REPORT TO THE PUBLIC PCT TRUST BOARD
TO BE HELD ON: 28th January 2009

Enclosure: 4viii
Subject: Public Health Annual Report 2009 – Changing Hearts and Minds (Draft)
Lead Director: Judith Wright
Lead Officer: Jo Robins
Recommendation: For Approval  For Discussion ✓ For Information

PURPOSE OF THE REPORT:

Each year the Director of Public Health produces an annual report on a significant health issue relevant to the population of South Staffordshire. For 2009 the draft report Changing Hearts and Minds focuses on cardiovascular disease. To illustrate how cardiovascular disease impacts on the population the report is categorised into key sections on prevalence, health inequalities, primary prevention on a population level, identification and management of those with existing CVD risk factors and management and support for those with CVD. Key recommendations are made at the end of the report.

KEY POINTS:
The report gives an overview of the impact of cardiovascular disease on the population including:

- Data on prevalence, and premature mortality, and initial profiling information on the provision and uptake of some services and treatments in primary and secondary care.
- The impact of cardiovascular disease on health inequalities
- The current position on what is being provided around the three major intervention categories (the management of those with existing CVD, identification and management of those with lifestyle risk factors and primary prevention for the whole population), this includes a section on self help.
- A section on implementing change covering Mind The Gap, the five year public health plan, the CVD identification and management programme, implementation of the stroke strategy, and the need for additional work on the use of health equity audit to improve commissioning and provision of services.
- Some findings from the 2008 Adult Lifestyle Survey are included on lifestyle behaviour around smoking, alcohol use, nutrition and weight and physical activity.
- The recommendations are relevant for the commissioners of services and Local Strategic Partnerships

CORPORATE OBJECTIVES:
Implement the agreed Choosing Health plans
Reduce inequalities in health outcome by 10% by 2010 as measured by infant mortality and life expectancy at birth

RESPONSIBLE COMMITTEE:

NAME:

APPROVED at cmte: YES/NO Date of Cmte:

IMPLICATIONS:

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<th>Legal and/or Risk</th>
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<tr>
<td>Standards for Better Health</td>
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<td>Other</td>
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RECOMMENDATIONS / ACTION REQUIRED:

The PCT Trust Board are asked to: consider the draft report and its recommendations
Changing Hearts and Minds

The Director of Public Health’s Annual Report

2009
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Executive Summary

The PCT is committed to taking the lead on the prevention agenda as well as continuing to provide care and support for those with existing conditions. Cardiovascular disease is one area where if we work collectively across the NHS economy, with our partners in the statutory, private and voluntary sectors over a sustained period of time we will see changes in the health status of our population. The PCT is taking a leading role to encourage people to change their behaviour and adopt healthier lifestyles both in its commissioning process and through the provision of services and information.

Recent national strategies and plans emphasise the role and responsibilities of primary and secondary care in taking a more proactive role in the promotion of healthier lifestyles. In addition individuals are expected to take positive steps to make changes to their everyday behaviours around smoking, physical activity, nutrition and alcohol consumption. This report incorporates these themes making them applicable to the issues in South Staffordshire and specifically recognises the association between health inequalities and cardiovascular health.

We will need to have and make better use of the data available to us, to ensure that services have good quality data systems in place to record patient information including outcomes. We will need to use profiling to help us plan services more effectively but also to understand what helps people to change their behaviours. To commission effectively we need to know what works and what is cost effective.

There is strong emphasis on reducing cardiovascular disease in areas of deprivation and amongst those experiencing health inequalities giving consideration to the prison population which is a specific feature in the PCT area.

This report demonstrates a continuum of care which ranges from treatment through to the promotion of health and well being using a care pathway approach. It acknowledges the crucial role of primary care in identifying, and managing those at greatest risk of cardiovascular disease and the role of the wider NHS workforce who in their everyday interactions with patients can give out messages about healthier lifestyles and behaviours. It also includes a strong focus on self care and patient involvement which is crucial for sustained behaviour change and to prevent people from progressing through the stages of disease.

Local strategies on stroke and obesity are in place and others are being developed to further support the cardiovascular agenda. A local lifestyle survey has been produced, a cardiovascular disease audit is underway and some services are already being commissioned. Recently developed plans and programmes such as the Five Year Public Health Plan, the cardiovascular disease risk management programme and the alcohol reduction plan are being implemented but additional work needs to be done if we are to have a
lasting and long term effect on cardiovascular morbidity and mortality. To achieve this we need to implement the following recommendations:

- Commissioning and delivery of high quality cardiovascular treatment and care services
- The development of accessible lifestyle services to a sufficient level to make an impact
- Raising awareness among patients and the public
- Training and using the workforce across all sectors to support the public
- Target those communities most in need first and fastest.
Foreword

Welcome to my public health annual report on cardiovascular health in South Staffordshire.

Why a focus on cardiovascular disease? Because it causes over a third of deaths nationally, is responsible for one fifth of all hospital admissions contributes to health inequalities and reduce a life expectancy, uses huge resources in primary and secondary care and, most importantly, is largely preventable. Nearly 600 people die in South Staffordshire each year before the age of 75 from cardiovascular disease. This represents over a quarter of all premature deaths.

To achieve a visible reduction in premature mortality from cardiovascular disease we will need a focused, systematic and long term commitment across the NHS economy and other partners in South Staffordshire. We need to focus our actions on:-

- management of those with existing cardiovascular disease
- working with primary care to identify and manage those with existing cardiovascular disease risk factors
- primary prevention on a population level by supporting existing good practice and working with partners to expand cardiovascular disease prevention programmes through opportunities such as the LAA and with local strategic partnerships

Addressing these three broad areas should result in reduced levels of disease, better self care, and healthier lifestyles, (reduced prevalence of smoking, obesity, alcohol and improved diet and exercise). Hospital admissions and costs of treatment and care should reduce in the future.

We need better information about the prevalence of cardiovascular disease the equity of and access to services, rates of admission and referral to hospital in order to improve care. We need effective lifestyle modification programmes across the whole population but targeting those in areas of deprivation reaching those with multiple lifestyle risk factors.

The National Service Framework (NSF) for Coronary Heart Disease has been in place for ten years and will be reviewed in 2009. A care pathway approach is at the heart of the NSF covering prevention, treatment and care using 12 standards. Each standard has indicators that can be used to give an analysis of current service provision. Although it only covers coronary heart disease some of the standards can be used towards the overall picture for cardiovascular disease. The PCT Stroke Strategy identified standards for stroke care and this report builds on those.
Further work is progressing on many of the other standards and a comprehensive health equity audit is being compiled by the Health Intelligence Team within Public Health.

A key delivery mechanism for this report is Mind the Gap a five year public health plan focusing on the reduction of cardiovascular disease and health inequalities. It outlines key actions for primary prevention and the implementation of a cardiovascular risk management programme to identify and support those most at risk.

My previous report on alcohol focused on one aspect of the public health plan providing the basis for service improvement
What is Cardiovascular Disease?

Cardiovascular disease encompasses a number of conditions which can be categorised as chronic diseases. They are increasingly the most prevalent, costly in health and economic terms and are often preventable.

**Cardiovascular disease (CVD)** is a general term used to describe disorders that can affect the body’s circulatory system of the heart (cardio), arteries and veins (vascular).

Cardiovascular disease is caused by the narrowing of blood vessels due to the build up of fatty deposits or damage to the vessels. This impairs the flow of oxygen to muscle and brain tissues, a blockage can occur followed by stroke or heart attack.

Cardiovascular disease includes coronary heart disease, cerebrovascular disease and peripheral arterial disease.

*Coronary heart disease (CHD)/ ischaemic heart disease (IHD)* is caused by the narrowing of the arteries that supply the heart. CHD may lead to myocardial infarction (heart attack), angina (chest pain due to insufficient oxygen reaching the heart) and other forms of CHD. *Cerebrovascular disease* affects the blood vessels that supply the brain and may lead to transient ischaemic attack (TIA), also known as ‘mini-stroke’ and stroke. *Peripheral arterial disease* affects the blood vessels supplying arms and legs and can lead to claudication (partially obstructed blood flow in arteries causing pain on exercise), gangrene (death of tissues in legs due to insufficient blood flow) and aneurysm (localised bulging or enlargement in the aorta or other blood vessel).

There are inter-related links between lifestyles and cardiovascular health. Smoking increases the risk of vascular disease as the chemicals in cigarettes damage the heart and blood vessels. The nicotine in cigarettes makes the heart work harder by constricting the blood vessels and increasing the heart rate and blood pressure. Regular physical activity helps to prevent heart disease by increasing blood flow to the heart and strengthens the contractions of the heart so that more blood is pumped with less effort. Physical activity also controls weight and can reduce stress levels. Diet is important because the high intake of saturated fat increases cholesterol levels and high salt can increase hypertension. Obesity increases the risk of vascular disease where fat is greater on the abdomen and is associated with increased cholesterol, hypertension, insulin resistance and impaired glucose tolerance.
Cardiovascular disease is the largest cause of long-term ill health and disability in the UK. In the Health Survey for England 2006, 14% of men and 13% of women had a reported diagnosis of cardiovascular disease. Prevalence of ischemic heart disease or stroke was higher among men than women, with 8% of men and 6% of women suffering from either or both conditions. The difference between the sexes was most marked among those aged 65 and over, with the prevalence of being approximately twice as high among men as women in the 65-74 age group.

The leading cause of death in England and Wales in 2006 was circulatory diseases (accounting for 34.7 per cent of all deaths), which includes deaths from ischaemic heart disease and strokes followed by cancers (27.6 per cent of all deaths) and respiratory diseases (13.7 per cent of all deaths). Circulatory diseases accounted for 26.9 per cent of premature deaths (age less than 75 years) in England in 2006.

The leading cause of death for both sexes was ischaemic heart diseases approximately one in five male deaths and one in seven female deaths during 2006. Cerebrovascular diseases (strokes) were the second leading cause of death for both sexes and accounted for a higher proportion of female deaths (11%) than males (8%).

Not only does the treatment of cardiovascular disease place an increasing burden on the NHS but also on the wider UK economy. The estimated cost of cardiovascular disease is approximately £29.1 billion, with hospital inpatient care costing £9.9 billion.
Picture of Cardiovascular Disease in South Staffordshire

South Staffordshire PCT serves a population of 609,000 making it one of the largest PCT’s in the country. The aim of the PCT is to prevent ill health and to promote long life and wellbeing. Significant improvements in the health of local residents will be made by preventing ill health and developing health services that are safe, effective and more responsive to people's needs. The PCT is also promoting independent living and, where appropriate, delivering care closer to people's homes.

The PCT covers a large geographical area (the southernmost two thirds of the county of Staffordshire) and is a mixture of rural and urban centres including the towns of Stafford, Cannock, Burntwood, Lichfield, Tamworth and Burton on Trent. Almost a quarter of the population is classified as rural compared to 19% nationally.

Whilst the current age structure of the PCT population is similar to England some local authority areas have higher numbers of young people and others have high numbers of older people compared to the national average. The predicted long term growth in the older population in those aged 65 and above is significantly higher than that predicted for England.

Whilst the overall life expectancy is similar to the national average of 79 years there are variations across the area with 8% of the population living in the most deprived areas in England mainly in East Staffordshire, Tamworth and Cannock. There is a strong correlation between premature mortality and deprivation with 22/123 wards having significantly higher rates than the national average. There are seven wards that have significantly lower life expectancy compared to the national average and there is an 11 year difference between some wards in South Staffordshire.

Whilst premature mortality rates are decreasing overall they are significantly higher for men and women compared to the national average. Circulatory disease is accountable for 36% of all deaths.
Cardiovascular Disease - A Priority For South Staffordshire

The PCT has prioritised the reduction of health inequalities and this is reflected in its corporate objectives. The rates of cardiovascular disease morbidity and mortality are higher in areas of deprivation and in recognition of this the PCT Trust Board has requested specific work to reduce the health inequalities gap within the PCT as well as between areas of the PCT and England.
Premature mortality for cardiovascular disease across the whole of South Staffordshire is lower than the national average although Tamworth, Cannock Chase and East Staffordshire have higher rates according to Figure 2.

**Figure 2 : Premature mortality due to Cardiovascular Disease (Data for Dec 2005 – Nov 2008)**


Figure 3 shows that the rate of fall in cardiovascular disease mortality within South Staffordshire appeared to have plateaued, with a small rise between 2005 and 2006. However, the rate has fallen once again in 2007.

**Figure 3 : Mortality from all circulatory diseases. Directly age-standardised rates (DSR). Less than 75 years 1993-2006 (Annual trends) per 100,000 European Standard population**
The majority of this reduction has resulted from changes in lifestyle in particular reduction in smoking. Risk factors for cardiovascular disease are more prevalent in the deprived areas (including smoking, obesity, physical inactivity, and poor diet). In South Staffordshire PCT, larger pockets of deprivation are found in centres of East Staffordshire, Tamworth and Cannock Chase local authorities. Cardiovascular disease is more prevalent in deprived areas and the map below shows premature deaths from cardiovascular disease.

Figure 4: Premature mortality from all circulatory diseases, 2005-07)
Figure 4 shows that of the 123 South Staffordshire electoral wards, 36 had a statistically significantly lower cardiovascular disease mortality rate, while two had a statistically significantly higher rate. The two wards with the higher rates were Heath in Uttoxeter and Stapenhill in Burton. Mortality rates varied from 17.2 per 100,000 persons in Bagots ward in rural East Staffordshire to 166.7 per 100,000 persons in Himley and Swindon, South of Wombourne (numbers of deaths in each wards are small so confidence intervals around these are quite wide)

Table 3 : Costs

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<thead>
<tr>
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<th>Estimated Costs to the NHS per annum (millions)</th>
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<tbody>
<tr>
<td>Circulatory Disease</td>
<td>£52.7 secondary care, £20.2 drug costs</td>
</tr>
<tr>
<td>Smoking</td>
<td>£20.2</td>
</tr>
<tr>
<td>Physical Inactivity</td>
<td>£100 (excluding obesity)</td>
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<tr>
<td>Alcohol</td>
<td>£20</td>
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<tr>
<td>Obesity</td>
<td>£143.7</td>
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Cardiovascular Disease and Health Inequalities

The burden of disease is not evenly distributed across the population. To reduce health inequalities we need to reduce cardiovascular morbidity and mortality as we have higher rates in areas of deprivation with marked differences between some areas.

Health behaviours are also not evenly distributed across the population. People in disadvantaged groups are more likely to smoke, consume excessive alcohol, have higher rates of obesity and a poor diet compared to those in more affluent groups. For males, 30% in Social Class Five have 2-3 high risk behaviours compared to less than 10% in Social Class One. For females, 20% in Social Class Five have 2-3 high risk behaviours compared to less than 5% in Social Class One.

Table 4 : Risk Behaviours and Health Inequalities

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<thead>
<tr>
<th>Lifestyle Risks for Health Inequalities</th>
<th>Description</th>
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<tr>
<td>Smoking</td>
<td>Despite a reduction in overall smoking prevalence in the UK over the last 30 years there has been little change among those living on low income and those who are most disadvantaged</td>
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<tr>
<td>Alcohol</td>
<td>For men, alcohol-related death rates for those living in deprived areas were 5 times higher than for those living in least deprived areas</td>
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<tr>
<td>Physical Activity</td>
<td>People on low income, adults with disabilities and/or mental health problems and women from black minority ethnic groups participate less in physical activity</td>
</tr>
<tr>
<td>Diet</td>
<td>Diabetes, a diet related disease, is 1.5% more likely to develop in those in the most deprived 20% of the population compared with the average</td>
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<tr>
<td>Obesity</td>
<td>Prevalence of obesity in women from routine and manual groups is higher than those in more affluent groups</td>
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People are living longer today than ever but not across all sections of society. The health of the most disadvantaged has worsened, widening the health gap. This is unacceptable and requires change. There are geographical inequalities, those caused by social and environmental factors (education, unemployment, housing) and by lifestyle factors. In 2002 the government introduced a target for PCT’s and local authorities to :-

Reduce inequalities in health outcome by 10% by 2010 as measured by infant mortality and life expectancy at birth.
The PCT has endorsed this commitment to reduce health inequalities in South Staffordshire especially in those areas where there is a widening health gap. Tamworth is a Spearhead area which means it has worse health outcomes than other areas. Overall life expectancy is increasing more slowly in the Spearhead areas than for England overall and the health gap continues to widen. In Tamworth the health gap is reducing for men and widening for women. Although other local authority areas in South Staffordshire were not identified as Spearheads, inequalities still exist and Cannock Chase has a lower life expectancy for men and women and East Staffordshire has a lower life expectancy for women compared with England.

By improving the life expectancy of the five most deprived wards to that of the least deprived wards in each local authority would reduce premature deaths, the burden of disease, and increase quality of life.

Increases in life expectancy can be achieved through initiatives tackling major causes of premature death such as heart disease, cancer and infant mortality.

Cardiovascular disease accounts for the largest contribution to differences in life expectancy. For example in England, socioeconomic differences account for nearly 6,000 premature deaths from cardiovascular diseases a year in men under 65 years. This trend is seen in people on lower incomes across all age groups. In Tamworth by reducing cardiovascular disease, life expectancy can be increased by 13 months for men and 10 months for women.

Nationally the three key interventions identified as effective ways of closing the life expectancy gap are:

- Reducing smoking in manual social groups
- Preventing and managing risks for coronary heart disease, and cancer including poor diet, obesity, physical inactivity and high blood pressure through effective secondary and primary care
- Targeting the over 50’s

Lifestyle Health of Prisoners

In addition to geographical inequalities there are also some groups who experience poorer health outcomes including older people, adults with mental health issues, children and adults with learning disabilities, teenage parents, and some black minority ethnic groups. Prisoners also have poorer health and there is a large prison population (approximately 3600) across South Staffordshire which is planned to increase in the future.

Health care within prisons has historically been provided by HM Prison Service, but from the 1st April 2005 this role became the responsibility of South Staffordshire Primary Care Trust. The impetus behind the transfer of responsibility was that prisoners should have access to the same quality and range of health care services that are available to the general public in the community.
Prisoners however are not representative of the general population in terms of their health and it is recognised their health needs differ greatly from the general population. Studies show a greater prevalence of common physical illnesses and an advanced ageing process for those in the prison system. Evidence indicates that prisoners’ health equates to a community population of an average 10 years older\(^4\), which has implications for the provision of health care within the prison environment.

In 2007/08 a Physical Health Needs Assessment was carried out in all six prisons across South Staffordshire. They identified various health interventions and services in the prisons including Substance Misuse Services, Sexual Health Advice, Dental Health and Health Screening. To date no data has been recorded for cardiovascular disease risk.

Overall the needs assessment identified a range of lifestyle issues. Smoking is higher than the general population and evidence suggests this relates to high nicotine dependency, mental illness and a lack of smoking cessation programmes\(^5\). However each of the South Staffordshire prisons have weekly Smoking Cessation Clinics delivered by the Time to Quit services.

**Figure 5 : Smoking Prevalence in South Staffordshire Prisons (2007)**

Drake Hall, Featherstone and YOI Brinsford have all adopted a Strategic Framework for Health Promotion in the prison setting with three year delivery plans including health promotion events.
Since 2006, the Department of Health through Care Services Improvement Partnership (CSIP) has funded pilot Health Trainers Schemes in prisons. Successful bids have led to the implementation of Health Trainers at Drake Hall, Stafford & Swinfen Hall prisons. The Prison Health Trainer schemes to date have had over 200 referrals, tackling a range of lifestyle issues including weight loss/healthy eating, exercise, smoking cessation, and eating disorders (Drake Hall)

The local focus on health inequalities and cardiovascular disease is in the early stages of development and further work is required in the Spearhead area and those areas where life expectancy is lower to :

What do we need to do?

To achieve a visible reduction in premature mortality from cardiovascular disease requires a focused systematic and long term commitment across the NHS economy and partners in South Staffordshire. Tackling cardiovascular disease on three fronts will result in better treatment and care, treating people at risk earlier and preventing people becoming ill in the first place.

This should ultimately lead to a reduction of hospital admissions and reduced costs in treatment and care.

(a) managing existing cardiovascular disease through access to high quality care services

Readily accessible services can make a real difference to those people with existing cardiovascular disease. To ensure that those people who need the services most can access them quickly we need to understand and address inequities of access giving particular consideration to vulnerable groups such as older people, those with mental health and/or learning disabilities, black minority ethnic groups.

Our patients are treated in a range of primary care settings, as well as secondary care and tertiary centres. Primary care is provided by General Practitioners, Ophthalmic Opticians, Opticians and a variety of staff (district nurses, nurse specialists, therapists) from community health services in the PCT.

Secondary care is mainly provided at Mid Staffordshire NHS Foundation Trust and the Burton Hospitals Foundation Trust, both based within the South Staffordshire PCT geographical area. Forty percent of cardiovascular admissions are accounted for by hospitals within the PCT area. There is a variety of provision outside the PCT boundaries including all tertiary centres. We have community hospitals including the Sir Robert Peel Hospital, Tamworth, and the Samuel Johnson Hospital, Lichfield.
Third sector providers are also very involved in the treatment of patients with cardiovascular disease, such as the Stroke Association and The British Heart Foundation. It should not be forgotten that by far the majority of these patients remain at home, looked after by carers.
**Hospital admissions:** Cardiovascular disease hospital admissions increase with the age as shown in figure 6

**Figure 6 :** Cardiovascular Disease Admissions in South Staffordshire PCT, 2005/06 to 2007/08

Over the next five years, areas such as Lichfield and Tamworth will see a significant growth in numbers of older people (Figure 7). The predicted increase in older people is especially important when assessing future prevalence of cardiovascular disease.

**Figure 7 :** Percentage change between 2007 and 2012 in people aged 65 and over (number of people in 2012) by local authority

*Source: 2004-based sub-national population projections 2004-2029, National Statistics, Crown copyright*
(b) working with primary care to identify and manage people with existing risk factors

Because the majority of risk factors for cardiovascular disease are modifiable it is essential that we take a proactive approach to identify those people who are at greatest risk. As many people with risk factors already attend their GP, developing primary care cardiovascular disease risk registers will identify people at greatest risk.

There is an increased risk of cardiovascular disease for the following:-

- Those with diabetes, hypertension, high cholesterol and chronic kidney disease. For example, cardiovascular disease accounts for around 32% of deaths in men under the age of 75, in men with diabetes this increases to 63%, the pattern is similar for women.

- Those with a family history of vascular disease, some ethnic groups and increasing age.

- People who smoke, who are obese or overweight, who drink heavily, have a poor diet and who are physically inactive. Evidence shows that modification of these lifestyle factors reduces the risk in the development of cardiovascular disease and contributes to improved health of those with the condition.

Table 5

<table>
<thead>
<tr>
<th>Increased Risk of Cardiovascular Disease From Lifestyle Factors</th>
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<td><strong>Smoking</strong></td>
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<td><strong>Alcohol</strong></td>
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<td><strong>Physical Activity</strong></td>
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<td><strong>Diet</strong></td>
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<td><strong>Obesity</strong></td>
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In South Staffordshire there are 95 GP Practices and some of those currently assess their patients in an opportunistic way however this is not consistent across the PCT and has been uncoordinated and insufficiently resourced. Risk factors are cumulative; diabetic obese smokers are at the highest risk of a cardiovascular event.

In response to this, the PCT will implement a systematic approach to the identification, assessment and management of those people aged 40-74 living in South Staffordshire who are at high risk of developing cardiovascular disease in the next 10 years (an estimated 44,000 people). This will be a joint programme across primary care, lifestyle services and public health. Patients will be supported by a package of services to make lifestyle changes to reduce cardiovascular disease risk factors. Because they are identified to be at risk these patients may be more motivated to change their behaviour and with support from their GP and the lifestyle services will be able to reduce their risk of cardiovascular disease.

Sensible drinking, diet and exercise have all been shown to reduce blood pressure, but even small reductions in blood pressure can significantly reduce the risk of heart disease or stroke. A 2mmHg reduction in systolic blood pressure at a population level can lower stroke mortality by 10% and lower mortality from ischemic heart disease and other vascular conditions in middle age by 7%.

(c) preventing cardiovascular disease through self care

There is growing evidence to show that supporting self care leads to a range of positive impacts including; the patient’s physical and mental health, improved patient satisfaction, fewer primary care consultations, the reduction in visits to out-patients and A&E departments, and a decrease in the use of hospital resources.

Self care is part of daily living. It is the care taken by individuals taking responsibility for their own health and well-being and includes the actions people take for their children, their families, friends and others in their neighbourhoods and communities. We need to ensure that self care is central to all of our NHS services but especially where simple changes to daily living around lifestyle, uptake of health services and compliance with treatment can all result in improved health.

Self care was highlighted in the NHS Plan as one of the key building blocks for a patient-centred health service. It is a key component of the model for supporting people with long term conditions. Helping people self care represents an exciting opportunity and challenge for the public sector but the reward of people leading healthier lifestyles is enormous.

So far in England over 30,000 people with long-term health conditions have taken part in the Expert Patient Programme and key research findings from a randomized trial carried out by the National Primary Care Research and Development Centre found that course participants have:
• improved partnerships with doctors
• increased confidence to manage their condition
• improved quality of life and psychological wellbeing
• increased energy - and
• a high satisfaction with the course

A major self care initiative launched in 2006 is NHS LifeCheck. NHS LifeCheck is for everyone - through a straightforward questionnaire it provides personalised information and practical advice, supporting people in making small changes that make a big difference to future health and well-being. The Early Years Lifecheck\textsuperscript{11} for parents and babies 5-8 months old is now available, the Teen LifeCheck (12-15 years) will be launched in autumn 2008, with the Midlife LifeCheck (45-60 years) following in 2009.

To support a whole population approach to behaviour change we need to consider the contribution that patients themselves can make. One way of proactively engaging patients themselves is through social marketing. This is being increasingly used by PCT’s as a method of delivering healthcare messages resulting in lifestyle change. Social marketing is defined as the ‘systematic application of marketing, alongside other concepts and techniques to achieve specific behavioural goals, for a social good’. \textsuperscript{12} At the very heart of social marketing is the engagement and involvement of local people who provide the answers on the best ways to achieve change.

Investing in “healthcare marketing” and support, is a cost-effective means of bringing about change in people to become well-motivated and reducing the need for health and social services.
What are we doing now

Commissioning of Lifestyle Services in Primary Care

In 2008 the PCT developed a model of care including risk assessment, universal, and targeted prevention.

Figure 8

During 2008 practice based commissioners commissioned and implemented lifestyle services on a locality basis through the five consortia. Health professionals can directly refer patients who are at greatest risk of cardiovascular disease or who have lifestyle risk factors to local services.

A new health trainer service has been commissioned by practice based consortium to focus on those most at risk of ill health. Health trainers form a major part of the lifestyle services and are a national initiative designed to reach those who have poorer health and provide support to improve lifestyle in various ways:-

- by giving people clear up to date information about lifestyle and health,
- identify practical ways to improve health
- identify local services, and make referrals or signpost individuals
- develop skills and knowledge
- identify health damaging patterns
- set realistic goals for behaviour change
In South Staffordshire, health trainers have been recruited from local communities across the PCT and are offering one to one support to individuals with specific health needs who want to adopt a healthier lifestyle. They use motivational interviewing, goal setting and develop skills within the patient to support behaviour change. In some areas they are providing generic lifestyle support around smoking cessation, physical activity, alcohol reduction and in others there is a greater focus on weight reduction.

**Commissioning services to a new stroke pathway**

Work through the Long Term Conditions Service Improvement Board has resulted in a revised care pathway for stroke and a broader strategy which covers prevention, treatment, care and rehabilitation. This has been produced in consultation with local clinicians, providers of services, carers and patients and has been benchmarked against the National Stroke Strategy (2007) using quality standards. Central to the strategy is the provision of acute stroke services and the challenges faced by the urban/rural geography of the PCT.

**Commissioning the five year public health plan**

In 2009/2010 The Five Year Public Health Plan, Mind the Gap, which focuses on population health, will be commissioned. The plan articulates the growth in lifestyle related illness and the burden on future services and resources. The key elements of the plan are about working with primary care and partners to deliver a systematic cardiovascular risk assessment and management programme. This will be population wide, delivered through primary care and targeting those with high risk factors starting with those areas experiencing health inequalities. Additional lifestyle services will be commissioned to meet the demand for lifestyle change on a large scale.

**Developing An Obesity Care Pathway**

The Staying Healthy Service Improvement Board has developed an obesity care pathway strategy and action plan. The obesity care pathway covers prevention, treatment and surgery for the varying levels of overweight and obesity. This is being done in consultation with clinicians, a wide range of professionals across the PCT and with partner agencies. It will enhance the existing delivery of weight management services that are already in place and will include primary prevention through social marketing. The criteria from NICE have been used to establish a PCT baseline position on obesity.

Self care is a key element of any care pathway and long term prevention programme. Creating a climate where patients feel able to take control of their health and proactively help themselves is being increasingly used in secondary and primary care. The Expert Patient Programme is one example of supporting people to manage their own health.
The Expert Patient Programme

What is the Expert Patient Programme?

The EPP is a free six week course for people with chronic or long-term conditions such as diabetes, epilepsy or multiple sclerosis. The course is delivered by trained and accredited tutors living with a long term health condition. It aims to give people the confidence to take more responsibility to self-manage their health, while encouraging them to work collaboratively with health and social care professionals. The EPP does not provide health information or treatment, nor does it address clinical needs. Sessions cover healthy eating, exercising for fun and fitness, understanding and managing common symptoms, relaxation techniques and coping with feelings of depression. Anyone interested in attending a course can contact either of the PALS offices at the PCT.

“What I most appreciated about the course was the opportunity to meet a number of people who have long-term health conditions.”

Find out more about taking part in the expert patient programme:

PALS West
Block D Beecroft Court
Off Beecroft Road
Cannock WS11 1JP
Tel: 01543 465106
Fax: 01543 465110
e-mail: PALS@southstaffspct.nhs.uk

PALS East
South Staffordshire PCT
Samuel Johnson Community Hospital
Trent Valley road
Lichfield WS13 6EF
Tel: 01543 412929
e-mail: PALS@southstaffspct.nhs.uk

Working with partners

Service development

South Staffordshire Primary Care Trust covers the boundaries of four Heart and Stroke Networks, of which the Shropshire and Staffordshire Heart and Stroke Network covers the largest part of our PCT. The other Networks are Birmingham, Sandwell and Solihull Cardiac and Stroke Network, the Birmingham, Black Country Cardiovascular Network and the East Midlands Cardiac and Stroke Network.
The Cardiac and Stroke Strategy Manager is the main conduit for linking in with all the networks. The Networks have established links with clinical staff across the PCT and local health economy. Shropshire & Staffordshire Heart & Stroke Network are in the process of recruiting a Service Improvement Manager to cover the South Staffordshire PCT area.

PCT local strategies and care pathways for cardiovascular disease are being developed through the Service Improvement Boards. A number of primary and secondary prevention programmes are planned through the Service Improvement Boards for Long Term Conditions and Staying Healthy. A stroke strategy is already in place, with plans for a diabetes and renal strategy in 2009.

Service Delivery

The initial setting for service delivery is in primary care in GP practices, community pharmacists and community health services. The PCT is working with a number of partners in primary care to deliver the cardiovascular risk assessment and management programmes, developing systems and services that will identify and manage those most at risk of cardiovascular disease. The PCT is working with partners in local authority, the voluntary sector and private sectors on a number of aspects of cardiovascular management and there are opportunities to do more.
What Happens Next

To be able to commission high quality services to improve cardiovascular health we need to understand where services are being provided and how they are being used. A useful tool for this process is health equity audit.

Health equity audit is one tool which can be useful to assess whether services are being provided and accessed equitably and/or to assess rates of a condition compared with prevalence. Health equity audits provide information that can help to narrow the health inequalities gap by supporting decisions on investment, service planning, commissioning and delivery. A number of these are proposed

Early work has begun with some initial profiling. The indicators chosen are from the care pathway in the National Service Framework (NSF) for Coronary Heart Disease (2000). This will lead to a more comprehensive health equity audit in 2009 to identify how services or other resources are distributed in relation to the health needs of different groups and areas across South Staffordshire.

Key Messages from Cardiovascular Disease Profile

In South Staffordshire PCT Cardiovascular, CHD and angina admissions rates are significantly lower than for England with some variation across the PCT.

The heart failure admission rate for the PCT is similar to England with variation across the PCT.

The percentage of patients with CHD taking aspirin / anti-platelet therapy / anticoagulant varies little across the PCT.

Although there is little variation in the percentage of patients with newly diagnosed angina being referred for exercise testing, angina admission rates are variable across the PCT.

New diagnosis of heart failure is fairly consistent across the PCT although treatment with ACE inhibitor or Angiotensin Receptor Blocker does vary.

The procedure rate for Coronary Artery Bypass Graft (CABG) is similar to that for England.

The angiography procedure rate is significantly lower than for England which is reflected across the PCT.
Model Impact of Interventions

As we develop evidence based programmes to reduce cardiovascular diseases, we need to model the potential impact of these interventions. This is complex as there are a number of factors that affect both the risk and development of cardiovascular disease and the PCT is working on a number of factors at the same time. However, we need to ensure that our efforts are focused on the right factors, that the interventions are the most effective and that there has been an impact. In 2009 the PCT will be developing a number of models to help us commission more effectively.

Implementation of the Cardiovascular Disease Assessment and Management Programme

In 2009 the cardiovascular risk assessment programme will be implemented. This is being developed through primary care involving local clinicians in the planning and delivery phase. The programme will include pro-active patient identification, risk assessment, and a lifestyle modification package for adults with a persistent cardiovascular disease risk of above 20% aged 40-74 registered with a GP in SSPCT. Initial work will start in areas of greatest inequality and will then be rolled out across the 95 practices in the PCT.

Patients once assessed will benefit from lifestyle services on smoking cessation, weight management, physical activity, and alcohol. The services will be audited on an ongoing basis to ensure quality and effectiveness.

A programme of training for healthcare staff will be delivered around data systems and cardiovascular disease risks to ensure quality and consistency. Practice audits around the prescribing of statins will be carried out as the current prescribing is 9% below the national average.

Implement the Stroke Strategy for South Staffordshire

In 2008 the Long Term Conditions Service Improvement Board developed a stroke strategy agreed by the PCT board. This identifies service standards across the whole stroke pathway and practice based commissioning consortia are commissioning different aspects of the pathway with further aspects being commissioned in 2009/2010.
Implement the Public Health Five Year Plan “Mind the Gap”

The PCT Trust Board requested a plan to tackle health inequalities and the Five Year Plan focuses on reducing cardiovascular disease and infant mortality. The plan spans five years of activity and commissioning and implementation will begin in 2009/2010.

Extend the Cardiovascular Risk Reduction Beyond the Primary Care Setting

Many of our partners in local authorities and the voluntary sector are already working with us on the prevention agenda. However, we need to do more. Partners are in contact with many of the groups we need to reach. We can deliver key public health messages and interventions through pharmacies, workplaces, partner agencies and by clinicians in the acute sector. We have an army of frontline staff in the NHS and other sectors who could deliver messages on public health and support behaviour change. We need to train the NHS workforce in brief interventions and motivational interviewing.

We need to work collectively with partners in public, private and voluntary sectors to make societal changes so that healthy lifestyles choices are easier to make. Partners play a key role in supporting good health through the provision of many of their services such as transport, education, crime and disorder reduction, fire safety, housing, social services, retailing, planning and legislation. There are opportunities to improve and promote health lifestyles through existing structures such as leisure, parks and recreation, social service provision (adults and children) and schools.

Develop the Diabetes Strategy

The Long Term Conditions Service Improvement Board has identified a diabetes strategy as a priority for 2009. The SIB has restructured the diabetes network across the PCT, bringing together a number of different groups. The strategy will review the diabetes care pathway identifying need at different stages and recommending standards of care for South Staffordshire.

Analysis of Findings from the Adult Lifestyle Survey 2008

A lifestyle survey among adults has been completed by the PCT in 2008, to assess attitudes and behaviour relating to a range of key health-related issues. This survey provides an update and builds upon data collected in the last survey in 2002. A random sample of 21,000 people was drawn by the PCT from GP records, stratified by local authority area, gender and age and each was sent a postal self-completion questionnaire. The response rate was 43%, and to ensure results were representative of the population, minor adjustments in demographic profiles were made to the data by weighting.
The 2002 survey samples 20,000 adults of which 10,555 responded. The 2008 survey questions were designed to be comparable wherever possible with the 2002 survey.

The comprehensive findings from the survey will be disseminated during the course of 2009 in various reports, through seminars and forums across the PCT, practice based commissioning and local authority. The results contain a rich and varied picture of the attitudes and behaviours of local people and will be used to support commissioning and behaviour change programmes on primary prevention.

Included in the survey are specific questions relating to various lifestyle issues including smoking, alcohol, weight, diet, physical activity that are relevant to cardiovascular disease. Some of the key headline messages will be used in the implementation of the Five Year Public Health Plan and a small number are included in this report to give a broad overview.

As part of the lifestyle survey, a lifestyle “composite” was developed by combining several questions into one overall indicator of lifestyle. When compared with peoples self perceived general health, four key groups in the population were identified (Table 6):

<table>
<thead>
<tr>
<th>General Health</th>
<th>Lifestyle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those with no current health problems, but poor lifestyle, which may suggest potential future problems</td>
<td>24%</td>
</tr>
<tr>
<td>Those with current health problems and poor lifestyle</td>
<td>5%</td>
</tr>
<tr>
<td>Those with no current health problems and good lifestyle</td>
<td>67%</td>
</tr>
<tr>
<td>Those with current health problems and good lifestyle</td>
<td>4%</td>
</tr>
</tbody>
</table>

The group that has no current health problems but undertakes a poor lifestyle is probably of greatest interest for reducing long term health problems. They represent just under a quarter (24%) of the adult population. As would perhaps be expected they become more prevalent with increasing age, but that said, 19% of them are aged under -35.
Table 7: Profile of those with good health but poor lifestyle

<table>
<thead>
<tr>
<th></th>
<th>Profile of those with good health but poor lifestyle</th>
<th>Profile of total weighted sample</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>53.1%</td>
<td>50.0%</td>
<td>106</td>
</tr>
<tr>
<td>Female</td>
<td>46.9%</td>
<td>50.0%</td>
<td>94</td>
</tr>
<tr>
<td>16-24</td>
<td>6.5%</td>
<td>13.7%</td>
<td>47</td>
</tr>
<tr>
<td>25-34</td>
<td>12.1%</td>
<td>13.9%</td>
<td>87</td>
</tr>
<tr>
<td>35-44</td>
<td>18.5%</td>
<td>18.7%</td>
<td>99</td>
</tr>
<tr>
<td>45-54</td>
<td>19.7%</td>
<td>17.0%</td>
<td>116</td>
</tr>
<tr>
<td>55-64</td>
<td>19.8%</td>
<td>16.2%</td>
<td>122</td>
</tr>
<tr>
<td>65+</td>
<td>23.3%</td>
<td>20.5%</td>
<td>114</td>
</tr>
</tbody>
</table>

The Local Picture of Health – Key Issues

From those who were surveyed across all districts the following results are presented on four lifestyle issues (smoking, alcohol, nutrition, physical activity)

Smoking

As with national trends the level of smoking in the area has reduced since 2002. The lifestyle survey, 2008 shows that over the six-year period since the previous survey the number of current smokers has fallen by three percentage points from 19% to 16% compared with the national prevalence of smoking in England which is 24%.\(^{13}\)

The lifestyle survey, 2008 received insufficient respondents to accurately report at electoral ward level. As a result, wards have been grouped into larger areas for analysis purposes. Highest levels of smoking were reported in central Stafford, Rugeley and in Cannock, while lowest levels of smoking were reported to the East of Stafford (including Weston, Weeping Cross, Hixon and the Haywoods).

Smoking is slightly more prevalent among males than females. On average, men indicated they were smoking more than women: an average daily consumption level of 15 for men compared with 13 for women.

The proportion of heavy smokers (over 20 cigarettes a day) has decreased over the last six years. The fall in heavy smoking among men is significant, down by almost a third (from 15% to 11%). The proportion of heavy smoking fell from 18.3% in 2002 to 6.8% in 2008. Despite the fall, heavy smoking is more prevalent among men and older age groups.
Smoking is more prevalent in the most deprived areas compared to the more affluent areas and there is higher smoking rates amongst males in the most deprived areas.

There is still considerable take-up of smoking among young people, the highest proportion of current smokers was aged 16 to 24 (24%).

Quitting Smoking – What did our Local Residents Tell us

Desire to quit is widespread with 43% of smokers having tried to give up in the last 12 months, a similar level to that recorded in 2002 (46%).

To give up smoking respondent preferred help or advice from a health professional with face-to-face with a doctor, nurse or pharmacist as the favoured method for 52% of smokers (63% among those who expressed a desire to quit). Only 9% expressed a preference to receive help or advice in a group with other people trying to quit smoking and 8% indicated they would prefer e-mail or text support.

Local Good Practice in South Staffordshire

timetoQuit is the stop smoking service working in partnership with the six Local Authorities, Staffordshire County Council, Smoke Free Staffordshire and other national agencies to provide a FREE 12 week support programme combined with medications on prescription and a choice of service tailored to suit patients needs in the following settings:-

- GP
- Pharmacy
- One to one drop ins
- Virtual service
- Workplace
- Pregnancy
A county wide multi-agency partnership – “Tobacco Control Alliance” has been established in 2008 to develop and deliver a comprehensive stop smoking plan structured around key areas covering communication, service provision, working with young people, tackling illegal and under age availability and maintaining and promoting smoke free environments.

**Stop smoking**

Smoking is particularly dangerous for people with diabetes, because among other things it:

- raises blood sugar levels
- hampers the body’s ability to use insulin
- doubles the likelihood of having problems with healing

If you have diabetes and continue to smoke you are much more likely to have a heart attack or stroke.

**Nutrition and Weight Loss**

**Consumption of fruit and vegetables**

The Government recommends that everyone should eat at least 5 portions of a variety fruit and vegetables each day, to reduce the risks of cancer and coronary heart disease and many other chronic diseases. Consumption of 5 or more servings of fresh fruit or vegetables every day has increased significantly over last 6 years (from 16% in 2002 to 24% in 2008).

Consumption of 5 or more servings of fresh fruit or vegetables every day is lowest in 16-24 year olds (12%). Similarly low levels (14%) are shown among those in the most deprived areas.
Almost two-thirds of respondents (62%) would like to eat more healthily. The desire to eat more healthily declines with increasing age with over 7 out of 10 under-45 year olds expressing a desire to eat more healthily, falling to 52% of those aged 55 to 64 and 38% of those aged 65 and over.

Dietary changes in the last 12 months were more evident among women and those aged over 55. However reduced fat and salt intake had only been achieved by a quarter of respondents.

The main barriers identified to changing to a more healthy diet were lack of time (27% in 2002 to 39% in 2008) and cost (22% in 2002 to 34% in 2008).

**Overweight and Obesity**

A desire to lose weight was expressed by 54%, this being more evident among women (62%) than men (46%). Over 80% of those who were obese expressed a desire to lose weight.

The majority (90%) of those had tried at some point to do so on their own. 13% tried to lose weight through a slimming club and 6% with the help of GP/nurse. Whilst only small levels used a slimming club, they achieved the highest level of success – 41% were almost or completely successful in losing weight in the last 12 months. Those trying on their own achieved notable success with 22% being almost or completely successful and only 15% not at all successful.

**Support to Lose Weight**

Despite the lower level of success of dieting with the support of GP or nurse, this was the preferred method of support for 39% of those interested in losing weight, 30% prefer advice of medical professionals at other NHS facilities and 11% find NHS group support useful in weight loss. Opinion on slimming clubs was the most sharply divided, with 36% in preference and 28% against the idea.
Local Good Practice in South Staffordshire

Weight management services for adults have been commissioned by the five PBC with direct links to primary care. All are evidence based and use a combination of behaviour modification, dietary change and exercise. These are delivered by the PCT Community Services, Weight Watchers, Slimming World and a locally enhanced service in some primary care. The newly established Lifestyle Team in the east locality will take referrals in 2009.

Staffordshire County Council has a public health team that focuses on nutrition. They have a well established scheme to promote healthy eating amongst staff and local businesses.

**Staffordshire Health Options Award** is given to restaurants, cafeterias, hotels, workplace and hospital restaurants, pubs and takeaways which maintain good hygiene practices and offer healthy options to their customers.

Bob, aged 71, Cannock Chase

I was referred to the health trainer by my practice nurse. She was concerned about my weight (BMI 32).

During my first appointment with the health trainer, we discussed my dietary habits. I was taking only one portion of fruit or vegetable daily and my meal portions were large. My health trainer gave me practical tips to lose weight. Motivated by our discussion, we agreed on certain goals. I started eating more portions of fruits and vegetables and also reduced the portion sizes of my lunch. I was in regular contact with my health trainer through phone and one-to-one appointments.

I lost 6 pounds in a month and I feel better in myself. Losing weight has also helping in reducing my long-term back pain. I am really happy with my progress and motivated to continue losing weight by eating healthily and start exercising. I have set further targets in agreement with my health trainer to achieve these goals.

Making small changes to your diet is one of the simplest and most effective ways to reduce your risk of cardiovascular disease. You can do this by

- reducing fat in your diet, especially saturated and trans-fats
- eating more fruit and vegetables, wholegrain food and soluble fibre
- drinking alcohol in moderation
- reducing salt to maintain a lower blood pressure
Alcohol

The Annual Report of the Director of Public Health 2008 On Track or off the Rails\textsuperscript{14}. Considered the impact of alcohol in South Staffordshire and the recommendations have been taken forward through partnerships. The report can be found at http://www.southstaffordshirepct.nhs.uk/YourHealth/docs/DPH_AR08.pdf

The proportion of the population that drink alcohol has fallen over the last six years from 88\% in 2002 to 75\% in 2008.

There has been an increase in consumption levels among those who do drink. A quarter of all drinkers exceeded the recommended maximum level of units per week (compared with 22\% in 2002). The increase in levels was higher for men i.e. from 26\% in 2002 to 31\% in males.

Younger age groups recorded a higher prevalence with 12\% of 16 to 24 year old drinkers and 14\% of 25 to 34 year old drinkers.

A smaller proportion of the most deprived consume alcohol, 64\% compared with the overall proportion of 75\%. However, those who do drink, on average consume more (20 units per week compared with overall average for total sample of 18).

The preferred source for support was the GP with 64\% indicating this to be the case. The Internet featured high as a potential source of information and support followed by health clinics, practice nurses and friends or relatives.

Local Good Practice in South Staffordshire

Tamworth Safer Nights public awareness campaign aimed at the over 18’s

\textbf{Arrest referral officer project} is funded through East Staffs LSP and Tamworth Crime Disorder Reduction Partnership

\textbf{Alcohol and drug services in Staffordshire} provide free confidential information, advice and support to anyone concerned about their own or someone else’s misuse of alcohol and/or drugs (illegal or prescribed).

\textbf{BAC O’Connor Centre}

Offers a community based rehabilitation service for alcohol misusers in a supportive environment through a highly trained staff team.
AWAITING CASE STUDY
**Physical Activity**

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.\(^\text{15}\)

The examples of moderate or vigorous exercise used within the Lifestyle survey are:

**Moderate** - Heavy gardening, heavy housework or DIY, energetic dancing, exercise class, tennis, swimming, cycling, badminton, cricket or other similar activities

**Vigorous** - Only include activities that made you out of breath or sweaty (e.g. squash, running, high impact aerobics, strenuous hill walking, weight training, boxing, football, rugby, hockey, vigorous swimming, vigorous cycling or similar activities)

The level of activity taken was encouraging with moderate exercise maintained by 76% throughout all age bands, with women undertaking only slightly less than men. The mean number of days (based on all adults) was between 7 and 10 in a four week period.

In areas of deprivation physical activity levels are lower with 64% undertaking some form of moderate exercise (compared with 76% of total sample).

Vigorous exercise shows a decline with age. While for the youngest age group (16 to 24 year olds) vigorous exercise accounts for a significant proportion of the total exercise undertaken; it features less prominently with increasing age. Also of note is the gender difference, especially among those aged under 35, with men partaking in much more vigorous exercise than women.

The most popular forms of exercise are walking. Just over half (52%) partake in short walks - walks of at least a quarter of a mile involving five to 10 minutes of continuous walking. This is lower than the 66% recorded in 2002. Cycling and swimming were also popular the former enjoyed by 20% (24% in 2002), and swimming enjoyed by 18% (24% in 2002). 14% of respondents go to the gym and 12% go running or jogging. 12% of respondents recorded no form of exercise.

Desire to partake in exercise was high with 63% of respondents indicating that they would like to take more exercise (a small reduction from the 66% recorded in 2002). Highest desire to take more exercise was among those aged 25 to 44. The desire to partake was also evident among those who were obese.
## Local Good Practice in South Staffordshire

The ‘Health Fit’ programme is an integrated physical activity programme developed by the South Staffordshire PCT in partnership with the County Sports Partnership - Sport Across Staffordshire and Stoke on Trent. It aims to increase the physical activity levels of adults identified with health risks and contribute to improved health and wellbeing.

Health Fit is focused within the most deprived areas of the PCT. The target group will be adults with health risks (obesity, hypertension and high cholesterol). This group will include adults primarily over the age of 45, women, people from black and minority ethnic groups and people on low incomes.

### Exercise on Referral Scheme:
A structured physical activity programme for patients with specific medical conditions such as diabetes, and obesity who would benefit from some structured exercise. Referrals are made by primary care clinicians to a trained exercise professional for assessment onto a tailored programme.

### South Staffordshire District Council

**Health Watch in South Staffordshire:** This project delivered by the district council. Two physical activity coaches will develop and deliver new sport and active recreation activities for 900 people in the area.

**Super Active Seniors:** A team of six volunteers will be recruited and trained to a nationally recognised standard to provide regular gentle exercise classes at community groups for older people to improve health and wellbeing.

### Harold aged 71, Burton

Harold a 71 year old male who since attending the Walking for Health scheme run by East Staffordshire Borough Council has met new people and feels the exercise is good for his health. When he started the walks, he was not participating in any health related activity, and was initially out of breath. After attending the walks for a few months he is no longer out of breath, and his old knee injury seems to be better. He now attends twice a week and has become a volunteer leader and joined the ramblers club short walks programme. Harold enjoys the walks as he likes being in the fresh air, meeting new people and talking to people on the scheme.
Recommendations

It will be a long and challenging task to reduce cardiovascular disease across South Staffordshire and we will need to retain our focus, energies and resources on the challenge if we are going to have an impact.

A number of plans have been developed that need to be implemented which will be the responsibility of a wide range of partners from the Practice Based Commissioners to community and acute health providers, the public, private and voluntary sectors.

Above all we will need the engagement of patients and the public to access services and make lifestyle changes. The overarching recommendation is that we all work together on this key health issue for South Staffordshire. This will include:

- Commissioning and delivery of high quality treatment and care services
- The development of accessible lifestyle services to a sufficient level to make an impact
- Raising awareness among patients and the public
- Training and using the workforce across all sectors to support the public
- Target those communities most in need first and fastest

Do you want to become more active, meet new people and try out some new and exciting activities?

Why not become part of Health Fit - the new physical activity programme for South Staffordshire!
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Achievements so far</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol and Pregnancy</strong></td>
<td></td>
</tr>
<tr>
<td>• New resources and publicity campaigns to be targeted at pre and post conception giving clear consistent messages about alcohol</td>
<td></td>
</tr>
<tr>
<td>• All pregnant women should be routinely asked about alcohol consumption at antenatal booking</td>
<td></td>
</tr>
<tr>
<td>• Training in brief interventions should be provided for all staff involved in pre and post conception care</td>
<td></td>
</tr>
<tr>
<td>• Healthcare staff should monitor all pregnant women with suspected or confirmed history of alcohol consumption at low to moderate levels and offer them brief intervention counselling</td>
<td></td>
</tr>
<tr>
<td><strong>Young Children and Families</strong></td>
<td></td>
</tr>
<tr>
<td>• All frontline staff working with young children and families should provide information about the harmful effects of alcohol and the services available</td>
<td></td>
</tr>
<tr>
<td>• Further work is required to determine what services are required to support young children and families affected by alcohol misuse</td>
<td></td>
</tr>
<tr>
<td>• Training in brief interventions should be provided for voluntary and statutory agencies in regular contact with families</td>
<td></td>
</tr>
<tr>
<td>• All staff working with young children should be trained to identify alcohol problems within the family</td>
<td></td>
</tr>
<tr>
<td><strong>Teenagers (children under 16)</strong></td>
<td></td>
</tr>
<tr>
<td>• All secondary schools should prioritise alcohol education as part of citizenship and Personal, Social and Health Education (PSHE) programmes</td>
<td></td>
</tr>
<tr>
<td>• Using existing local good practice agencies need to develop, deliver and evaluate an evidence based programme of education for young people</td>
<td></td>
</tr>
</tbody>
</table>
• A public information campaign promoting safe drinking limits and risks associated with excessive alcohol use should be delivered
• Training in brief interventions should be provided for all school nurses and other health professionals working with young people and parents
• Appropriate services need to be developed and commissioned to support young people

**Young Adults Aged 16-24**

• Develop a social marketing campaign aimed at young people through colleges, police and other agencies working with young people
• Work with publicans and nightclubs to develop marketing campaigns which encourage responsible drinking
• Provide training in brief interventions for all staff working with young offenders
• Commission adequate services for young people and young offenders
• As part of the sentencing options of the courts refer offenders to alcohol services

**Adults**

• Raise awareness of the health risks associated with alcohol to professional groups through existing partnership structures
• Promote local and national campaigns to highlight the harmful effects of alcohol misuse throughout public services
• Ensure all staff in different settings are trained to identify and deliver brief interventions (including primary care, A&E, outpatients, prisons, probation and the workplace)
• With partners, develop local action plans to deliver the Local Area Agreement (LAA) target on alcohol
Develop a proactive working group between the A&E departments and wider partners to identify joint work to reduce alcohol-related violent crime

- Commission prevention and treatment services designed for different population groups
- Determine appropriate services for the alcohol-dependent population in order to inform future commissioning decisions
- All providers of services to monitor and regularly submit reliable and high quality data to the lead commissioner

### Prisoners
- Develop the identification, assessment, training for staff in brief interventions, information, and delivery of evidence based practice for alcohol-related issues within prisons
- Provide additional support for alcohol-related problems in prisons through the existing substance misuse programme
- Through the prison health partnership identify appropriate support mechanisms for prisoners with an alcohol problem on their release.

### Older People
- Provide information to clients about the interactions of medication with alcohol through community pharmacists
- To ensure alcohol awareness is part of the falls prevention programme
- Training in brief interventions and basic effects of alcohol should be provided for all frontline staff working with older people
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