Choosing Health

Whilst prevention of ill-health has been debated in government circles for sometime, the past five years has been characterised by a significant shift in policy in this area and more importantly the way in which various key policies interact. The origin of this policy shift can be traced back to the Wanless Review.

Derek Wanless' independent review of NHS spending 'Securing our Future: Taking a Long Term View' (2002) put forward a case for promoting health and well-being and tackling inequalities based on financial and economic arguments. He described a 'fully engaged' scenario, in which £30 billion in NHS expenditure could be saved. Wanless predicted that failure to implement such a strategy could cost the public a third more. In his report, Wanless made the following observations:

"People need to be supported more actively to make better decisions about their own health and welfare because there are widespread systematic failures that influence the decisions individuals currently make. These failures include a lack of full information, the difficulty individuals have in considering fully the wider social cost of particular behaviours, engrained social attitudes not conducive to individuals pursuing healthy lifestyles and addictions. There are also significant inequalities related to individuals' poor life styles and they tend to be related to socio-economic and sometimes ethnic differences."

Wanless' review instigated major public sector reform which continues unabated. The first key policy document, the Green Paper – 'Independence Well-Being And Choice', made clear the government's commitment to encouraging "a shift to prevention and integrated delivery across health and social care". This was followed by the White Paper - Our health, our care, our say (OHOCOS), which followed up on this commitment but also highlighted that:

"…where you live has a huge impact on your well-being and the care you receive. These health inequalities remain much too stark – across social class and income groups, between different parts of the country and within communities" (Department of Health, 2005).

As part of detailing what this approach might look like the White Paper used key phrases such as "taking greater control over their health" and "supported to remain independent wherever possible" (Department of Health, 2005). Clearly information would be a key element of the prevention agenda; and hence the White Paper emphasised the need for better, more accessible information available to the public and better sharing of information between Primary Care Trusts and Local Authorities. It also called for a stronger, better defined role for Directors of Public Health in their work with Local Authority Overview and Scrutiny Committees and in contributing to joint reviews of the health and well-being of their populations.

As part of taking forward a programme of prevention work, the White Paper, Choosing Health was published towards the end of 2004. Given this is a cross-Government

strategy, greater harmonisation of approaches to information for health and well-being across Government and between local agencies is one of the desired outcomes of this strategy. Whilst the attention and financial resources given over to prevention in recent years is unprecedented, one of the difficulties facing the prevention agenda and a legacy of previous activity is that the UK spend on prevention and public health has been relatively low compared to that of other advanced economies. The White Paper, OHOCOS made a commitment to addressing this shortfall thus creating an incentive for reform. With such a commitment also comes targets and these have been challenging. For example, the 2002 public service agreement included a target to reduce inequalities in health outcomes by 10% by the year 2010, as measured by infant mortality and life expectancy at birth.

7 Reducing Inequalities in Health

This scrutiny report seeks to explore the extent to which preventative initiatives have had a beneficial effect on areas of deprivation. Whilst it is recognised that this is not the aim of Choosing Health, it is a key requirement of the LAA. Targeting of deprived communities is considered important because failure to do so is likely to result in a widening of inequalities, especially given it is those who have the economic and/or social resources who are most likely to take up opportunities for improving their health and well-being. It should be emphasised that whilst this scrutiny review focuses on initiatives aimed at improving lifestyle choices in areas of poverty and deprivation it is not being suggested that one causes the other. In reality the causal factors are complex.

The importance of reducing inequalities in health is highlighted by the large number of research studies which show a powerful relationship between the gap in life expectancy and local measures of deprivation. In the North West in 2001- 2003, men and women living in the most deprived fifth of areas nationally can expect to live on average 6.8% and 5% respectively less than the average for England and Wales. In contrast, men and women living in the most affluent fifth of areas nationally can expect to live 3-4% longer than the average for the country.

The Choosing Health White Paper Making Healthier Choices Easier (2005) sets out the importance of ensuring that as the country strives to improve its health, a priority must be given to tackling health inequalities so that all groups in society benefit. The White Paper states that inequalities in health are not acceptable and sets out a fundamental aim to create a society where more people, particularly those in disadvantaged groups or areas, are encouraged and enabled to make healthier choices. Clearly, in order to close the gap, the Government must ensure that the most excluded groups and areas in society see faster improvements in health.

The challenge is how to make healthier choices easier choices, without widening health inequalities. This is because more affluent people:

- Usually live in a more hazard free environment, for example children growing up in more affluent areas are at less risk of accidents.
- Are likely to have more control over their lives, including work.
- Have access to wider choices and as a result find it easier to make lifestyle changes.
- Often use services more than those that need them most.

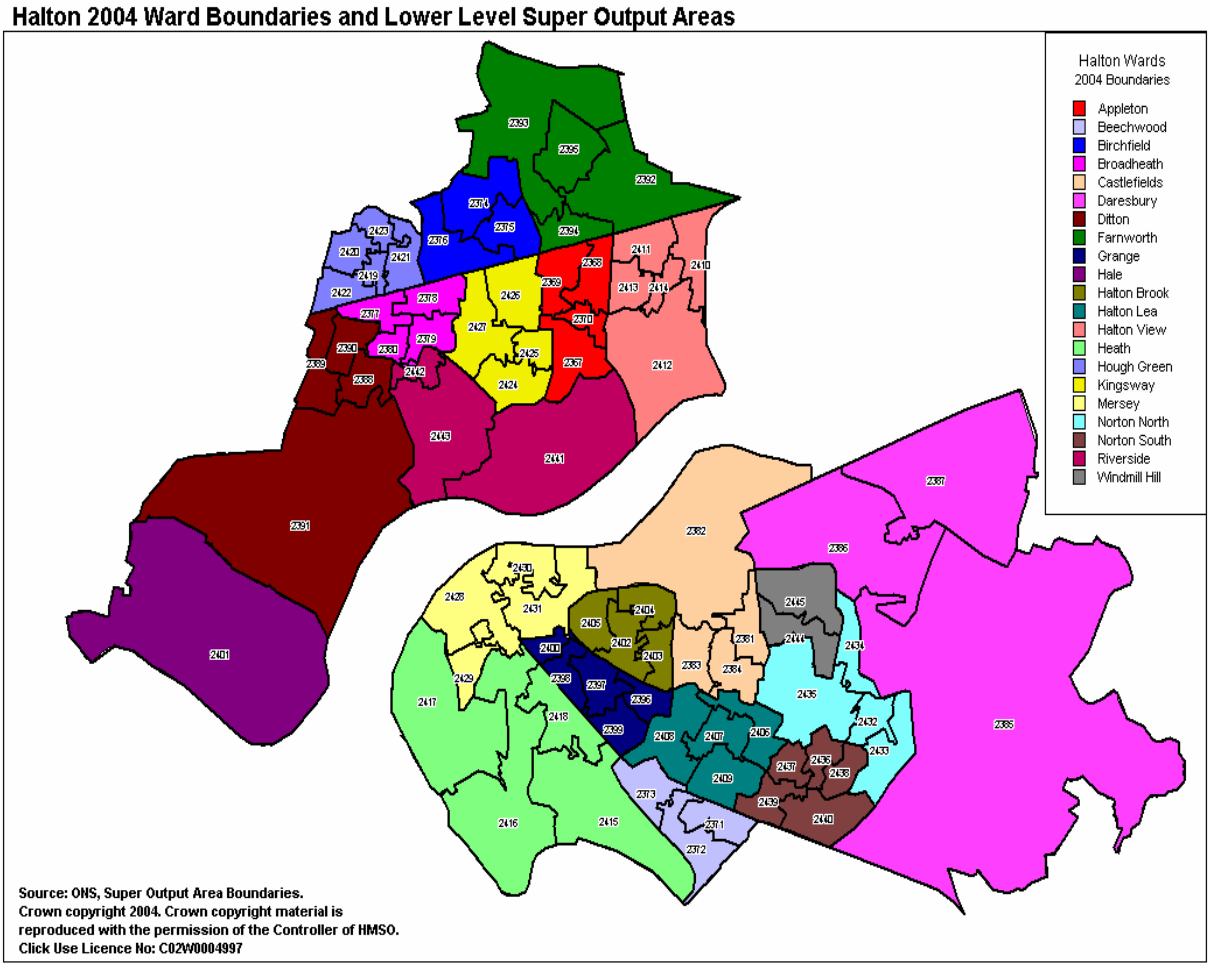
For these reasons, activities aimed at improving the health of the population are more likely to be taken on by more affluent people thereby widening the health inequalities gap. Furthermore, healthy choices are often more difficult for disadvantaged populations given:

- Limits are imposed by income as well as other factors such as education, housing, access to services, green space, employment etc.
- The effect of having less than those around you (relative poverty), a belief that your contribution to society is less valued or under valued and being socially excluded all impact on stress levels which in turn has physiological consequences.

8 Inequalities in Health within Halton

There are national targets to reduce health inequalities. Given the levels of deprivation in the borough they are particularly pertinent to Halton. Whilst maps are available to depict poverty and deprivation at the level of Super Output Area (SOA), unfortunately this information is lacking for the lifestyle choices targeted by the Choosing Health programme. For the map below, green areas have lowest or 'best' rates, and red areas highlight where rates are high, or of concern. As can be seen from the Map 1 below, Halton's most deprived areas are found in the wards of Kingsway, Riverside and Appleton in Widnes, and Castlefields, Halton Lea, and Windmill Hill in Runcorn. These areas are amongst the worst 5% in England. The pattern of health related deprivation within Halton follows a very similar pattern to the overall pattern of deprivation in that Kingsway and Riverside in Widnes, and Castlefields, Windmill Hill and Halton Brook in Runcorn, which suffer highest levels.

Map 1: To show 2004 Ward Boundaries and Lower Level Super Output Areas (SOAs)



The table 1 below highlights these areas in more detail, as these are greatest concern in terms of closing the inequalities in health gap.

Table 1: To show Index of Multiple Deprivation (IMD) within SOA & Ward against National Rank (where Halton 1 is most deprived)

Rank within Halton	SOA & Ward	National Rank where 1 is the most deprived.
1	EO1012424 Kingsway	193
2	EO1012381 Castlefields (South)	345
3	EO1012444 Windmill Hill (west)	380
4	EO1012445 Windmill Hill (east)	508
5	EO1012407 Halton Lea (east)	592
6	EO1012367 Appleton	640
7	EO1012408 Halton Lea (west)	1080
8	EO1012382 Castlefields (north)	1098
9	EO1012403 Halton Brook	1195
10	EO1012441 Riverside	1294

As has already been stated, there is a strong relationship between deprivation and health related problems. The conditions which account for the majority of premature mortality are, however, preventable. Research conducted by the World Health Organisation which demonstrated that 80% of all heart disease, 90% of type two diabetes and one third of cancers can be prevented by addressing the three key lifestyle issues smoking, diet and exercise. To further expand on this relationship, the table in Appendix 1 shows how obesity, smoking, diet and exercise have a significant impact on health. Given this strong relationship, PCTs are making strong efforts to adapt their services accordingly.

Halton & St. Helens PCT was a co-author to a 'Commissioning Strategy' which demonstrated the impact that adopted lifestyles could have:

- One third of all disease burden is attributable to tobacco, alcohol, high blood pressure, cholesterol and obesity.
- The cost of smoking and alcohol harm alone to the NHS is £3.1 billion per year. Applied to Halton, St Helens and Warrington populations this equates to £30.7m per year of potentially avoidable costs.
- In these three PCTs almost one quarter of all male deaths are due to smoking. (Commissioning Strategy, 2006).

It should be emphasised the NHS alone cannot have a sufficient impact on addressing the underlying causes of ill-health. In fact, Halton's Local Strategic Health Partnership has worked together to embed health and health inequalities in the overarching Halton Community Strategy 2006, the Local Area Agreement (LAA) 2007 and a number of jointly developed strategies. That said, the Choosing Health programme is a key element of their delivery responsibilities in this area. Within the Choosing Health Operational Plan 2007, which was agreed by the Halton Health Partnership, each health improvement service has a service plan and outputs against key targets are checked on a quarterly basis. The progress towards implementing this programme assessed below evaluates the effectiveness of support given to local people to lead healthier lives.

9 Progress to date

The Health SSP established a Performance sub group in January 2008. This group has a terms of reference that includes:

- To formulate a strategic vision, priorities and targets for health in Halton in the context of national and local priorities which actively promotes health improvement to address health inequalities and to address the needs of the local community. This will take into account the Community Strategy and Local Area Agreement, Choosing Health, Our Health Our Care, Our say, Every Child matters and shared commissioning arrangements.

- To ensure the development of a commissioning model and investment plan, an understanding of other local health needs, and any available evidence-base.

- To reduce health inequalities through targeted and focussed data and research-driven interventions to support improvement in the most deprived/needy geographical areas and amongst excluded groups within the community.

The draft local area agreement has a number of outcomes areas that compliment those identified in the Scrutiny review including:

- Halton residents will lives longer and healthier lives with a reduced gap in life expectancy.

- Inequalities in mental health and provision of mental health services reduced.

- Older people, vulnerable adults and carers receive the right support at the right time to live independently at home.

- Halton residents, particularly older people, vulnerable adults and carers, will have improved economic, physical and emotional well-being.

With respect to the Joint Strategic Needs Assessment, a thorough analysis has been conducted of health and social care needs to enable an evaluation of service provision and improve commissioning for the longer term. Following a public consultation in July, a final version will be available.

One of the target areas in this report, obesity, has been a key issue in the implementation of the Scrutiny of Healthy Eating report. The dual interventions on the part of the PCT and BC, has facilitated a joined up approach to tackling a complex area as well as maximising the potential for the adoption of healthier lifestyles.

10 Progress in implementing Choosing Health funded projects in Halton

Introduction

The implementation of Choosing Health in Halton has resulted in the following work programme commitments:

1. Action on Diet and Exercise for Obesity.
2. Alcohol interventions.
3. Tobacco Control.
4. Sexual Health services modernisation.
5. Health Trainers (Work in a more comprehensive fashion by providing targeted lifestyle advice towards individuals in areas of greatest need).

6. Workforce development
7. Physical health of seriously mentally ill patients.

Whilst the importance of certain lifestyle factors is recognised given their significant impact on mortality, lifestyle information is unfortunately not readily available at local level on a regular basis. The information of a local nature detailed in this report available has been gathered through either 2001 Health and Lifestyle Survey conducted by North Cheshire Health Authority or Halton Health and Lifestyle Survey 2006.

The easiest method of analysing Choosing Health activity would be to determine whether it is meeting the targets set by government. The PCT produces reports on regular basis and currently all programmes are on target. To assist in the implementation of the LAA, the scrutiny topic group has focussed on whether inequalities in health across Halton are being addressed. This exercise is being conducted in recognition of Choosing Health activities being for the whole of Halton not just the most deprived areas.

Action on Diet and Exercise for Obesity.

Halton's weight management service is a collaborative diet and exercise intervention programme to promote lifestyle behavioural change for weight management and management of long term conditions across the borough of Halton for all adults aged 18 and over. The weight management programme is a patient focused service which addresses some of Halton's Key health concerns by raising the awareness of the physical, psychological and social benefits of exercise for adults. The aims of the service are to prevent ill health, reduce health inequalities, help individuals develop confidence and create long term adherence to exercise, healthy eating, promoting lifestyle change and addresses social isolation.

A factor which has a significant impact on the uptake of activities is the fact that all referrals come from GPs. The above programmes are set up this way as a clinician must assess patient suitability for engagement but a net effect is that individuals are attached to different surgeries not necessarily where they live.

The tables below for Specialist Weight Management (SWM), Fresh Start and Recipe for Health show a similar pattern of 65%, 60% and 55% of activity falling within the first two quartiles. In addition whilst activity for SWM tends to be graduated with those in the affluent (bottom) quartile showing the least activity, activity for Fresh Start and Recipe for health tends to be more evenly distributed in the 3rd and bottom quartile.

Table 2: To show amount of diet, exercise and obesity related activity across the SOAs.

	Specialist Weight Management	**% of Total**
Top Quartile (Ranks 1-20)	259	40.65%
2nd Quartile (Ranks 21-40)	157	24.64%
3rd Quartile (Ranks 41-60)	137	21.50%
Bottom Quartile (Ranks 61-79)	84	13.21%
Total	637	100.00%

	FreshStart	% of Total
Top Quartile (Ranks 1-20)	132	32.59%
2nd Quartile (Ranks 21-40)	113	27.90%
3rd Quartile (Ranks 41-60)	77	19.01%
Bottom Quartile (Ranks 61-79)	83	20.50%
Total	405	100.00%

	Recipe for Health	% of Total
Top Quartile (Ranks 1-20)	515	30.63%
2nd Quartile (Ranks 21-40)	411	24.44%
3rd Quartile (Ranks 41-60)	413	24.56%
Bottom Quartile (Ranks 61-79)	342	20.37%
Total	1681	100.00%

A key question for the scrutiny process is the extent to which these interventions are impacting on lifestyles. In 2001 the Health and Lifestyle Survey was conducted by North Cheshire Health Authority (NCHA). The survey questionnaire asked respondents to state their weight and height. From this data, a measure of obesity could be derived. Those with a body mass index (BMI) of 25 or over may be considered overweight. A body mass index of 30 indicates obesity. Widnes had the highest proportion of overweight adults, at 53.4%, this compares with 50.8% in Runcorn. Overall, a far lower proportion of respondents indicated by their survey responses that they were obese, with a body mass index of over 30, 15.1% across Halton as a whole. As well as showing similar results the Halton Survey of 2006 demonstrates the trend is increasing quite substantially and that a higher proportion of males are overweight, (63% compared with 50% of females) with highest prevalence amongst males in the 40-64 age band (71%). These trends reflect national trends of increasing overweight individuals and compared to the national figures Halton is not above average for overweight adults.

Whilst the figures in the Halton 2006 Survey shows an improvement in that 46.6% of respondents indicated that they are inactive, this is still a high proportion of residents. Females were more likely to be inactive than men.

With respect to diet there has been a marked improvement. Almost 80% of Halton residents indicated in 2006 that they ate less than the recommended 5 portions of fruit and/or vegetables a day compared to 88% of residents in 2001. Whilst this suggests that the health promotion message about the benefits of fruit and vegetables may be getting through the current level of poor diet is still very high. The age group with the poorest diet is that of men in the 18-34 age group.

Ultimately it is the effect on the levels of coronary heart disease that matters which the above interventions seek to address. Cardiovascular disease, a key improving health target to reduce death from heart disease, stroke and related diseases, has reduced by 39% on the 1995-1997 baseline. This percentage decrease exceeds the percentage reduction experience across both the North West and England as a whole. The gap between mortality rates within Halton and England as a whole has narrowed from 29.5% in 1995-1997 to 23.7% in 2003-5.

Alcohol interventions.

Whilst the Healthy Living Programme (HLP) address alcohol issues through the Health Trainer and MOT checks, it is Health Promotion (HP) that leads on more targeted interventions. HP have made a number of successful interventions to improving the statistics related to alcohol consumption, as follows:

- A pilot initiative has resulted in a reduction in the waiting list from six months to four months. Figures have, however, increased slightly due to extensive marketing of the services within Ashley House.
- In order to improve early identification and treatment for those who attend or are admitted with alcohol problems/concerns, an Alcohol Intervention Specialist is being recruited to be based in the Minor Injuries Unit, Halton General Hospital.
- A wide range of courses have been set up to improve the early identification and treatment of alcohol problems and onward referral which have received a very positive uptake.
- Appropriate care pathways have been designed and implemented.
- Appointment of An Alcohol in the Workplace post who will review existing organisational strategies around alcohol in the workplace starting with PCT Strategy.
- A programme of integrated alcohol harm reduction education will now take place from November 2007.
- Focus Groups have taken place within both primary and secondary schools within a neighbourhood Management Area (Castlefields and Windmill Hill) to identify alcohol related training and support needs as well a range of activities to improve consistency, providing support to young people and training of school nurses.
- Ongoing communication/campaigns to be developed including the targeting young people 18-25.
- Improved communication between health agencies through the development of a directory of local alcohol services together with a portfolio of self-help materials.
- Development of a protocol of joint working between Mental Health and Alcohol services.
- Obesity and alcohol topic training event took place attended by 15 health professionals from a wide range of statutory, voluntary and community agencies with a further course planned.
- Developed a co-ordinated approach to the evaluation of health impact in relation to targeted intervention.

As with the previous section, it is the extent to which these interventions are impacting on lifestyles that is key. Survey respondents were asked four questions regarding their drinking habits. From these responses, it was possible to determine unsafe drinking levels. For men risk categories are defined as: 21 units or less per week ('low'), between 21 and 50 units ('medium'), and more than 50 units per week is deemed 'high' risk. For women the equivalent figures are: 14 units or less ('low'), between 14 and 35 units ('medium') and 35+ units per week 'high'.

Overall, 17.5% of Halton respondents indicated that they drank more units per week than considered safe under these guidelines. This represents an increase on the 2001 figure of 15.7%. Whilst a greater proportion of males drink to unsafe levels, (22.5% compared with 12.4% of females) the proportion of women drinking unsafely has increased considerably from the 6.9% figure reported in 2001, whereas the proportion of

males drinking unsafely has decreased from 24.8% in 2001. Highest rates amongst males are in the 18-39 age-band, and in the 40-64 age-band amongst females.

As may be expected, the younger age group reports highest rates of binge drinking, with 54.1% of males, and 33.2% of females aged 18-39 reporting that they drank more than the recommended number of units per day in the last week. Binge drinking is more prevalent in Widnes, 36.5%, compared with 28.7% in Runcorn.

Tobacco Control

HBC was successful in bidding for a Communities for Health grant to set up smoking cessation sessions with a funding allocation of £100k. The Roy Castle Foundation has been commissioned to run the sessions, which started in June 2007. Post establishment of the infrastructure including recruitment and training of staff and the setting up of groups, there are now successful groups at the following venues:

- Upton Community Centre
- Windmill Hill Surgery
- Castlefields Community Centre
- Palacefields Community Centre
- Windmill Hill Play Centre
- Halton Direct Link
- Murdishaw Community Centre
- Ditton Community Centre
- Halton Direct Link (Runcorn)
- Halton Direct Link (Widnes)

There have been 162 referrals to the service and so far 118 have set quitting dates. Only 2 attendees have relapsed. The project will be reviewed in January by Halton & St Helens PCT and the report made available to HBC.

HP have made a number of successful interventions, as follows:

- All patients offered stop smoking advice & support in all 17 GP Practices in Halton. Approx 20% of patients smoke.
- Specialist service accepts referrals from Health Visitors after their brief intervention.
- 18 Hospital dentists trained in stop smoking activity - Staff trained, resourced and supported; Intermediate Service established.
- Maternity staff trained and working with pregnant mums and their partners as well as referring to Smoking Cessation Specialist Midwife.
- 1 pregnancy and smoking specialist - Person in post; now finalising Guidelines for the Provision of NRT to Pregnant Women.

With respect to the effects such interventions are having the 2001 North Cheshire Health Authority survey showed that the prevalence of smoking amongst Halton residents to be 29.2%. Rates were higher amongst Runcorn residents 31% compared to 27% in Widnes. A slightly higher proportion of females smoked within Halton (29.9%), compared to 28.5% of males. The more recent Halton Lifestyle survey showed prevalence has fallen. In 2001 smoking prevalence was estimated to be 29.2%, in 2006

the survey showed a prevalence of 25.6%; not markedly higher than the national average of 24%.

Finally, Halton successfully implemented the new legislation on smoking in public places through a combined approach in terms of joint funding and workshops for businesses. Both the borough council and the PCT have smoking policies in place. The PCT and the borough council offer free smoking cessation services for staff and local residents through local GPs and specialist smoking cessation services. Halton has consistently reached it's DoH smoking cessation target. As outlined above Halton is now drilling down to decrease smoking prevalence in areas of high deprivation and smoking prevalence via community smoking cessation staff jointly funded by the council and PCT.

Whilst the attempts to reduce smoking prevalence are cause for a degree of optimism, ultimately it is the effect on cancer rates which matters. The link between smoking and cancer is self-evident and smoking related cancers account for the majority of all cancers. Cancer rates for Halton show a 9.7% reduction on the 1995-1997 baseline however, in 2004 rates increased sharply and remained high in 2005, meaning the rate for the current three year period is higher than in previous years, and the gap between Halton and England as a whole has increased since the baseline. In conclusion, this upward trend is related to the long lead in time for lung cancer. The Early Cancer Detection Strategy being put in place should help reduce mortality rates.

Sexual Health Services

In terms of the modernisation of sexual health services, PCTs will be assessed against the 'Recommended standards for sexual health services' which also ask key questions of PCTs. The standards are endorsed by the Department of Health and 'describe what people should be able to expect from a sexual health service'. In the their 'Annual Health Check Public Health Performance Report' the PCT provided answers to these as listed below:

- Does the PCT have in place a strategy to encourage sexual health service uptake, including specific actions to reach population groups who are less well served by, or find it more difficult to access, existing provision?
- Does the PCT have in place a process (e.g. regular audits) to ensure that consistent information about local sexual health service provision is readily available for staff and members of the public, to enable people to access the services they need (ie the most appropriate method of contraception, which could be the pill, condoms, long-acting methods or other methods)?
- Does the PCT have in place a process (e.g. regular audits) to ensure that people have access to clear, accurate and up-to-date contraceptive information and advice?
- Do all PCT-provided or commissioned contraceptive services either provide, or signpost where people can access, free condoms?
- Does the PCT have in place a process (e.g. regular audits) for assessing competencies and training needs for general practitioners providing contraceptive services?

Details of the PCT's response can be found in Appendix 4.

Given the recency of this modernisation process the potential impact on the sexual health of the Halton population is impossible to measure. Recently gathered information shows that this area is cause for concern. For example, the Annual Health Check for 2006/2007 showed underachievement in reducing the under 18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve Sexual Health.

The latest information from Department of Health has shown that nationally the percentage of people seen with 48 hours is only 9% below the offered figure. In Halton and St Helens Genito-Urinary Medicine departments this is substantially lower. There is now a push to collect information on appointments offered but not seen within 48 hours to understand our patient's needs. Both GUM departments will be implementing software upgrades to capture this information which will be a future focus for GUM access.

Finally, teenage conceptions figures for the PCT show a stark position with Halton 18% above national baseline and St Helens 15% below baseline. Locally both Halton and St Helens councils alongside the PCTs are collating information locally to try and get a clearer and more up to date picture of the current position and needs. The data analysis is being collated through November 2007and so a full report of the local information will be provided for the January 2008 Board.

Comprehensive Interventions (i.e. Reach for the Stars, Health Trainers & Recharge Reach for the Stars).

Reach for the Stars' provides the over 50s with the chance to improve the health and quality of their lives by encouraging and facilitating the uptake of social and educational activities in the community. Aimed mainly at the socially isolated older person living in any Halton ward, but open to anyone over 50, the service helps to build confidence and self-esteem providing support to help reintegrate clients into the community. The project enables older people to work as volunteers in three ways: to buddy other older people into education and social activities, to work as peer health mentors or to sign post other older people to services. It attempts to inspire clients to learn new skills, meet new people and be healthier, happier and live longer. *Reach for the Stars* was shortlisted for the prestigious Health & Social Care Awards in 2007 under the Dignity and Care of Older People category.

As demonstrated in the table below 74% of activity takes place in the top two quartiles. The balance of the activity is distributed evenly across the bottom two quartiles.

Table 3 to show activity related to Reach for the Stars against SOA.

Rank (1 is most deprived)	**RftS**	**% of Total**
Top Quartile (Ranks 1-20)	194	31.44%
2nd Quartile (Ranks 21-40)	263	42.62%
3rd Quartile (Ranks 41-60)	76	12.31%
Bottom Quartile (Ranks 61-79)	84	13.63%
Total	617	100.00%

The Health Trainer service launched in April 07 and receives referrals from a variety of sources including self-referrals. The service is for people who would like to adopt

healthier lifestyles around the key *Choosing Health* topic areas as follows, smoking cessation, physical activity and healthy eating, sensible drinking, mental health, sexual health and builds on the legacy of Reach for the Stars to include social and educational activities. Fully trained Health Trainers are a practical resource to link people into local opportunities to achieve their personal health goals. Health Trainers are based in the community procuring referrals as well as responding to referrals made by GP practices. The Health Trainer Programme is staffed by local people and offers personalised advice. This programme started in 2006 with Health Trainer leads attaching themselves to the Neighbourhood Management Areas.

Health Trainer activity, as with Reach for Stars again shows high levels in the top and 2nd quartiles at 75%. In addition there is a more significant tapering off of activity with those people living in the affluent areas showing very low uptake.

Table to show activity related to Health Trainers against SOA.

	Health Trainers	**% of Total**
Top Quartile (Ranks 1-20)	142	44.24%
2nd Quartile (Ranks 21-40)	100	31.20%
3rd Quartile (Ranks 41-60)	59	18.38%
Bottom Quartile (Ranks 61-79)	20	6.18%
Total	321	100.00%

Recharge provides a relaxed, supportive environment for carers and people with/recovering from serious health conditions to participate in arts, gentle exercise, healthy eating and complementary therapies. These activities provide a model for healthy choice and have been designed specifically for people with ongoing serious health conditions e.g. cardio-pulmonary, MS, COPD, Cancer and others. Many of the people who attend are older, isolated and have problems with confidence and/or mental health difficulties. The activities provide opportunities to both sample healthy options and provide ongoing support. These sessions also provide a connection with others and a sense of community. Recharge provides opportunities for people post- rehab to ensure they remain active and integrated.

Recharge activity is similar to that of Health Trainer and Reach for the Stars in that the vast majority of residents who access this service are from more deprived areas. There is, however, an important difference in that a higher proportion of residents access this service from affluent parts of the neighbourhood.

Table to show activity related to Recharge against SOA.

	Recharge	**% of Total**
Top Quartile (Ranks 1-20)	132	29.37%
2nd Quartile (Ranks 21-40)	149	33.40%
3rd Quartile (Ranks 41-60)	74	16.59%
Bottom Quartile (Ranks 61-79)	91	20.64%
Total	446	100.00%

Given the comprehensive nature of these two projects, outcomes are best determined through measures such as self-esteem, sense of well-being, confidence etc. It is still possible, however, to see numerous measurable benefits to Choosing Health targets. An

example of the latter is reflected in Health Trainer research which clearly demonstrates physical and mental health benefits (e.g. in a 2 month period out of 24 people educated about cancer recognition 3 people recognised with non malignant lumps, 2 with cancer and 1 currently investigated).

Workforce development

Health Trainers are a new public heath workforce for England. The national competencies for HTs were set by Skills for Health and the British Psychological Society. Each NHS HT has been awarded with a specifically designed City and Guilds VRQ level 3. Professional supervision for this new workforce comes from Health Psychologists public health trainers or community development specialists. In addition retaining full competency is ensured by links to clinical governance (NICE Guidance). The professional registration of Health Trainers is being proposed within "Trust The Regulation Of Health Care Professionals (DH 2007)

People with mental health problems

There are now 2 Serious Mental Illness nurses in place to work with mental health patients in Halton on their physical health.

From a more preventative perspective, the HLP has established complementary therapy projects as part of improving a sense of well-being. The Complementary Therapy referral pathway is via a medical professional for clinical governance needs. However the parameters have expanded this year to include long-term conditions and mental health with cross referral pathways within the psychological team. The criteria for referral are individuals with or recovering from long-term conditions, mild to moderate mental health difficulties and more serious mental health problems. In comparison to the interventions described so far, complementary therapies show a more even distribution across the borough.

Table 4: To show level of mental health improvement activities against SOA.

	Complementary Therapies	**% of Total**
Top Quartile (Ranks 1-20)	314	23.34%
2nd Quartile (Ranks 21-40)	325	24.16%
3rd Quartile (Ranks 41-60)	354	26.31%
Bottom Quartile (Ranks 61-79)	352	26.19%
Total	1345	100.00%

The recently agreed Mental Health Promotion & Social Inclusion Strategy & Framework for Action 2007, has put in place a 4-year action plan, the key strategic priorities being as follows:

In Year 1 -

- To build strong partnership working between all stakeholders.
- To promote a joint sense of ownership of the key 'health promoting' priorities for each setting, as listed in the 'Framework for Action'.
- For Champions to forge links with agencies working across relevant key settings, and to evaluate 'collective progress' in delivering health promoting activities

independently of one another, in accordance with the goals laid out in the 'Framework for Action', using a stocktaking process.
- For Standard One Leads to facilitate spring and autumn stock takes with stakeholders, and to demonstrate continued progress in attaining goals as laid out in the 'Framework for Action'.

In Year 2; 3 & 4 -

- For stakeholder organisations to devise a year on year action plan to focus efforts to attain goals laid out in the 'Framework for Action'.
- For stakeholder organisations to pick up action(s) as agreed in the year on year action plan, and to evidence satisfactory progress towards attaining the action(s) at year-end. For stakeholder organisations to agree allocation of joint funding for promotion activities, and for this funding allocation to increase each year until year 4.
- At the end of year 2 - the Standard One Leads will review the strategy, to determine how effective the strategy is proving to be in terms of attaining goals laid out in the 'Framework for Action'.

The need for this strategic approach and the importance of interventions in this area is demonstrated by the mental health statistics for Halton as the follows:

- Halton has a high incidence of mental health problems when compared against similar LAs, regionally and across England and Wales.
- Hospitalised Prevalence of mental illness is far higher in Halton than that of Warrington, St Helens and Knowsley.
- As with other mortality and morbidity data there is a strong correlation between hospitalised mental illness and deprivation, with the prevalence of hospitalised mental illness increasing in areas of high deprivation.
- Approximately nine out of ten adults with mental health problems, and one quarter with severe mental health problems receive all their support from primary care. The most common mental health problems presenting in Primary Care are depression, eating disorders and anxiety disorders and therefore preventable.
- Although things are improving Halton still only provides less than 1 hour of counselling per week per 1000 people in the population rather than the recommended 4 ½ hours per week.

FINDINGS

AND

RECOMMENDATIONS

11 Analysis and evaluation

As part of informing the implementation of the LAA, the intention of this scrutiny review is to assess the extent to which Choosing Health are targeting areas of deprivation and to identify areas for learning. It has been suggested that unless activities are specifically targeted to those living in poorer areas then the affluent sections of the population are more likely to take advantage of these opportunities.

Fortunately evidence arising from the data suggests that in the vast majority of cases the uptake has been from people living in more deprived areas. Analysis of the results shows that current intervention activity level is at 60% in the top 2 quartiles across all interventions. Furthermore, activity for the specialist weight management is over 70% and even higher for Health Trainers. It is the complementary therapies which are lower the average of 60% as here the uptake is more equally distributed. This is because complementary therapies rely on GP referrals which can come from practices not necessarily in those top 2 quartiles.

As had been implied above, in comparing the uptake across different programmes important differences arise. For example, the Health Trainer activity is highly graduated with very few people participating from affluent areas of the borough and to a lesser extent this also applies to Recharge. The same cannot be said for the other initiatives with significant proportions of the population from less deprived areas accessing health improvement interventions. Whilst it is recognised that Choosing Health has purposely been made available to the whole of the population, in keeping with DH guidance, it would still be useful to explore this differential uptake. The importance of targeting future initiatives is underpinned by recent local indicators which show a widening in health inequalities. Hence, such further analysis would help in targeting other health improvement initiatives; including the targeting of initiatives to communities of interest whose health inequalities are not necessarily determined by socio-economic factors.

Ensuring initiatives are effectively targeted is not simply a matter of geography. There is a wealth of evidence to suggest it is the quality of the interactions between individuals, communities and their social and economic contexts that determine health status. This supports an approach which adopts a life course approach and hence acknowledges the importance of the cumulative effects and risks, connections being explored between social, environment and economic and the net effects these can have through psycho-social factors like stress.

In keeping with this research, the most recent government report from the Social Exclusion Unit states that in a consultation the unit found one fifth of respondents argued mental health services should have a social approach to mental health rather than a medical one. Halton has many projects which offer socially focused solutions. These include work in the statutory and voluntary sector on projects such as Good Neighbour, Time for Me, The Carers Sanctuary, Arts for Health and Reach for the Stars.

The case for ensuring the approach utilised in such projects being applied to all health improvement initiatives is highlighted by the work of Mawle who challenges the ‘personal choice’ perspective. In contrast to ‘choice’ being the key issue for improving public health he argues that there are wider range of determinants outside individual control which have an impact on health and well-being (Mawle, 2005). The significance of this point has not been lost on the government who acknowledge in the OHOCOS that it is harder for disadvantaged sections of the population to make healthy choices.

As part of addressing and responding positively to this context, interventions need to address these wider determinants in order to create better conditions for disadvantaged people and reduce the barriers to individual behaviour change. Such wider determinants should include aspects of social status and social position as well as the following:

- Involvement and valuing of the involvement of people from disadvantaged groups in identifying solutions and planning services through building on positive aspects of the local community.
- Supporting individual and community empowerment in the provision of all services, especially for disadvantaged people.
- Provide services that are holistic and centre on solutions as users perceive them.

Whilst the success of this approach is clearly evident in existing health improvement interventions, the lessons of these successes need to be carried through to the LAA.

12 Conclusion

Whilst there has been a plethora of national initiatives targeted at reducing health inequalities, there is increasing recognition that the best way of securing lasting improvements is to place health inequalities within the mainstream of service delivery, ensuring that resources are targeted at disadvantaged areas and groups. Such a strategic approach will require bold action on behalf of the PCTs. Support from partner organisations will be critical too. We know that the NHS alone cannot have a sufficient impact on addressing the underlying causes of ill-health. We must therefore find ways to build on the current work with partner organisations, particularly local authorities, so that together we can support local people to lead healthier lives.

In conclusion, with respect to the parameters set for evaluating Choosing Health initiatives, in the light of the information provided in this report it is possible to make the following recommendations:

Recommendation1: That SMT note the findings of the CH scrutiny review and progress to date.

Recommendation 2: That the report be submitted to Halton health Partnership

Recommendation 3: That the Healthy Halton Special Strategic Partnership be responsible for monitoring and evaluating progress to achieving the above recommendations. The SSP may wish to ask the performance sub-group to ensure these actions continue to be addressed in future commissioning.

APPENDIX 1

(Extracted from Halton & St Helens & Warrington PCT's Commissioning Strategy)

Lifestyle factors probably account for most premature deaths from coronary heart disease or strokes, as well as about half the years of life lost from premature cancer deaths.					
	Heart disease	Cancers	Respiratory disease	Diabetes	Musculo-skeletal conditions
Diet/obesity	Diet explains at least half of coronary heart disease (CHD) deaths (high cholesterol alone accounts for about 26% of CHD deaths).	Obesity and physical activity result in about 10% of all cancers. Dietary factors account for 25% of years of life lost due to cancer.	Being overweight or obese is a risk factor for obstructive sleep apnoea.	Being overweight or obese increases the risk of type 2 diabetes (relative risk of 42.1 for men and 93.2 for women for BMI >/= 35).	Obesity is a risk factor for degenerative joint disease.
Smoking	More than half (57%) the deaths from ischaemic heart disease in adults aged 35-54 are due to smoking. Smoking accounts for 10% of years of life lost due to CHD.	30% of years of life lost from cancer are due to smoking. Almost all deaths from cancer of the lung (85%) or oesophagus (70%) are due to smoking.	Almost all deaths from chronic obstructive lung disease are due to smoking. Smoking in parents contributes a 50% increased risk of childhood asthma.		3-4 times risk of degenerative disc disease. Double risk of rheumatoid arthritis in women.

Physical activity	Physical inactivity approximately doubles the risk of dying from coronary heart disease. Only 37% of men and 25% of women in the UK take adequate amounts of exercise.	Physical activity has a protective effect for colon cancer (most active people have a 40-50% lower chance of colon cancer than the least active. Reduced risk of breast cancer in post-menopausal women (30% reduction in risk).		Lowers the risk of developing type 2 diabetes by increasing insulin sensitivity.	Reduces falls by 20% and also protects against osteoporosis.

Alcohol	Heavy drinkers have a higher mortality from coronary heart disease (moderate drinking may be protective). It was estimated that in 1996 there were approximately 75,000 years of life prematurely lost due to alcohol consumption. Binge drinking is associated with greater risk of death from myocardial infarction (heart attack).	Heavy drinking increases the risk of upper gastro-intestinal cancers, and probably of breast and colorectal cancers.			

APPENDIX 2

Annual Health Check Public Health Performance Report

November 2007

1 Introduction

The Annual Health Check for 2006/2007 showed underachievement of targets for

- Reducing the under 18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve Sexual Health and

- Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

This report aims to give some context to the data and provides text to explain reasons for any perceived under or over performance. The report will concentrate on the sexual health broader strategy, the element of the heart disease and stroke mortality target that the PCT failed upon and the new Obesity target to comply with NICE 43 guidance.

A table summarising performance for 2006/2007 and performance to date is attached.

Target: Reducing the under 18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve Sexual Health and specifically the performance indicators of:

2 Access to GUM Clinics – broader strategy to improve sexual health

The PCT target for GUM is to ensure that 100% of people contacting GUM services are offered an appointment with 48 hours and this needs to be achieved by March 2008.

A PCT resident base LDP plan for 2007/08 shows that up to August 2007 that 98.7% of our residents were offered an appointment with 48 hours this was against a planned target of 72%. The proportion seen with 48 hours dropped to 79% against a plan of 67%. This data gives the PCT a more accurate and up to date monitoring of the throughput in GUM and access to GUM services than the Health Protection Audit which was carried out quarterly throughout one week.

Table 1: August 2007 UNIFY data for access to GUM

GUM department/Resident data	Percentage offered an appointment with 48 hours	Percentage seen with 48 hours
Halton GUM	99.1%	73.5%
St Helens GUM	99.4%	78.5%
Halton and St Helens Residents	98.7%	79%
LDP plan	72.2%	67.2%

GUM access times have therefore improved since last year in both the clinics in Halton and St Helens when our year-end 2006/2007 figure was only 63%.

The latest information from Department of Health has shown that nationally the percentage of people seen with 48 hours is only 9% below the offered figure. In Halton and St Helens GUM departments this is substantially lower. There is now a push to collect information on appointments offered but not seen within 48 hours to understand our patient's needs. Both GUM departments will be implementing software upgrades to capture this information which will be a future focus for GUM access.

2 Access to reproductive health services

Ensuring wide and appropriate access to reproductive health services for the sexually active population is vital to the successful delivery of any local strategies to improve sexual health, and will in turn help to deliver national objectives for improved sexual health.

In November 2004, the Government published the white paper 'Choosing Health: Making Healthy Choices Easier'. The white paper highlights that the provision of contraception is an essential health care service and plays a pivotal role in protecting against both unplanned pregnancies and sexually transmitted infections (STIs). Both 'The national strategy for sexual health and HIV commissioning toolkit' (Jan 2003) and the Department of Health commissioned and endorsed 'Recommended standards for sexual health services' (March 2005) also highlight the importance of provision of open access services that offer the full range of contraceptive methods.

Chlamydia is the most common sexually transmitted infection (STI) and there is evidence that up to one in 10 young people aged under-25 may be infected. It often has no symptoms, but if left untreated can lead to pelvic inflammatory disease, ectopic pregnancy and infertility. Chlamydia is very easily treated.

The national chlamydia screening programme (NCSP) has a community focus and concentrates on opportunistic screening of asymptomatic sexually active men and women under the age of 25 who would not normally access, or be offered a chlamydia test, and focuses on screening in non-traditional sites (youth services, military bases, universities, contraception services, primary care).

3 Construction:

This is a two-part composite indicator, each part carrying equal weight. Results for parts one and two will be combined to give a single overall score.

4 Part one - access to contraception:

PCTs will be assessed based on their responses to the following questions, linked to the 'Recommended standards for sexual health services. The standards are endorsed by the Department of Health and 'describe what people should be able to expect from a sexual health service' (ref 'Recommended standards for sexual health services' p6):

1) Does the PCT have in place a strategy, (sufficiently recent to take account of the 'Recommended standards for sexual health services' document published in March 2005,) to encourage sexual health service uptake, including specific

actions to reach population groups who are less well served by, or find it more difficult to access, existing provision? (ref 'Recommended standards for sexual health services', standard 4 and standard 4, paragraph 21)

The current strategy is managed by HBC. The PCT has a draft strategy that is being developed and is planned for completeion by April 2008. The strategy has been influenced by a health needs assessment which is nearing completion. Information on service users is currently being collected and will help to influence the strategy further.

2) Does the PCT have in place a process (e.g. regular audits) to ensure that consistent information about local sexual health service provision is readily available for staff and members of the public, to enable people to access the services they need (ie the most appropriate method of contraception, which could be the pill, condoms, long-acting methods or other methods)? (ref 'Recommended standards for sexual health services', standard 4, paragraph 22

A review of sexual health information resources will take place between January and March and recommendations for development of sexual health information

3) Does the PCT have in place a process (e.g. regular audits) to ensure that people have access to clear, accurate and up-to-date contraceptive information and advice including:

- Discussion of evidence for the relative effectiveness of available methods, how they work, how to use them, risks and benefits, any common side-effects, and return to fertility after discontinuing use
- Clear accurate and up-to-date information leaflets for each method of contraception, to supplement verbal advice
- A range of leaflet formats, such as written, pictorial and audio, and versions which are culturally appropriate and in relevant languages for the local population
- (ref 'Recommended standards for sexual health services', standard 7, paragraph 7 and standard 7, paragraph 8)

A review of leaflets was undertaken last year and the services provided information using nationally recognised leaflets produced by Family Planning Association. This again needs to be reviewed to ensure that the information is available in the correct format for our population. The data from the health needs assessment on user views will help to inform improvements. This will be unbdertaken as part of the audit planned for point 2.

4) Do all PCT-provided or commissioned contraceptive services either provide, or signpost where people can access, free condoms?
(ref 'Recommended standards for sexual health services', standard 7, paragraph 12)

Condoms are available through contraceptive services as well as GP practices signed up through health promotion and through young peoples services via teenage pregnancy C-Card scheme.

5) Does the PCT have in place a process (e.g. regular audits) for assessing competencies and training needs for general practitioners providing contraceptive services:

- that ensures that access to the full range of contraceptive methods are offered?
- that defines minimum training standards for all practitioners providing (general) contraceptive services within the PCT patch?
- that includes a strategy to define, assess and support training requirements for long-acting reversible contraceptive methods? [ref 'Recommended standards for sexual health services', standard 7]

The PCT as part of the health needs assessment is undertaking an audit of sexual health skills and training within GP practice. This will inform future practice and training requirements as well as setting minimum standards.

5 Part two - Chlamydia screening:

The delivery of Chlamydia Screening for Halton and St Helens was part of a tender process which was completed in April 2007 and was awarded to Terrance Higgins Trust and signed off by the Board in June 2007.

Staff were appointed and began operating towards the end of July. After 6 weeks co-ordination and development the first screens took place in September in time for the college fresher fairs. By the end of September after 3 weeks of screening 181 young people had been screened for chlamydia. This is 0.5% of the 15 to 24 population.

Despite this being an excellent start Terrance Higgins Trust (THT) need to develop a robust plan to ensure that the PCT hits the target to screen 5736 youg people by March 2008.

In order to achieve this target THT would need to ensure that 232 young people are screened per week over the next 6 months. As commissioners of the service the PCT has set up quarterly performance monitoring meetings and have requested an action plan from THT to describe how they plan to meet the target. We have also had some interest from general practice in supporting the screening programme and will be working through an enhanced scheme for GPs to contribute to this target.

Teenage conceptions figures for the PCT show a stark position with Halton 18% above baseline and St Helens 15% below baseline. Locally both Halton and St Helens councils alongside the PCTs are collating information locally to try and get a clearer and more up to date picture of the current position and needs. The data analysis will be collated through November and so a full report of the local information will be provided for the January Board.

Target: Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole and specifically the performance indicators of:

6 Practice Based Registers

This is the only part of the heart disease indicator that the PCT has failed on. In terms of progress to reduce mortality from heart disease the PCT has made good progress. Cardiovascular disease, a key improving health target to reduce death from heart disease, stroke and related diseases, has reduced by 39% on the1995-1997 baseline.

This percentage decrease exceeds the percentage reduction experience across both the North West and England as a whole. The gap between mortality rates within Halton and England as a whole has narrowed from 29.5% in 1995-1997 to 23.7% in 2003-5.
The establishment of registers of at risk patients in all practices is a standard in the National Service Framework for Coronary Heart Disease: 'general practitioners and primary health care teams should identify all people at significant risk of cardiovascular disease, but who have not yet developed symptoms and offer them appropriate advice and treatment to reduce their risks'. The local reviews by the Commission for Health Improvement (CHI) and Healthcare Commission have found implementation to be patchy. Primary care teams will be better able to offer systematic care to all patients to maximise their quality of life, to minimise their incidence of disease, and to predict future service requirements if they have an effective means of identifying (and intervening with) patients at risk - registers are the means by which these patients will be identified.

Effective disease prevention in at risk patients will make an important contribution to the overall public service agreement (PSA) mortality target. In previous years risk registers have been based on identifying patients with a greater than 30% risk of CHD over the next ten years. Recent guidance from the National Institute for Health and Clinical Excellence (NICE) and from the Joint British Societies suggests the threshold for at risk patients should be a 10-year cardiovascular (CVD) risk of 20% or greater (which equates to a 10-year CHD risk of 15% or greater). The expectation, therefore, is that plans and performance in 2007/2008 will have moved to the 20% CVD risk model.

7 PCT position

The Annual Health-check target is for all practices to have PCT validated registers of patients at risk of CHD by March 2008. As of March 2007 the planned figure was 29. However, the actual number of practices was 21. Therefore the aim is for all 51 practices to be actively managing CHD at-risk registers by March 2008.

The development of the registers have been facilitated in St Helens via an enhanced scheme, this has not been the case in Halton. Therefore, following the formation of the new PCT, the St Helens scheme was reviewed by the commissioning team and demonstrated a significant improvement to baseline in the numbers of patients being identified and managed as a result of the scheme implementation. Subsequently, the review informed the decision to roll out across all practices. The enhanced scheme report was also fed into the PCT enhanced scheme review which was undertaken.

The review informed the development of a business case and this is due to go to Management Executive on the 10th December and following this to the LMC. If approved, all practices will be invited to participate in the scheme.

Target: Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole and specifically the performance indicator of:

Obesity: compliance with NICE Guidance 43
Obesity is responsible for more than 9,000 premature deaths per year in England. Obesity is also associated with many illnesses and is directly related to increased mortality and lower life expectancy. Prevalence of obesity has trebled since the 1980s,

and well over half of all adults are either overweight or obese, the Department of Health suggest almost 24 million adults. This indicator focuses on the broader strategy to tackle obesity. As a key priority of the white paper 'Choosing health: making healthier choices easier' (Department of Health, 2004), tackling obesity is a national priority. Obesity in adults is an important risk factor for a number of chronic diseases such as heart disease, stroke, some cancers, and type 2 diabetes. In addition, obese people are more likely to suffer from a number of psychological problems such as low self-image and confidence, social stigma, reduced mobility and a poorer quality of life. It is estimated that obesity already costs the NHS directly around £1 billion a year and the UK economy a further £2.3 to £2.6 billion in indirect costs. It has been estimated that, if the present trend continues, by 2010 the annual cost to the economy would be £3.6 billion a year (National Audit Office, Healthcare Commission and Audit Commission, 2006)

In December 2006, NICE published national guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children in England and Wales. This guidance aims to stem the rising prevalence of obesity and diseases associated with it; increase the effectiveness of interventions to prevent overweight and obesity and improve the care provided to adults and children with obesity. The guidance states that the clinical management of obesity cannot be viewed in isolation from the environment in which people live and thus all NHS provider services have a role to play in halting the rise of obesity.

The workplace may have an impact on a person's ability to maintain a healthy weight both directly, and by providing healthy eating choices and opportunities for physical activity, and indirectly, through the overall culture of the organisation. Taking action may result in significant benefit for employers as well as employees (NICE 2006).

8 Construction

Trusts will be assessed on the plans they have in place to meet key recommendations applicable to NHS trusts set out in NICE clinical guideline 43: 'Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children' as at 31st March 2008.

Trusts will be assessed based on their response to the following question:

In line with NICE clinical guideline 43, ref 1.1.2.2 and 1.1.6.2, does the trust, in their role as an employer, have plans in place for the development of public health policies to prevent and manage obesity, which follows existing guidance and the local obesity strategy?

In deciding whether to respond yes or no to the above question, trusts may find it helpful to consider the audit criteria published by NICE with the clinical guidance number 43 in December 2006. The objective of the audit is to assist health services to determine whether they are implementing the guidance.

9 PCT Position

A review of NICE guidance 43 has been undertaken and an action plan developed to ensure that the PCT meets it's responsibilities in relation to this obesity guidance. The recommendations within the NICE guidance focus on the PCT as an advocate employer for healthy workforce in relation to obesity. This includes ensuring prevention

of obesity is a priority strategically, that policies are in place within the workplace to prevent and manage obesity and promote physical activity. The action plan identifies clear responsibility for the development of programmes and policies to ensure the PCT is compliant with the guidance.

The development of the workplace Active Workforce Programme funded through Sport England programme has allowed the PCT to work with partner organisations to improve uptake of physical activity within the workplace and therefore means that the PCT is already meeting part of the NICE guidance. The programme includes lifestyle health checks, activity sessions, pedometer challenges, health information, instructor qualifications and infrared stair monitors.

10 Public Health Performance Report on Cancer Inequalities, Early Detection and Prevention Strategy

Cancer Inequalities Early Detection and Prevention Strategy and Action Plan
Why a cancer inequalities strategy?

- Approximately 40% of cancer deaths are preventable
- Cancer rates are higher than the rest of England (death rates in MCCN are 14.7% higher than England for men and 14.3% higher for women)
- Local survival rates are broadly comparable to national rates
- Bladder cancer is becoming more common
- Lung cancer, one of the most unequal cancers, is rising among women
- For colorectal cancer, local women are more likely to present with late-stage disease, and have lower chances of survival than women the rest of England
- Melanoma is increasing and affluent people tend to survive longer

The PCT is part of a cancer network project that began in April 2007, to reduce cancer inequalities, improve early detection of cancer and enhance survival. The Cancer Task Force endorsed this project at its meeting on October 17th. The project has identified six key cancers where inequalities are most marked. These are Lung, Bowel, Bladder, Skin, Cervix, and Breast Cancer. An important workshop is being held this month to agree a detailed two-year plan to address them in the eight PCTs. The plan will include:

- what can be done to make the most of current good work such as the new bowel cancer screening programme and the lobby for sun bed controls;
- specific recommendations for NHS commissioners on how to improve performance in other screening programmes;
- clear plans for the effective use of social marketing approaches to encourage early detection and awareness of the possibility of cure for cancer
- assessment of the most effective balance between actions to prevent cancer and those that will lead to earlier diagnosis.

The two year action plan will be launched at a North West event in January 2008, with the national cancer czar, Mike Richards, present.

Halton and St Helens PCT host one of two Healthy Community Collaborative sites where local work is being done to reduce cancer inequalities and improve early detection of cancer. A new Cancer Screening Oversight Group has also been formed serving Halton and St Helens with Warrington and Knowsley PCTs. This group will make sure that we reduce inequalities in screening coverage and implement the bowel screening programme successfully. For the first time, the number of people never screened will be used as a performance measure.

APPENDIX 3

Appreciative Inquiry?

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