NHS
Stoke on Trent

Reducing inequalities in health outcomes: Progress in Stoke on Trent

2007 / 2008 Annual Report of the Director of Public Health

07 / 08

Foreword

I am very pleased to be able to present my annual report for the year 2007/08.

I am particularly pleased, because the latest accurate figures (April 2006) on outcomes suggest a very positive picture and grounds for optimism for the future. The highlights are that:

- Life expectancy is at the highest level ever (Chapter 2)
- Infant mortality is at it's lowest level ever (Chapter 3)
- Premature mortality from cancer, circulatory diseases and respiratory illnesses are also at their lowest levels ever (Chapter 3)

However, we do need to look at this picture with some caution. These figures are based on one year and are subject to considerable variation on an annual basis. If the 2007 data confirms this trend then, that would be an important milestone.

It is also clear from the trends that we are beginning to close the gap between Stoke on Trent and England. In some instances, this is progressing quite quickly (circulatory disease) and in other areas slowly (infant mortality). It is likely that in future years the pace of reduction will vary quite considerably. However, I think we ought to take confidence from the fact that many of the actions we have implemented over the past decade are very strongly based on evidence of effectiveness. As a consequence, the health status should continue to improve. At a strategic level, the most important intervention is the programme to transform primary care in Stoke on Trent that was agreed by the Stoke on Trent Primary Care Trust in March 2008.

However, although many of the actions taken by the NHS in Stoke on Trent will help, they alone are unlikely to change the pattern of inequalities in health outcomes dramatically. For that to happen, we need to improve educational achievements and income levels of people in Stoke on Trent to the average in England.

Nationally, two major public health events took place in 2007. Firstly, the ban on smoking in public places came into force. We were able to support a range of organisations in Stoke on Trent to adhere to the law. One of the consequences of this legislation was that the number of people accessing smoking cessation services increased during the period June to October 2007.

The second major event was that in June 2008, the Government published a refresh of it's approach towards reducing health inequalities titled "Health Inequalities: Progress and Next Steps". At the same time, the Audit Commission reviewed the health inequalities approach taken in Stoke on Trent and recommended that the system needed considerable improvement. Given this set of circumstances, it is entirely appropriate I think for the Stoke on Trent approach to be refreshed in light of our successes and failures. In Chapter 1 of this report I have taken the opportunity of contributing my initial thoughts on the matter.

Finally, my thanks to Paul Trinder, Nigel Bennett and Keith Swift for help in producing this report.

I hope you find the report interesting and helpful. If you have any views on the issues covered in this report, please do not hesitate to write to me.

Dr Giri Rajaratnam
Director of Public Health
City of Stoke on Trent

Chapter 1

Tackling inequalities in health outcomes in Stoke on Trent.

Introduction

During 2007/08, the Audit Commission completed a review of the Stoke on Trent approach to tackling inequalities in health outcomes. The review acknowledged the good work that was already taking place in Stoke on Trent but also identified the need for strengthening some important areas. In summary the areas that needed strengthening included:

- Developing a more strategic approach to tackling health inequalities in priority areas
- Improving the understanding and involvement of Councillors and Non Executive Directors of the Primary Care Trust
- Strengthening performance management
- Developing and promoting community, health champions
- Improving our approach to diversity and community engagement

The purpose of this chapter is to set out my views on health inequalities in order to stimulate action, particularly in relation to the fist two issues identified above.

What do we mean by inequalities in health outcomes?

Inequalities in health outcomes can be defined as the difference in health status between different groups of people. For example, health status differs most strongly by socio-economic groups (that is the degree of affluence of communities). Health status can also vary by, gender, ethnicity, geography and even disability. These issues were first highlighted by the Black Report (Inequalities in Health) published in 1980 which have been followed by a number of other reports. The most recent is that published by the Government in June 2008 and titled "Health Inequalities: Progress and Next Steps".

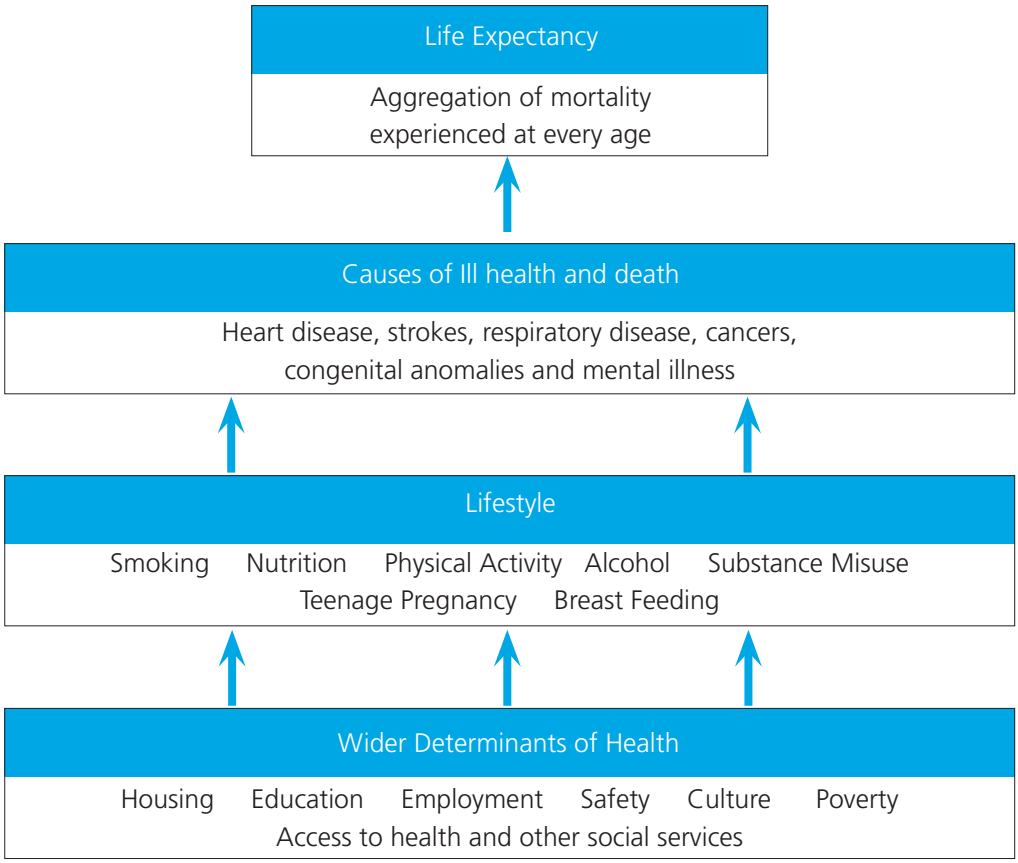
Since the early 1980s, considerable research has taken place both in the UK as well as elsewhere. Unfortunately the research has not fully explained the causal pathways that lead to inequalities in health outcomes. However, there is clear and incontrovertible evidence that:

- Health inequalities arise as a consequence of the interaction between individuals, communities and socio-economic policies including health care.
- The extent of inequalities in health outcomes is dependent on relative poverty or relative affluence. Communities which have large differences in the distribution of affluence will have large health inequalities and vice a versa.

What has been our approach in Stoke on Trent?

We have accepted that the most important measure of health inequalities at a strategic level is life expectancy. As a consequence, conceptually, we have used figure 1 as the basis of the work we have been undertaking since 2002.

Figure 1 Factors influencing life expectancy in Stoke on Trent



The most important messages from figure 1 are:

- The ability of individuals and communities to cope with the determinants of health result in a variety of lifestyles. Research shows that deprived communities have a poorer experience of determinants of health which then result in unhealthy lifestyles.
- The lifestyles people lead directly influence the probability of ill health. Deprived communities as a consequence of unhealthy lifestyles are at higher risk of ill health and death.
- People's experience of the determinants of health coupled with their lifestyles often determines their ability to use health and health care services appropriately. Scientific research in the UK suggests that deprived communities access to health and health care services are compromised.
- This in turn results in increased risk of disability, illness and death at a much younger age. It is the case that communities with high levels of deprivation have a greater frequency of ill health and death.

The above is a simplification of a complex interaction between communities and the social and economic policies that govern them. However, I hope it does make the point about the importance of the determinants of health as the major influence on the ability of communities and individuals to live a healthy life. In my view, the most important determinants of health for communities in Stoke on Trent are education and income coupled with the ability to both, shape services and influence individuals to use those services.

The scientific evidence suggests that in order to achieve a level of health in Stoke on Trent comparable to those seen in more affluent parts of England, the following are pre-requisites:

- A minimum level and a distribution of earnings that is comparable to the more affluent parts of the country.
- An increase in the number of highly skilled and well-paid jobs both within and near to Stoke on Trent.
- Higher than national average numbers of basic, intermediate and higher level skills and qualifications.
- A community with a national reputation for creating cultural, sporting and leisure opportunities.
- An NHS (primary care, community services and specialist services) with a national reputation for quality.
- A community which embraces change.

How are we turning this into reality?

Public, private and voluntary organisations in Stoke on Trent are working together through the Local Strategic Partnership to support communities in Stoke on Trent. Examples of how this translates into actions are set out below and details can be found in my annual report of 2006/07.

i. Determinants of Health: The City Council with support from a range of partners (from public, private and voluntary sectors) has strategies in place to address each determinant highlighted in figure 1. So, for example, there are major programmes to improve education levels, to regenerate housing and the economy as well as initiatives to reduce worklessness.

ii. Lifestyles: The NHS in Stoke on Trent partnered by a variety of organisations, has programmes in place to tackle each lifestyle issue set out in figure 1. There are major programmes for example to reduce the impact of tobacco and other substances, to improve physical activity and to improve sexual health.

iii. Death and Ill health: The NHS with support from key partners has major programmes of action identifying individuals at greatest risk (or with disease) and ensuring patients are treated at the right time of the natural history of the illness, at the right place and by the right team. These include programmes on mental illness, heart disease, cancer, respiratory disease and infant mortality.

However, although members of the communities in Stoke on Trent and their elected representatives are involved in much of this work, there appears to be a lack of coherence between services and the aspirations of the people of Stoke on Trent. This results in poor utilisation of services and communities not realising their potential for improvement. In my view some of this incoherence is to do with the way statutory services operate but I think there are also more complex issues to do with the communities in Stoke on Trent and these have yet to be explored and addressed.

What do we need to do?

In my view there are some important issues for the leaders of the key statutory organisations and the Local Strategic Partnership to consider. These are as follows:

a) Do they understand the gaps in health inequalities, the drivers and community needs, to a level that enables services to be shaped around, and to make en effective contribution to, reducing inequalities in health outcomes? The impact needed is not simply to improve the range of factors set out in figure 1 but to improve at a greater rate than elsewhere in the country.

b) Are the service planning, delivery and performance systems of sufficient calibre to give confidence that continuous improvements in inequalities in health outcomes take place?

c) Are there strong enough support systems to stimulate communities to change? This particular question needs to be carefully considered by both local Councillors and the Area Implementation Teams who are much more rooted within local communities. In some respect this is the most important issue.

Recommendations

I would welcome the following groups publishing their views on the questions raised above:

- Stoke on Trent Local Strategic Partnership
- The Board of the Stoke on Trent PCT
- The Councillors of Stoke on Trent City Council

Chapter 2

Life Expectancy

Life Expectancy

1.Targets

The target set by Government has two components to it:

- By 2010 to reduce the gap in life expectancy between the deprived and affluent areas of the country by 10%, using the figures from 1997-99 as the baseline.
- By 2010 to increase life expectancy in England, to 78.6 years for men and 82.5 years for women.

In previous annual reports, I translated these targets into the Stoke on Trent context and suggested that in order to reduce the gap at a reasonable pace, the target for Stoke on Trent, should be a reduction of 25% in the gap between Stoke on Trent and England by 2010.

However, a review undertaken in 2006/07 by the Stoke on Trent Local Strategic Partnership identified that between 1991 and 2004, the gap had in fact increased. As a consequence, the Local Strategic Partnership agreed a more conservative target which was to reduce the gap to 3.1 years for males and to 2 years for females. Although this was a good pragmatic approach, I have decided to continue with the original targets. My reasons for this are as follows:

- The 25% reduction in the gap is challenging but remains feasible as long as Stoke on Trent Primary Care Trust and partners prioritise actions appropriately.
- The funding crisis which applied during the period 2005 to 2007 is no longer an issue.
- The Local Strategic Partnership target set in early 2007, has been met (Table 1 below).

2. The Challenge in Stoke on Trent

The progress we have made in Stoke on Trent and England over the last fifteen years is set out in tables 1 (males) and 2 (females) below.

Table 1 Male life expectancy over the period 1991 to 2006

	91-93	95-97	97-99	99-01	02-04	03-05	04-06	(1) Target for 2009-11
Stoke	71.5	72.5	72.6	73.1	73.2	73.7	74.5	76.9
England	73.7	74.6	75.1	75.7	76.6	76.9	77.3	78.6
Difference between Stoke and England	-2.2	-2.1	-2.6	-2.6	-3.4	-3.2	-2.8	-1.7

Source: Compendium of Clinical and Health Indicators 2008

1 – Baseline taken as 1991-93 and therefore a 25% reduction in the gap leads to a difference of 1.7 to be achieved by 2009-2011.

Table 2 Female life expectancy between 1991 and 2006

	91-93	95-97	97-99	99-01	02-04	03-05	04-06	(1) Target for 2009-11
Stoke	77.1	78.6	78.6	78.8	78.7	79.1	79.6	81.0
England	79.1	79.7	80.0	80.4	80.9	81.1	81.6	82.5
Difference between Stoke and England	-2.0	-1.1	-1.4	-1.6	-2.2	-2.0	-2.0	-1.5

Source: Compendium of Clinical and Health Indicators 2008

1 – Baseline is taken as 1991-93 and therefore a 25% reduction leads to a difference of 1.5 to be achieved by 2009-2011.

Life expectancy in Stoke on Trent and England increased over the entire period. However, the pattern of improvement throughout that fifteen year period has been variable.

- During the early 1990s, the gap between Stoke on Trent and England decreased.
- Between 1996 and the early 2000s however, the gap increased.
- Since about 2004, this trend has been reversed and for both males and females, the gap between Stoke on Trent and England is now reducing.

It is important to note that it is still too early to be very confident that the changes will be sustained over the period 2006 to 2011. Nevertheless it does give us some optimism.

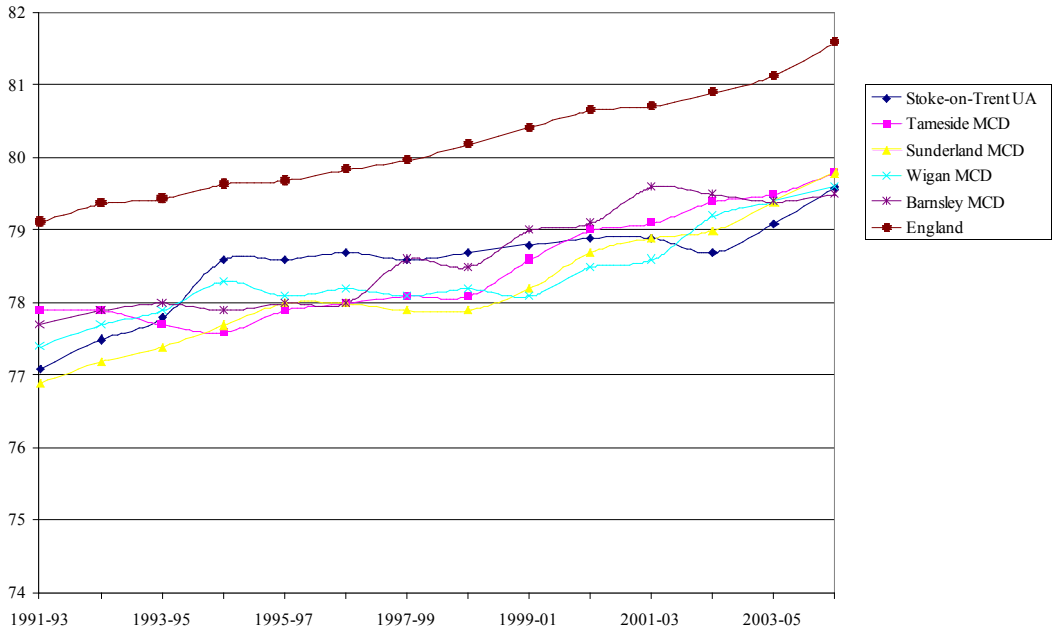
How do we compare with like cities? When we did the major review in 2006/07, we identified a number of cities (Tameside, Wigan, Sunderland and Barnsley) that were similar to Stoke on Trent in terms of deprivation. Table 3 and figure 1 provide the comparison for females and figure 2 and table 4 for males.

Table 3 Life expectancy amongst females in selected cities between from 1991 to 2006 have been undertaking since 2002.

	Life expectancy 1991-93	Life expectancy 2004-06	% Change between 1991 and 2006	% change between 2002-2006
Stoke on Trent	77.1	79.6	3.2	1.1
Tameside	77.9	79.8	2.4	0.5
Sunderland	76.9	79.8	3.8	1.0
Wigan	77.4	79.6	2.8	0.5
Barnsley	77.7	79.5	2.3	0.0
England	79.1	81.6	3.1	0.9

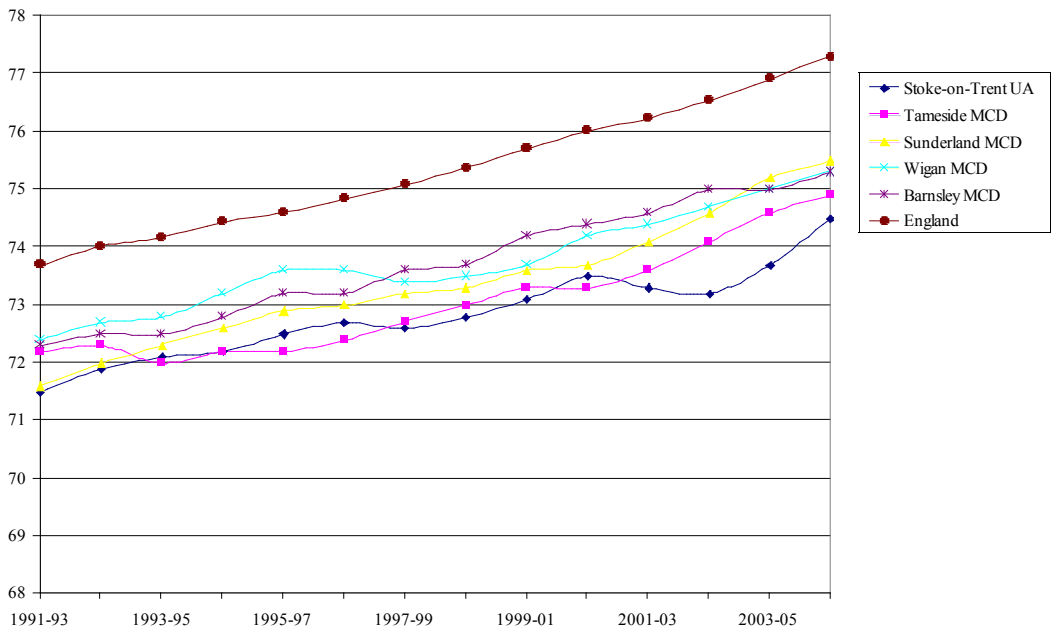
Source: Compendium of Clinical and Health Indicators

Figure 1 Life expectancy for females in selected cities for the period 1991/03 to 2004/06



Source: Compendium of Clinical and Health Indicators 2008

Figure 2 Life expectancy for males in selected cities for the period 1991/03 to 2004/06



Source: Compendium of Clinical and Health Indicators 2008

Table 4 Life expectancy amongst males in selected cities between from 1991 to 2006

	Life expectancy 1991-93	Life expectancy 2004-06	% Change between 1991 and 2006	% change between 2002-2006
Stoke on Trent	71.5	74.5	4.2	1.8
Tameside	72.2	74.9	3.7	1.1
Sunderland	71.6	75.5	5.4	1.2
Wigan	72.4	75.3	4.0	0.8
Barnsley	72.3	75.3	4.1	0.4
England	73.7	77.3	4.9	1.0

Source: Compendium of Clinical and Health Indicators

Overall, life expectancy for both males and females has increased in Stoke on Trent at a faster rate particularly during the period 2002 to 2006 than in comparable cities except for Sunderland where improvement over the entire period has been at a consistent rate. In contrast, as explained previously, the pattern of improvement in Stoke on Trent has been very much more variable.

Within Stoke on Trent, there are substantial differences in life expectancy across the City (Table 5). As there are only a small number of deaths in each ward, we have aggregated numbers across five years in order to calculate the life expectancy within each ward.

Table 5 Life expectancy for wards in Stoke on Trent based on mortality data for the period 1999-2003

Ward	Male life expectancy	Female life expectancy
Abbey Green	73.4*	81.7
Bentilee & Townsend	71.7*	78.8*
Berryhill & Hanley East	72.2*	78.0*
Blurton	72.7*	79.3
Burslem North	72.2*	78.0*
Burslem South	68.5*	74.1*
Chell and Packmoor	72.7*	77.8*
East Valley	75.1	78.3*
Fenton	73.1*	81.7
Hanley West & Shelton	71.3*	76.9*
Hartshill and Penkhull	73.9*	79.3
Longton North	74.4	78.2*
Longton South	73.9*	77.9*
Meir Park and Sandon	75.0	81.6
Northwood & Birches Head	75.0	80.6
Norton and Bradeley	72.6*	78.0*
Stoke and Trent Vale	71.7*	81.9
Trentham & Hanford	76.9	80.1
Tunstall	70.7*	78.0*
Weston & Meir North	73.5*	78.5*
Stoke-on-Trent UA	73.1*	78.8*
England (2000-02)*	**76.0**	**80.7**

* Significantly lower than for England

Source: Office for National Statistics 2006

In the majority of wards life expectancy was significantly less than that for England. The word "significant" is important in this instance as it signifies that the difference between the ward and England is more than we would expect by chance alone. Clearly, it is important to note that the figures used for this comparison are historical and may not reflect the experience for the period up to 2006.

We do not have life expectancy figures for a geographical level smaller than wards. We can however, use mortality figures to look at much smaller aggregations of communities. Stoke on Trent City Council have developed neighbourhood zones. There are 54 such zones in Stoke on Trent each containing approximately 5000 people. At this level, based on the number of deaths between 2002 and 2007, the areas listed below are seen to have significantly higher death rates (not life expectancy) than elsewhere in Stoke on Trent:

- Goldenhill in Tunstall ward
- Stansfield & Millhill in Burslem North ward
- Middleport & Longport and Burslem & Sneyd Green West in Burslem South ward
- Longton in Longton South ward
- Trentham West in Trentham and Hanford ward

It is important to note that the figures used for the purpose of identifying neighbourhood zones do not distinguish between deaths at particular ages. The appearance of Trentham West in this group is a surprise. I think part of the explanation for this lies in the proportion of older people (65+) in the community in Trentham West which is approximately 29%, the highest within the neighbourhood zones.

Taken together with the information in table 4, I would suggest that, Tunstall, Burslem North, Burslem South, Longton South should be the initial focus for action. Subsequently, the focussed approach should move to other wards which have life expectancy significantly lower than England.

3.The Major Killers

Although the people of Stoke on Trent die of a variety of causes and at different ages, the overall pattern is no different to elsewhere in the country. We simply have more deaths at an earlier age. Table 6 provides an indication of the major causes of death and table 7 shows the number of deaths by age group.

Table 6 Major cause of deaths in Stoke on Trent in 2007

ICD10 Chapter	Total	%
Circulatory system	823	33.0
Cancer	734	29.4
Respiratory system	416	16.7
Digestive system	141	5.7
Mental & behavioural disorders	75	3.0
Genitourinary system	61	2.5
Diseases of the nervous system	58	2.3
Accidents	43	1.7
Endocrine, nutritional & metabolic diseases	34	1.4
Infectious & parasitic diseases	28	1.1
Musculoskeletal system	20	0.8
Intentional self-harm	8	0.3
Other	55	2.2
Total	**2,496**	**100**

Source: Public Health Mortality File 2008

Table 7 Number of deaths by selected age groups

	Number	Major causes
Under 1	16	A number of causes such as congenital malformation and prematurity.
1 to 35	28	A large number of causes such as suicides, trauma etc.
35 to 75	835	Circulatory diseases, cancer and respiratory account for the majority.
75+	1617	As above.

Source: Public Health Mortality File 2008

Table 8 below provides an indication of the areas where the greatest gain in life expectancy might be made in Stoke on Trent in comparison with England.

Table 8 Life expectancy gained if the most deprived quintile of super output areas of Stoke on Trent had the same mortality rate as the England average

Cause of death	Male	Female
Heart disease	1.2	0.7
Stroke	0.1	0.1
Lung cancer	0.6	0.4
Other cancers	0.4	0.3
Chronic liver cirrhosis	0.3	0.1
Pneumonia	0.2	0.2
Chronic obstructive airways disease	0.4	0.2
Mental and behavioural disorders	0.4	0.2
Suicides and undetermined injuries	0.3	0.1
Deaths under 28 days	0.4	0.4

Source: www.lho.org.uk/NHII

Super output areas are much smaller than wards and neighbourhood zones. They typically contain between 1000 and 1500 individuals. There are approximately 165 SOAs in Stoke on Trent.

This shows that opportunities to make the greatest impact lie in tackling heart disease, cancers and respiratory diseases. However, it is important to note that tackling the impact of cirrhosis (related to alcohol abuse), mental disorders and deaths before the age of 28 days should also result in important improvements in reducing the gap in life expectancy.

4. Action

The recommendations from previous annual reports set out the key issues for Stoke on Trent. The actions resulting from those recommendations do need to be sustained over the longer term. The critical issues are:

- Continuing to increase smoking quit rates
- Reducing complications of circulatory disease (e.g. heart disease, strokes and diabetes) through the use of effective therapies now available.
- Identifying and taking action to ensure people at very high risk of cardiovascular disease do not go on to have the disease.
- Others such as early detection of cancer and effective treatment of both, respiratory illnesses and alcohol related diseases.
- Developing and maintaining a very high quality primary care system.

5. Recommendation

The Local Strategic Partnership should support Area Implementation Teams to develop action plans for those wards where life expectancy is significantly less than the average in England. The objectives of these action plans should be to increase uptake of services in those areas by helping to refining service delivery and stimulating local demand for those services.

Chapter 3

Major killers in Stoke on Trent

Infant Mortality
Circulatory Disease
Cancer
Respiratory Disease

Infant Mortality

1.Targets

Infant mortality refers to the first year of life. The national target is to reduce infant mortality by 10% by 2010 with the baseline being the infant mortality rate in1997-99.

The Stoke on Trent Local Strategic Partnership reviewed progress in 2006/07. As there had been little progress since 1998, the partnership agreed to set a new local target of reducing the infant mortality rate by 10% taking as the baseline the rate for 2003-2005. The new target differed only in terms of the baseline year.

2. The Challenge in Stoke on Trent

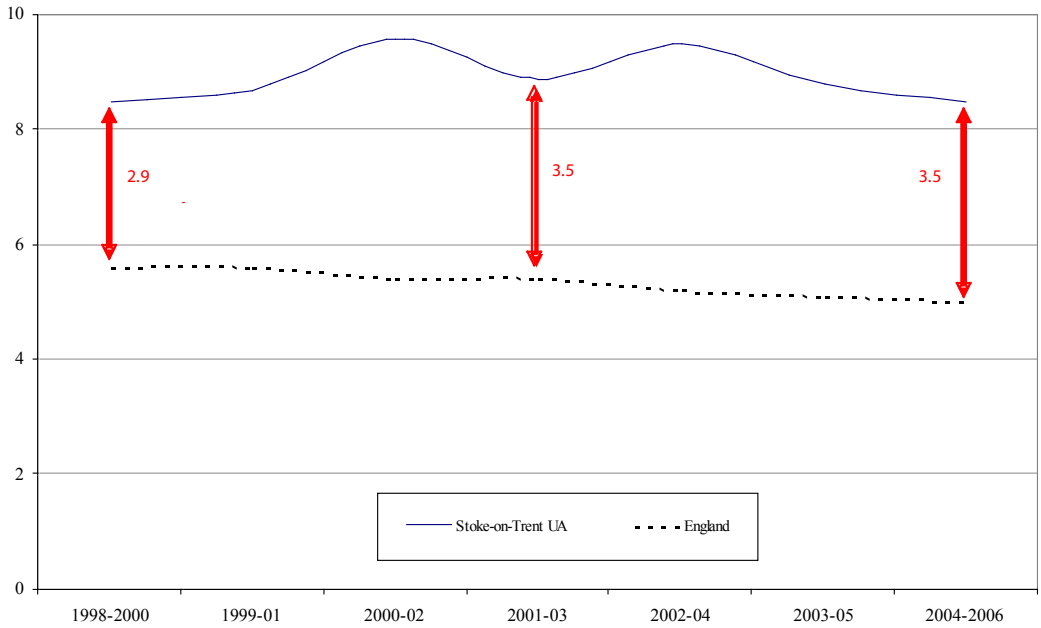
In contrast to England where there has been a steady reduction, the 3 year average in Stoke on Trent has varied between 8.5 and 9.6 per 1000 live births since 1998 (Table 1 and Figure 1).

Table 1 Infant mortality rates (per 1000 live births) in Stoke on Trent and England

	1998-00	2000-02	2001-03	2002-04	2003-05	2004-06
Stoke on Trent	8.5	9.6	8.9	9.5	8.8	8.5
England	5.6	5.4	5.4	5.2	5.1	5.0

Source: Compendium of Clinical and Health Indicators 2008

Figure 1 Trend in infant mortality rate between 1998 and 2006



Source: Compendium of Clinical and Health Indicators 2008

The shape of the graph in figure 1 suggests that there has been very little improvement.

However, the rolling three year average which attempts to stabilise for the annual variations may also hide important information about the way change is occurring. It is therefore important to also consider the change on an annual basis (Table 2). This shows a dramatic fall in the infant mortality rate in 2006 which is the lowest ever in Stoke on Trent.

Table 2 Annual infant mortality rate (per 1000 live births) in Stoke on Trent and England

	2000	2001	2002	2003	2004	2005	2006
Stoke on Trent	8.7	7.8	11.1	7.8	9.6	9.1	6.9
England	5.6	5.5	5.3	5.3	5.1	5.0	5.0

Source: Compendium of Clinical and Health Indicators 2008

We need to interpret this figure very cautiously. It is important to note that in 2001 and 203, the rates were very low but these were not sustained in subsequent years. Because the numbers of deaths are very small (approximately 16 to 30), this variation may well continue.

We need to wait for the 2007 and 2008 data and if the data for those years confirm the trend, then we can be confident, that the static trend we have seen over the last twenty years has finally begun to change.

In considering the types of interventions we need to implement, it is important to understand the pattern of deaths during that first year of life. We usually categorise death in terms of the first seven days, the first month and the subsequent 11 months. This is because the health of the infant during the first week of life is totally dependent upon the experience in the womb and therefore any interventions we may need to put in place, needs to be focussed on the mother. During the subsequent time periods, interventions will need to concentrate on the infant rather than the mother.

In comparison to England, the majority of infant deaths in Stoke on Trent take place in the first seven days of birth (Table 3). This suggests that pregnant women in Stoke on Trent are not as healthy as elsewhere and as a consequence, infants are at a greater risk of ill health and death in the first week of life than in England as a whole.

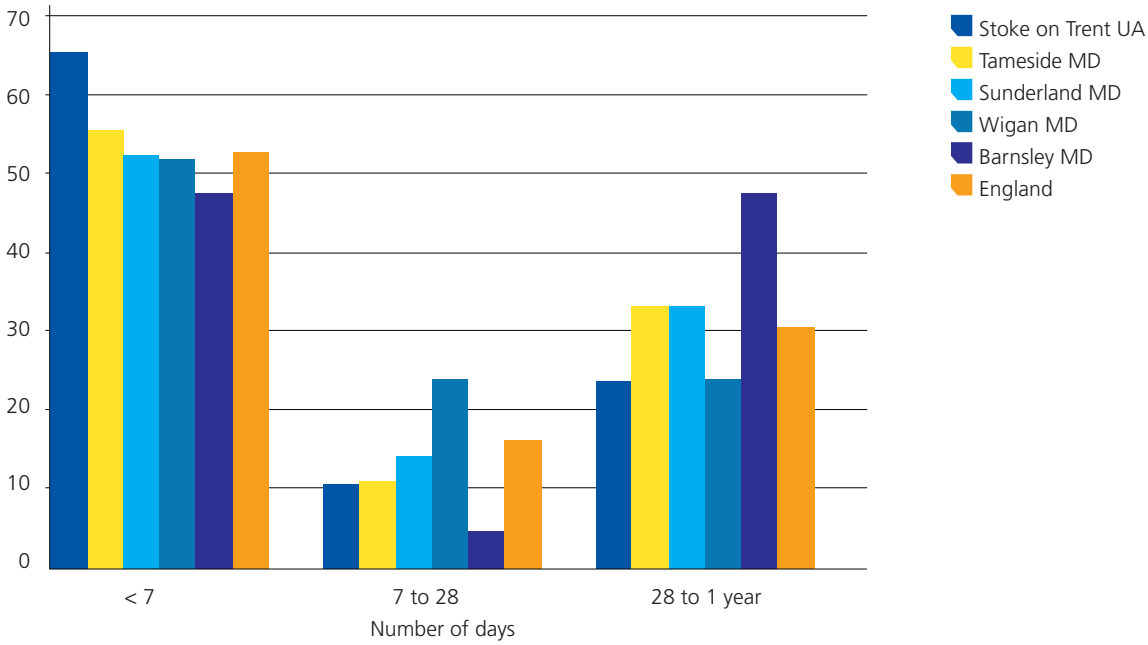
Table 3 Comparison of the proportion of deaths between England and Stoke on Trent at various times during the first year of life for the period 2004 to 2006.

	% of deaths within 7 days of birth	% of deaths between 7 and 28 days of birth	% of deaths between 28 days and 1 year	%Total (number)
Stoke on Trent	66	11	24	100 (84)
England	53	16	31	100 (9339)

Source: Compendium of Clinical and Health Indicators 2008

How does the distribution of infant deaths in Stoke on Trent compare with cities similar to Stoke on Trent? Figure 2 provides a comparison with Tameside, Sunderland, Wigan and Barnsley which were identified in 2006/07 as the nearest comparators to Stoke on Trent in the context of overall deprivation.

Figure 2 Comparison of the proportion of deaths (over the period 2004-06) within particular time frames in the first year of life between Stoke on Trent and like Cities and Towns



Source: Compendium of Clinical and Health Indicators 2008

Figure 2 shows that the pattern of deaths is different in Stoke on Trent. The proportion of deaths during the first week of life is greater in Stoke on Trent than in comparator towns and cities.

The importance of this observation is that there are clearly other factors which are influencing the health of women in Stoke on Trent which are not seen in the towns and cities used in the comparison above. My interpretation of this graph and the scientific literature on this issue is that the women in Stoke on Trent have less health resilience than women elsewhere in being able to provide a healthy environment for the infant whilst in the womb. The implication of this interpretation is that we need to ensure that women are as healthy as possible prior to pregnancy.

3. Actions

My 206/07 annual report provided a detailed discussion of the issues that we needed to tackle. These included:

- Increasing smoking cessation capacity to support pregnant women who are smokers
- Review of infant deaths
- Reviewing the way we support pregnant women and their infants up to the age of two in order to consider the feasibility of providing intensive support to high risk women. The purpose was to improve the health and social circumstances of the mother and the infant so as to reduce the risk of poor outcomes in subsequent pregnancies.

In addition, my report last year made reference to the need to improve education and alleviate poverty. The Stoke on Trent Local Strategic Partnership is attempting to do precisely that. However, this will take some years to feed through.

In the short term, there is one other action we can consider in addition to those identified in my annual report last year and this would be to develop a peer support system for school children to support children and young people throughout their school career. There is some evidence to suggest that education, self esteem and healthy behaviour can all be improved through a peer support system which in turn should lead to healthier young adults.

4. Recommendations

Consider the evidence for the effectiveness of a peer support system for children and young people in Stoke on Trent and if appropriate implement such a system in all schools in Stoke on Trent.

Circulatory Diseases

1. Targets

The national targets for circulatory disease mortality are as follows:

- A reduction in mortality of 40% in people under the age of 75 by 2010
- A reduction of 40% of the gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole by 2010.

Within the Stoke on Trent context, we have interpreted these targets as needing to achieve a reduction of 40% in the gap between Stoke on Trent and England.

2. The Challenge in Stoke on Trent

Progress towards our targets is shown in Table 4.

Table 4 Progress towards target

	Baseline rate* 1995-97	Current rate* 2004-06	Target rate* 2009-2011
Stoke on Trent	194.2	112.7	103.8 (1)
England	141.3	84.2	84.8
Difference between Stoke & England	52.9	28.5	19.0

Source: Compendium of Clinical and Health Indicators 2008

* deaths per 100,000 people under the age of 75

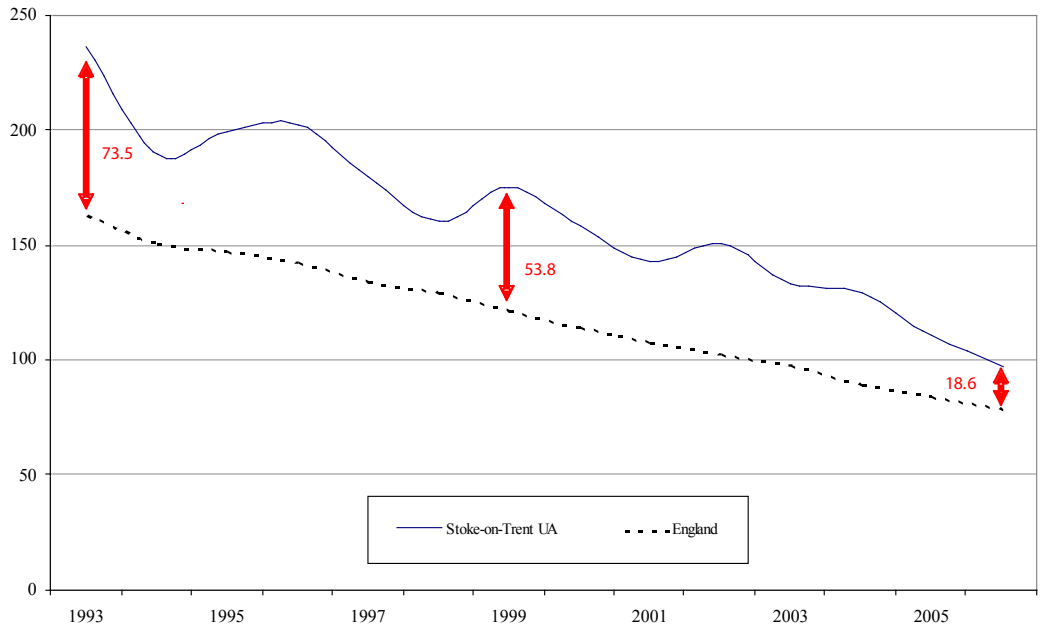
1 – estimated assuming a 40% absolute reduction as well as a 40% reduction in the difference between Stoke on Trent and England.

Circulatory disease mortality rates in Stoke on Trent continue to improve as do the rates for England. Table 4 shows that based on a rolling 3 year average, England has already reached the absolute target set for 2009-2011 (40% reduction) by 2004-2006. During that same period of time, the reduction in Stoke on Trent was 42%. However, if we are to meet the 40% reduction in the difference between Stoke on Trent and England by 2010, the pace of change needs to accelerate.

There are good reasons to be confident that the rate of reduction in Stoke on Trent will increase. Table 4 was based on a 3 year rolling average which smoothes the changes that take place on an annual basis. However, by doing so, they also conceal what might really be happening and I think that is the case in this instance.

Figure 3 and table 5 shows the trend on an annual basis. The shape of the graph (Figure 3) suggests very strongly that the reductions in mortality in Stoke on Trent are taking place at a faster rate than in England particularly since 2001.

Figure 3 Trends in mortality from circulatory disease amongst those aged less than 75 in Stoke on Trent and England between 1993 and 2006



Source: Compendium of Clinical and Health Indicators 2008

This is confirmed by table 5 below which shows that the mortality rate for circulatory diseases in Stoke on Trent for 2006 has already met and exceeded the overall target we set for 2009-2011. Given the peaks and troughs in figure 3, some caution is needed and until we see the figures for 2007 and 2008, we will not be certain of the sustainability of the improvement seen in 2006.

Table 5 Annual mortality rates for Stoke on Trent and England.

	2002	2003	2004	2005	2006
Stoke on Trent	151.4	133.8	129.4	111.1	97.6
England	102.8	97.8	89.7	84.0	79.0
Absolute Difference	48.6	36.0	39.7	27.0	18.6

Source: Compendium of Clinical and Health Indicators 2008

Table 6 shows the variation in mortality rates by wards. Even though we have aggregated five years' worth of data, the actual number of deaths due to circulatory disease at ward level is very small and as a consequence small changes tend to have a disproportionate effect on rates. This does make interpretation quite difficult.

Table 6 Mortality from circulatory disease for wards in Stoke on Trent for people aged less than 75 between 2003 and 2007

Ward	Number of deaths	Mortality rate per 100,000 population
Abbey Green	81	108.2
Bentilee & Townsend (1)	106	156.1
Berryhill & Hanley East	78	124.9
Blurton	67	107.5
Burslem North	83	132.2
Burslem South (1)	94	164.3
Chell and Packmoor	69	117.5
East Valley	66	93.8
Fenton	76	134.2
Hanley West & Shelton	47	150.4
Hartshill & Penkhull	59	101.6
Longton North	75	119.3
Longton South	79	103.2
Meir Park and Sandon	62	92.5
Northwood & Birches Head	63	104.5
Norton and Bradeley	64	89.1
Stoke & Trent Vale	66	111.2
Trentham & Hanford	64	87.0
Tunstall	85	133.6
Weston & Meir North	68	91.1
Stoke on Trent	**1452**	**113.8**

1 – Significantly higher than the rate for Stoke on Trent.

Source: Public Health Mortality File 2008

We have been making similar comparisons over a number of years. It is clear from reviewing those comparisons that Burslem South and Bentilee and Townsend have had consistently high mortality rates irrespective of the time period concerned.

The final word of caution is that if the comparator for table 6 had been England, it is more than likely that the majority of wards would have been significantly high. This is important because in order to have a realistic chance of reducing the gap between Stoke on Trent and England, sooner or later we need to impact communities living in all wards.

3. Actions

The critical issues were covered in the 2006/07 report. The additional challenge we need to grasp is the need to support the development of appropriate interventions in Burslem South and Bentilee and Townsend.

4.Recommendations

I recommend that all Area Implementation Teams include within their plans, actions to increase the number of individuals accessing cost effective interventions. This is particularly urgent in Burslem South and Bentilee and Townsend.

Cancers

1.Targets

Taking as the base line the mortality rate for 1995-97, the target is to reduce mortality rates by 2010 by:

- 20% in people under the age of 75
- 6% in the gap between the fifth of areas with worst health and deprivation and the population as a whole.

We have translated this to mean a reduction of 6% in the gap between Stoke on Trent and England by 2010.

2.The Challenge in Stoke on Trent

The mortality rate from cancer in Stoke on Trent is decreasing (Table 7 and Figure 4). The trends suggest that we should meet the absolute target of 20% reduction by 2010.

Table 7 Progress towards targets

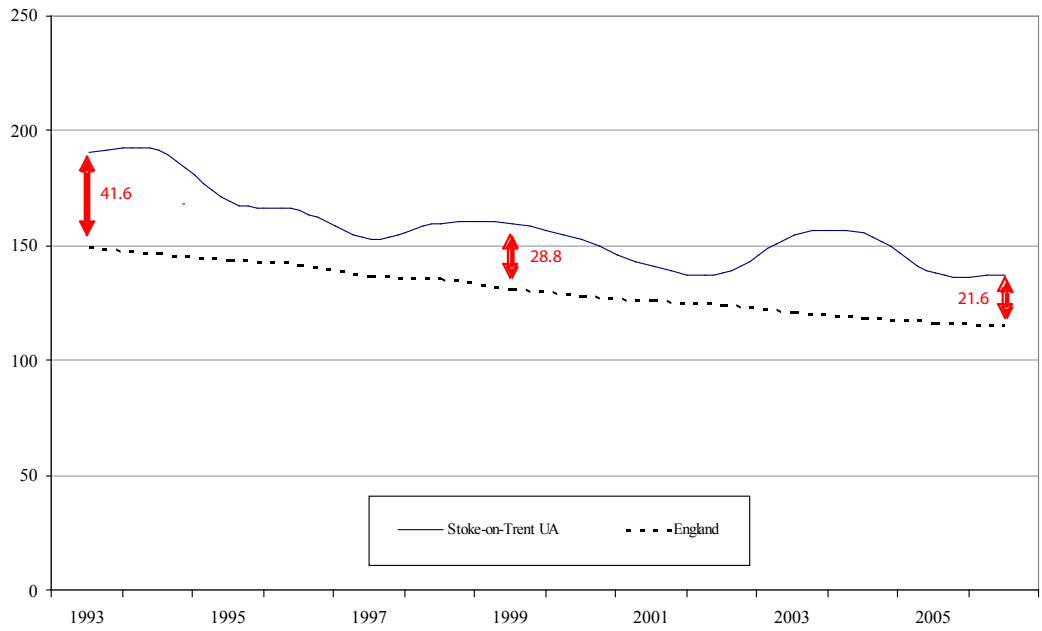
	Baseline rate* 1995-97	Rate* 2004-06	Target rate* 2009-11
Stoke on Trent	162.79	143.8	129.2(1)
England	141.20	117.1	113.0
Difference between Stoke and England	21.59	26.7	16.2

Source: Compendium of Clinical and Health Indicators 2008

* deaths from cancer per 100,000 people under the age of 75

1 – estimated assuming an absolute reduction of 20% and a reduction of 6% in the gap between England and Stoke on Trent

Figure 4 Trends in mortality from cancer amongst those aged less than 75 in Stoke on Trent and England between 1993 and 2006



Source: Compendium of Clinical and Health Indicators 2008.

Indeed, a more critical examination of table 7, suggests that the gap has actually increased in 2004-06 compared to the baseline. The risk of not meeting the target for the reduction in the gap between England and Stoke on Trent remains high.

In order to understand the pace of change better, we have examined the changes over the last fifteen years.

- Between 1993 and 2002, the difference between Stoke on Trent and England reduced from 41.6 to 13.8.
- However, in 2003 and 2004, cancer mortality in Stoke on Trent jumped which resulted in the gap increasing to 37.2.
- But by 2006, the pattern had changed and the difference had reduced to 22 (deaths/100,000 population under the age of 75).

We do not know the reasons for these changes. However, given that the 2006 cancer mortality is the lowest ever attained in Stoke on Trent, I am hopeful that pace of change will accelerate.

Table 8 shows the rates for the wards in Stoke on Trent. During the period 2003 to 2007, no ward had significantly higher mortality than Stoke on Trent. However, Meir Park and Sandon did have rates significantly better than for Stoke on Trent. On reviewing the figures for 2002 to 2006 and 2001 to 2005, it is clear that the improvement in Meir Park and Sandon is an important finding. But it is difficult to disentangle the small numbers effect and to identify the reasons for the improvement.

It is important to note that the comparator used in table 8 is Stoke on Trent. If England was the comparator, then the majority of wards in Stoke on Trent will have significantly higher mortality rates. It is highly unlikely that in such a comparison that any ward in Stoke on Trent would have had significantly better cancer mortality rate than England.

Table 8 Mortality from cancer for wards in Stoke on Trent for people aged less than 75 between 2003 and 2007

Ward	Number of deaths	Mortality rate per 100,000
Abbey Green	134	183.1
Bentilee & Townsend	116	179.4
Berryhill & Hanley East	81	130.3
Blurton	93	147.1
Burslem North	97	158.2
Burslem South	101	178.4
Chell & Packmore	85	143.9
East Valley	101	144.9
Fenton	92	159.3
Hanley West & Shelton	46	146.0
Hartshill & Penkhull	82	147.8
Longton North	98	155.9
Longton South	98	131.8
Meir Park & Sandon [1]	74	111.2
Northwood & Birches Head	73	119.3
Norton & Bradeley	105	151.5
Stoke and Trent Vale	81	139.8
Trentham & Hanford	88	116.8
Tunstall	94	152.3
Weston & Meir North	109	150.1
Stoke on Trent	**1848**	**146.3**

1 – Significantly lower than the rate for Stoke on Trent. Source: Public Health Mortality Files 2008

3. Actions

I made a number of recommendations in my annual report last year. Those recommendations need to be seen in the light of the Cancer Reform Strategy (CRS) which was published in December 2007. The critical issues are:

- Increasing the number of people taking advantage of the smoking cessation services
- Implementation of bowel screening
- Development of specific projects looking at raising cancer symptom awareness and early diagnosis in particular parts of the City
- Development of an action plan on nutrition in 2008/09
- Implementing the refreshed National Cancer Reform Strategy including improving the quality of care we provide to people with cancer.

The overall impact of the actions sets out above will be to reduce the impact of cancer in Stoke on Trent.

4. Recommendations

The Professional Executive Committee needs to ensure that the implementation programme for the Cancer Reform Strategy is robust

Respiratory Diseases

1. Targets

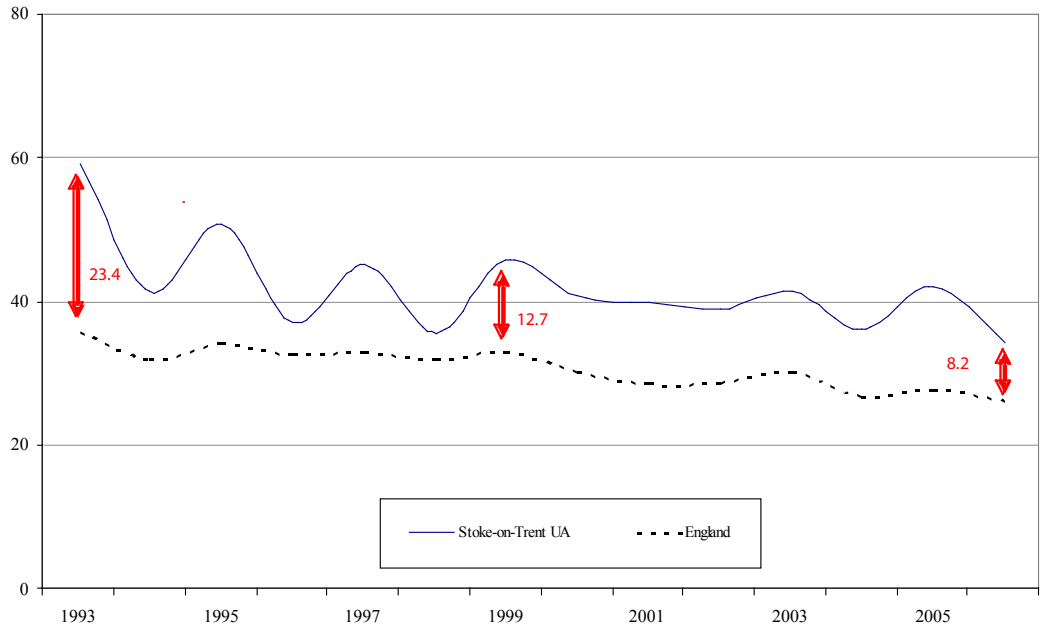
Although there are no specific national targets for respiratory diseases, it remains a major challenge for us in Stoke on Trent. Approximately 17% of deaths of people in Stoke on Trent are due to respiratory illnesses and this remains the third commonest cause of mortality.

The challenge in Stoke on Trent is to reduce the impact of respiratory diseases related to smoking and in particular the mortality and morbidity due to chronic obstructive pulmonary disease (COPD).

2. The Challenge in Stoke on Trent

The mortality rate for COPD has decreased in Stoke on Trent but remains above that for England (Figure 6).

Figure 6 Trends in mortality from bronchitis, emphysema and other COPD amongst all ages in Stoke on Trent and England between 1993 and 2006



Source: Compendium of Clinical and Health Indicators 2008

The shape of the graph is that of a steady reduction in Stoke on Trent over time. But, since 1999, the reductions appear to have tailed off. What is clear is that between 1993-95 and 2004-06, the reduction in England has been approximately 21% whereas Stoke on Trent achieved a reduction of 26%. Clearly, the critical issue is whether the improvement seen in 2006 is sustained in subsequent years.

How do mortality rates vary within Stoke on Trent? Table 9 shows that Burslem South had significantly higher rates than Stoke on Trent whilst three other wards (Blurton, Meir Park and Sandon and Stoke and Trent Vale) had lower rates than Stoke on Trent. Readers will find the presence of Blurton in the group of low mortality areas surprising. I think the explanation is that this is a chance finding and is as a consequence of the fact that the number of deaths from respiratory disease is very small even when aggregated over a number of years.

It is also important to note that the comparator is Stoke on Trent. If England was the comparator, it is likely that the majority of wards will be identified as having problems with COPD mortality.

Table 9 Mortality from respiratory diseases for wards in Stoke on Trent amongst people of all ages between 2003 and 2007

Ward	Deaths	Mortality rate per 100,000 population
Abbey Green	120	112.2
Bentilee & Townsend	89	102.1
Berryhill & Hanley East	111	109.4
Blurton1	86	79.3
Burslem North	122	120.7
Burslem South (2)	151	159.6
Chell & Packmoor	91	106.8
East Valley	116	104.1
Fenton	95	106.8
Hanley West & Shelton	61	118.0
Hartshill & Penkhull	107	99.4
Longton North	79	96.3
Longton South	123	96.3
Meir Park & Sandon (1)	57	70.5
Northwood and Birches Head	68	78.8
Norton & Bradeley	94	88.4
Stoke & Trent Vale (1)	65	72.5
Trentham & Hanford	135	101.6
Tunstall	123	115.0
Weston & Meir North	123	107.2
Stoke-on-Trent UA	**2016**	**102.6**

Source: Public Health Mortality File 2008

1 - significantly lower than Stoke on Trent

2 - significantly higher than Stoke on Trent

3. Actions

The most important cause of respiratory ill health is exposure to tobacco. Therefore, enabling people to resist taking up smoking as well as helping smokers to quit has to be the major component of our programme to reduce the impact of respiratory ill health.

The key actions which were identified in last year's report were:

- Tobacco control
- Identification, management and rehabilitation of smoking related respiratory illnesses. The only way of preventing deterioration of these illnesses is by stopping smoking. There are cost effective treatments which will slow down deterioration but will not stop it.

4. Recommendations

This is a repeat of the recommendation from last year: "Stoke on Trent PCT should ensure detailed plans that covers diagnosis, management and rehabilitation are constructed and implemented in a phased approach over the next 24 months".

Chapter 4

Progress in implementing the recommendations from the 2006/07 report

Implementing the 2006/07 recommendations

Chapter 2 Life Expectancy

i. I recommend that Stoke on Trent PCT develop a strategy to deliver a high quality primary care and community services in Stoke on Trent.

The strategy for primary care was agreed by the Board in March 2008. It is currently being implemented. It includes recommendations on standards and best practice, strengthening information systems, developing workforce, securing appropriate location for service delivery and building effective partnerships.

ii. In order to deliver the above, I recommend that the Stoke on Trent PCT set up a Primary Care Development Unit.

This is being taken forward as part of the primary care strategy. Progress to date includes discussions with Keele University about the development of a support unit, development of standards and development of a new incentive scheme that would better meet the needs of people in Stoke on Trent.

Chapter 3 Infant Mortality

i. Programmes to reduce smoking, obesity, sudden unexplained deaths amongst infants and teenage pregnancies should continue to be a major priority for the Stoke on Trent PCT for the foreseeable future.

The PCT continues to place a major emphasis on these issues. Further work on effective actions had identified the need to ensure support systems for the prevention of sudden unexplained deaths in infancy are in place. Informal discussion with health care professionals suggest that there is a good system. However, the system has not been refreshed in recent years. I therefore think that this needs to be done in the coming year.

ii. Stoke on Trent PCT in collaboration with partners should consider how the commissioning of and the nature of support provided to mothers from conception to when the infant becomes two, can be changed so as to deliver the range of benefits that programs in the United States are delivering to their poorest communities.

Phase 1 which was the scoping of the work and gaining consensus across the NHS, the City Council and the voluntary sector has been accomplished. Phase 2 which included setting up a Programme Board involving the key stakeholders and agreeing the work streams has also been completed. The most important work stream is that bringing together midwifery, health visitors and early years services. This is now working through the pathways that are required.

Chapter 4 Circulatory diseases

i. The importance of primary care services in reducing the impact of circulatory disease has to be acknowledged by the PCT.
Circulatory Disease remains a major priority for Stoke on Trent PCT. However, the approach taken has not been reviewed for a number of years. I would suggest that the PCT commission a refresh of the strategy. There are four interlinked diseases that need to be included in the review; heart disease, strokes, hypertension and diabetes. There is work being undertaken in all of these areas (for example, the audit of hypertension and care pathway development in diabetes and strokes). However, these need to be completed within a coherent planning framework for circulatory diseases to ensure maximum impact.

ii. Additional investment is needed in primary care: a) to make greater use of the practice based information systems to call and recall people at risk of and with circulatory disease; b) to strengthen the attitudes, knowledge and skills within primary care; c) develop a better skill mix of staff to ensure advances in knowledge and practice can be implemented efficiently and effectively in a timely manner.

New software has been implemented to enable practices to identify patients at high risk of heart disease. A new system of call and recall is also being set up to provide support to individuals at high risk. In addition, the PCT has developed an incentive scheme to support practices in assessing individuals who may be at high risk and providing appropriate care.

Issues around skills, attitudes and skill mix will be addressed as part of the primary care strategy.

Chapter 5 Cancer

i. The PCT should ensure that use of surgery in men with lung cancer is examined as soon as possible by the University Hospital of North Staffordshire. It is important that the analysis includes another hospital in the West Midlands as a comparator.

This was not included as part of the formal agreement between the PCT and UHNST for 2008/09. However, a clinical audit study was undertaken but it became quite clear that the electronic system and the multidisciplinary team notes did not have sufficient detailed information to come to a view about the use of surgery. Therefore, this recommendation remains current.

ii. The PCT should ensure that the University Hospital of North Staffordshire contributes to the national audit on lung cancer. This will make future analysis of the care provided to people with lung cancer much easier.

This recommendation was not implemented although discussions have taken place. The electronic system at the University Hospital of North Staffordshire is unable to contribute data electronically to the national audit. This recommendation remains current.

iii. The PCT should commission further studies to understand the reasons for people to present with higher or unknown grades of prostate cancer in Stoke on Trent than elsewhere.

This recommendation has not been implemented and remains current.

Chapter 6 Respiratory health

i. The PCT should ensure detailed plans that cover diagnosis, management and rehabilitation are constructed and implemented in a phased approach over the next 24 months. Given the work already undertaken by the clinical community in Stoke on Trent, the plans should be reviewed by the PCT in November 2007 so that any financial requirements are considered as part of the financial plan for 2008/09.

The Local Delivery Plan has made financial provision for implementation. The care pathways to support robust development of services have been agreed. The planning of the services required in order to deliver the new care pathways has now begun.

Chapter 7 Mental Health

i. Stoke on Trent PCT should increase the capacity (and in particular for cognitive behaviour therapy) within primary and community services for the management of people with mental health problems.

This is included as part of the services to be provided through the Healthy Minds Network which has now been implemented. Patients now have access to a range of therapies.

ii. Stoke on Trent PCT should increase capacity to manage and develop the Healthy Minds Network so that all people who may benefit have access.

This has been achieved.

iii. Stoke on Trent PCT supported by the City Council should develop a strategy on reducing the impact on dementia on the people of Stoke on Trent.

A strategy for consultation has been produced. To support this a clinical audit study of the care currently provided is being commissioned.

Chapter 8 Screening

i. Stoke on Trent PCT needs to review the 2006/07 Diabetic Retinopathy Screening Programme annual report detailing performance against national standards and quality assurance criteria when it is available. The review needs to include the treatment aspects of the screening programme.

This recommendation has been overtaken by the formal visit of the national Quality Assurance Team. This Team will undertake a full assessment of all quality issues to do with the screening programme. The initial visit took place in March 2008 and the formal review in July 2008. The results should be available by late summer 2008.

ii. Stoke on Trent PCT should though the Professional Executive Committee ensure that implementation of the bowel screening programme is successfully accomplished.

This is progressing and the programme will be launched in September 2008.

Chapter 9 Smoking

i. I recommend that the Stoke on Trust PCT as a matter of urgency works with practices to put in place systems to ensure all smokers are identified and are encouraged to attend smoking cessation. It is important that only people who are ready to quit are referred to smoking cessation services.

This recommendation has been challenging. During 2007/08 we supported approximately 2100 4 week quitters which was the target agreed with the West Midlands Strategic Health Authority. However, we did not meet the more challenging target we had set ourselves in order to have an impact on life expectancy and this was approximately 4000 4 week quitters.

This recommendation therefore remains current.

ii. I recommend that General Practitioners should ensure smoking status is recorded for every person who is 16 and over as a matter or urgency.

Stoke on Trent PCT implemented a locally enhanced scheme to enable General Practitioners to improve recording of smoking cessation status and this has been successful.
Overall, 85% of the population aged 16 and over have their smoking status recorded.

iii. Given the importance of smoking to the inequalities experienced by the people of Stoke on Trent, I recommend that the level of smoking status recording is reviewed by the PCT Board every quarter, until it reaches a target of 95%.

This remains current. Of the 55 practices in Stoke on Trent, 29 had reached this level by March 2008. 13 practices had recording status of between 90% and 95%. It is my view that the PCT should take whatever action is needed to improve recording in those practices where the current rate is less than 90%.

iv. I recommend that the PCT adds a clause to all of the service level agreements it has with providers to ensure that smokers are identified, brief interventions are provided and if appropriate the individual is referred to a smoking cessation service.

Not implemented and therefore remains current.

v. I recommend that Stoke on Trent lobby the Department of Health to collect 52 week quit rates which will provide us with more robust figures to judge progress in reducing smoking prevalence.

This has been raised with the Regional Director of Public Health.

Chapter 10 Alcohol

i. Undertake a lifestyle survey to describe patterns of drinking within Stoke on Trent.

This has been discussed within the Local Strategic Partnership and the decision taken to not proceed with this. The advice from academic institutions is that the accuracy of data gathered through self completed surveys is very poor and as a consequence is not useable for decision making. However, it is important that we implement a system for monitoring drinking patterns in Stoke on Trent.

ii. Agree and implement the draft alcohol strategy and in particular Stoke on Trent PCT needs to focus on ensuring all general practices are able to identify problem drinkers and are able to provide brief interventions as well as refer to more specialist services when appropriate.

The Stoke on Trent Drugs and Alcohol Action Team have agreed a strategy which is currently being refreshed and implemented. Primary care support for individuals with alcohol problems will be included in the standards being developed as part of the primary care strategy.

Chapter 11 Teenage Pregnancy

i. I recommend that the Stoke on Trent PCT mainstreams the work on reducing teenage pregnancies in 2008/09.

This has been implemented and has resulted in improvements in 3 specific areas. First, we have increased contraceptive services and provided access in a wider range of settings including schools and youth centres. Second, a new sex and relationship education programme for schools has been launched and all schools are expected to adopt the new scheme. Third, actions are being taken to improve levels of achievement in schools as well as to reduce the proportion of young people not in education, employment or training.

Chapter 12 Obesity

i. I recommend that the Stoke on Trent PCT review its obesity action plan for agreement at the March 2008 Board meeting. In reviewing the plan, the Board needs to be clear about the following:

- The evidence of effectiveness supporting each intervention and the numbers needed to achieve benefits.
- Where there is no evidence, the evaluation programme and in particular the outcome measures defining success and failure.

The Obesity action plan was reviewed by the Professional Executive Committee and the Board. The approach being taken forward by the Local Strategic Partnership is to consider the two components (physical activity and nutrition) of the obesity action plan separately to ensure each issue is given sufficient emphasis. The physical activity plan which aims to double the number of people taking physical activity (on 3 occasions lasting 30 minutes) each week has been completed. The plan for improving nutrition patterns in Stoke on Trent will be developed during the latter part of 2008/09.

ii. I recommend that the Stoke on Trent PCT identify and make available the resources needed over a 3 year period to support the implementation of the obesity action plan.

This is being implemented.

iii. I recommend that Stoke on Trent PCT works with general practices to enable high risk groups to be identified and referred for obesity management.

A lifestyle management programme aimed at adults is being implemented. This involves identification of individuals, assessment by life style coaches and if appropriate referral to programmes to improve nutrition and physical activity.

Chapter 13 Education

i. The PCT should as a matter of urgency debate the feasibility of commissioning a new model of combined midwifery, health visiting and Early Years services with clear outcomes to be attained.

This is the same as the progress described under Chapter 3, recommendation ii.

Chapter 14 Housing

i. The PCT and general practitioners need to both recognise the potential inherent in primary care to support action on improving the housing circumstances of people in Stoke on Trent and be willing to respond quickly.

Although the principle is accepted, in practice this has not happened in a sustainable way. Currently, the NHS has neither the capability or the capacity to do so. The recommendations in the primary care strategy if fully implemented, will address this deficit.

ii. The PCT should work with general practitioners and their teams in developing the proactive use of primary care information systems to identify patients who might benefit from housing support. These include patients with chronic respiratory disease, heart disease and the very elderly.

This recommendation should be picked up as part of the work on implementation of the primary care strategy and the primary care development unit.

iii. The PCT should ensure ready access to aggregated health data to support the development of housing policy by the City Council.

This has been implemented.

Chapter 15 Ethnic Minority Communities

i. I recommend that Stoke on Trent PCT reviews the level of ethnicity recording in the NHS information systems of relevance to the people of Stoke on Trent and takes all necessary steps to ensure improvement.

Stoke on Trent Primary Care Trust has implemented a specific scheme to enable practices to improve the recording of ethnicity status. Eight practices have achieved rates of 95% or more. Twenty five practices have rates of 50% or more. Given the importance of ethnicity in refining the nature of clinical care individuals need, I recommend that the PCT continues to ensure that those practices whose recording is below 90% take action to improve recording.

Chapter 15 Asylum Seekers and Refugees

i. I recommend that the PCT continues to maintain the additional support provided to asylum and refugee communities in Stoke on Trent.

This has been implemented.

Chapter 5

Recommendations for 2008 and onwards

Introduction

These recommendations are a mix of the outstanding recommendations from the 2006/07 report and some new recommendations arising from reviewing progress.

Chapter 1: Tackling inequalities in health outcomes

i. I would welcome the following groups publishing their views on the questions raised in the chapter:

- Stoke on Trent Local Strategic Partnership
- The Board of the Stoke on Trent PCT
- The Councillors of Stoke on Trent City Council

Chapter 2: Life Expectancy

i. The Local Strategic Partnership should support the Area Implementation Teams in those wards where life expectancy is significantly less than in England to develop action plans to improve uptake of services in those areas by helping to refine services as well as stimulating local demand for those services.

Chapter 3: Infant Mortality

i. I recommend that the Infant Mortality Group reviews the work on prevention of sudden unexplained deaths in infancy to ensure high quality delivery.

ii. Consider the scientific evidence on the effectiveness of a peer support system for children and young people in Stoke on Trent and if appropriate implement such a system in all schools in Stoke on Trent.

Chapter 3: Circulatory diseases

i. I recommend that the PCT commission a refresh of the strategy. There are four interlinked diseases that need to be included in the review (heart disease, strokes, hypertension and diabetes).

ii. I recommend that all Area Implementation Teams should include within their plans actions to increase the number of individuals accessing cost effective interventions. This is particularly urgent in Burslem South and Bentilee and Townsend.

Chapter 3: Cancer

i. The PCT should ensure that use of surgery in men with lung cancer is examined as soon as possible by the University Hospital of North Staffordshire. It is important that the analysis includes another hospital in the West Midlands as a comparator.

ii. The PCT should ensure that the University Hospital of North Staffordshire contributes to the national audit on lung cancer. This will make future analysis of the care provided to people with lung cancer much easier. Given the problems to do with the electronic systems, the PCT should ensure that clinical audits mirroring those undertaken nationally are implemented locally.

iii. The PCT should commission further studies to understand the reasons for people to present with higher or unknown grades of prostate cancer in Stoke on Trent than elsewhere.

iv. The Professional Executive Committee needs to ensure that the implementation programme for the Cancer Reform Strategy is robust.

Chapter 3: Respiratory health

i. The PCT should ensure detailed plans that cover diagnosis, management and rehabilitation are constructed and implemented in a phased approach over the next 24 months.

2006/07 Annual Report: Smoking and Ethnicity Minority Communities

i. I recommend that the Stoke on Trent PCT as a matter of urgency works with practices to put in place systems to ensure all smokers are identified and are encouraged to attend smoking cessation. It is important that only people who are ready to quit are referred to smoking cessation services.

ii. I recommend that the Stoke on Trent PCT adds a clause to all of the service level agreements it has with providers to ensure that smokers are identified, brief interventions are provided and if appropriate the individual is referred to a smoking cessation service.

iii. Given the clinical importance of recording smoking status and ethnicity in managing the health care needs of individuals in Stoke on Trent, I recommend that the PCT should take whatever action is needed to improve recording to a minimum of 90%.

2006/07 Annual Report: Alcohol

i. I recommend that as part of implementing the Alcohol strategy, we consider how best to monitor alcohol consumption patterns in Stoke on Trent.

NHS
Stoke on Trent