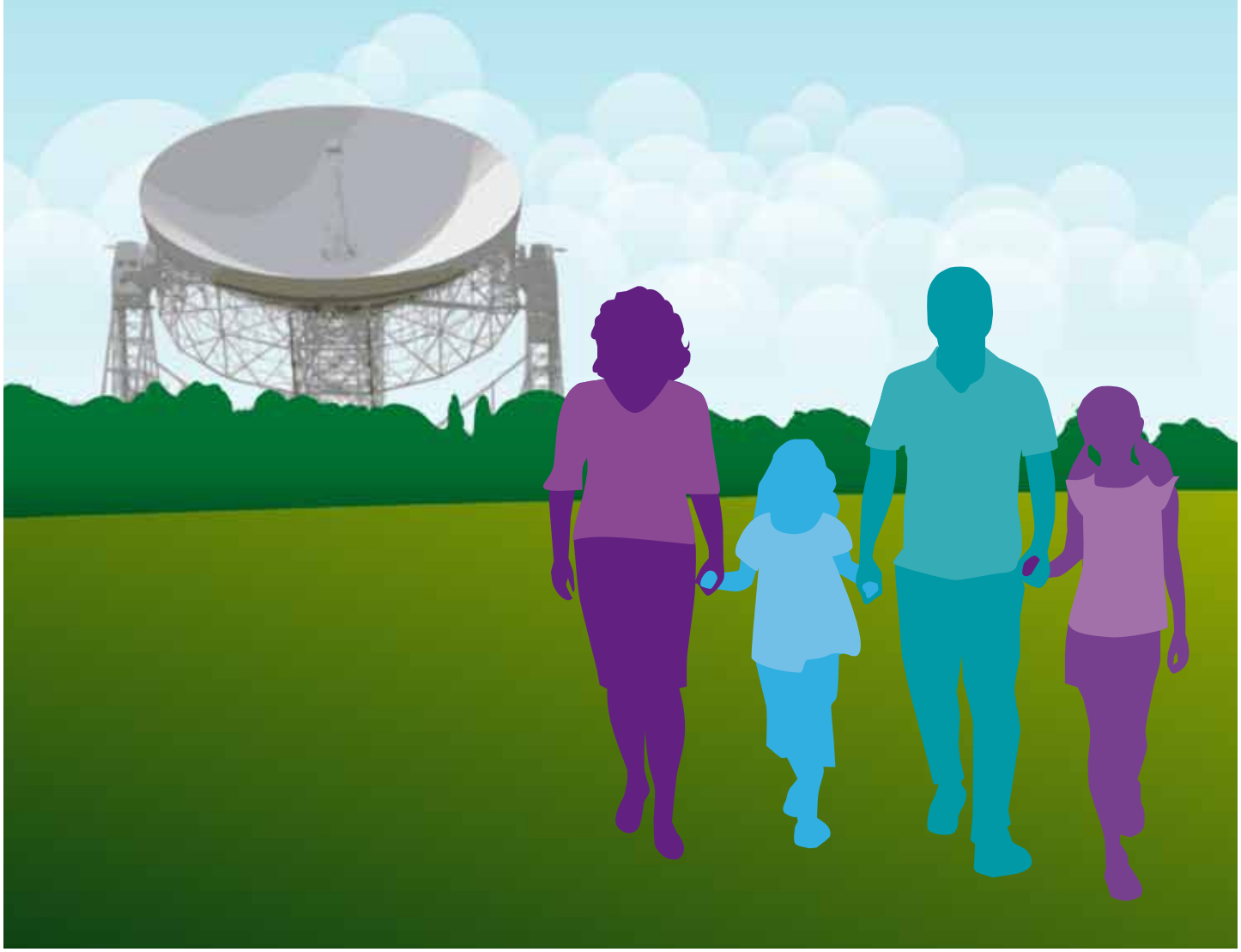
Central and Eastern Cheshire NHS
Primary Care Trust

Cheshire East Council

Living Well in Cheshire East

a call to action



Document Purpose	For information
PCT Website Link	www.cecpct.nhs.uk. Follow the route: Home Page > Healthy Living > Health Inequalities
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Description	Living Well in Cheshire East - a call for action provides a brief overview of what health inequality means, a picture of how health inequality is measured within Cheshire East and provides information on why finding the solutions and why being actively engaged in reducing health inequalities is everybody's business. This document also outlines some of the key challenges which are faced in reducing health inequalities, promotes the Living Well approach as the building blocks for partners to sign up to work to in the future and sets out our challenges for the future and invites responses on how best to tackle these locally.
Cross-reference	The Annual Report of the Director of Public Health 2010 Cheshire East Joint Strategic Needs Assessment Ambition for All: Cheshire East's Sustainable Community Strategy 2010 to 2025
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Action required	N/A
Timing	N/A
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Welcome

People across Cheshire East have varying health experiences and outcomes.

We believe that good health is a right for all and that differences in health outcomes experienced by our local population are unacceptable.

It is important that we identify areas where there are high levels of ill-health and where needs are not being met so that we can provide the support and guidance, and where necessary, the services to help bring about improvements in the quality of life for the people of Cheshire East.

Tackling the differences in health outcomes is not just the remit of one or two organisations - it's **everybody's business**. It is vital that we set and agree a future direction of travel for a range of partners to work together in new and innovative ways post 2010 set within the context of major public sector reform. We want to build on the good work already underway in Cheshire East and really seek to make meaningful and measurable positive differences in the communities that we serve. **We can do more, we will do more.**

The 'Living Well in Cheshire East: a call to action' document' is not a detailed plan of action. It is intended to be the starting point for the process of many partners committing to work together to address the shared problems that we face which influence the causes of our local health inequalities. It is a document that is not intended to direct but to inform and inspire the people and the organisations that commission and provide services now and in the future to rise to the challenges ahead.

The intentions outlined in this document support the wider work underway to achieve the Cheshire East Local Strategic Partnership 2025 vision for its population as outlined in *Ambition for All: Cheshire East's Sustainable Community Strategy 2010 to 2025*[1]. We also invite partners to sign up to an approach called Living Well, developed at a regional level as a platform for local areas to build on in tackling entrenched inequalities, and provide responses to the key challenges that we have outlined throughout the document.

We urge you to read this document and, as we have done, sign up to the Statement of Intent contained within the Appendix to show your commitment to tackling health inequalities in Cheshire East now and in the coming years.

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1. A call to action

Despite massive investment in services and the enormous efforts by dedicated people and organisations, patterns of inequality in health, income and aspirations persist across Cheshire East and blight many lives.

A combination of economic uncertainty, employment insecurity, major imminent public sector reforms, exiting health inequalities and an ageing population with a predicted increase in demand and need for services means that new ways of working and strong resilient partnerships will be needed if entrenched inequalities in health and well-being are not to get worse.

Living Well in Cheshire East: a call to action is intended as a call out to those with leadership responsibility in public, private and in voluntary and social organisations to come together to identify new ways of working, share their experiences, energy and resources and lead the way in supporting communities to find long lasting and meaningful solutions to the challenges which they face.

The purpose of this **call to action** document is to:

- reinforce the message to partners that tackling entrenched inequalities is **everybody's business.** We invite partners to sign up to a Statement of Intent to commit their organisation to look at new ways of working in partnership to tackle the differences in health outcomes which exist within Cheshire East, with an emphasis on the wider or social determinants of health
- set out a clear definition of what we mean by health inequalities
- show examples of the health differences between the best and worst areas within Cheshire East
- promote the Living Well approach as the building blocks for partners to sign up and work to in the future
- set out key challenges for the future and invite responses on how best to tackle these locally

The launch of this document at the *Living Well in Cheshire East - a call for action to reduce differences in health conference* on the 12th November 2010 should be seen as the start of new conversations about how we can create a local Cheshire East Living Well framework that takes a long term approach and describes how we can all work together to remove entrenched inequalities.

The first step in the approach to creating a Living Well framework for Cheshire East is the identification of those individuals and organisations who want to be active and engaged partners in finding a way to reduce our health inequalities and who can shape the framework. Signing the Statement of Intent within the Appendix of this document (and which also can be found on www.cecpct.nhs.uk/healthy-living/health-inequalities - from Tuesday 16th November 2010) will help us to identify these partners. **We're waiting for your pledge!**

Jodrell Bank, Lower Withington

2. What do we mean by health inequalities?

The term "health inequalities" refers to the unequal health opportunities and outcomes experienced by different groups of people within society. The term is often used as a way of identifying between those inequalities that are either avoidable or regarded as unfair in some way. In a fair and prosperous society, everyone should have the same chance to lead a long and healthy life (Live Well) and enjoy the same opportunities for leisure, health care, education, employment, safe environments and warm affordable housing.

There are three ways to think about the causes of health inequalities:

- inequalities in the wider or social determinants of health. For example, in education, employment or housing
- inequality in access to the health services people use. For example, travelling communities often have difficulty in accessing primary health care services and rural communities may not enjoy the same ease of access to services as people living in towns
- inequalities in health outcomes as a result of the lives people lead. For example, differences in average life expectancy at birth between people living in different parts of Cheshire East as a result of cancer or coronary heart disease. Risk factors for both include poor diet, physical inactivity and smoking

This thinking informed the approach that was undertaken in creating a framework for a tackling health inequalities in Cheshire East Strategy that was presented to and agreed by the Cheshire East Local Strategic Partnership (LSP) Executive in February 2010. The framework (**Figure One**) is divided into the delivery periods (short, medium and long term) which best indicate the necessary time frames to tackle the three ways of thinking about the causes of health inequalities.

The first level is short term actions and based on what can be done immediately. This mostly resides with the commissioning of NHS services but also covers some Local Authority / social care interventions. It relates to both prevention and treatment services. An example of this was the development of a local enhanced service specification which incentivised practices in areas with the worst health to identify and treat people with coronary heart disease. Payments to practices were weighted for socioeconomic deprivation to address health inequalities.

The second level, medium term actions, focuses on "lifestyle" factors and the Primary Care Trust and Cheshire East Council will play a key role here alongside other key stakeholders. Examples of this include the provision of Specialist Stop Smoking Services targeted at routine and manual workers and the progression of Baby Friendly accreditation at both Macclesfield and Leighton hospitals.

Figure One: Cheshire East framework for tackling health inequalities

Short term action	Medium term action	Longer term action
NHS (and Local Authority) access to high quality services	Lifestyle Issues	Wider determinants of health
CECPCT World Class Commissioning Priority Outcomes, and access to immunisations and vaccinations	Alcohol misuse Breastfeeding Smoking Diet and Physical activity	Marmot Review - six key policy recommendations
"The major contribution to this resides within the NHS contribution"	NHS and Cheshire East Council (and other key partner) contributions Local Strategic Partnership "Lifestyles Sub Group"	Local Strategic Partnership collective contribution Sub regional and regional contribution (Commission)

The third level focuses on longer term actions across the wider or social determinants which influence health and it is here that the evidence from the Marmot Review (as described below) will come into play. The LSP has a significant role here, both through its members, individual and joint roles as advocates for health (as a driver for economic sustainability) and through its joint governance structures (e.g. Thematic Partnerships and Local Area Partnerships). An example is the establishment of a Sub Regional Health Commission which will focus upon alcohol as a priority, bringing opportunities to learn from good practice in neighbouring authorities and to add value through working in partnership with a focus on minimum pricing on alcohol.

In recognition of the growing importance of the wider determinants of health, a national independent review of health inequalities was led by Professor Sir Michael Marmot. His February 2010 report, *Fair society, healthy lives - strategic review of health inequalities post 2010*,[2] focused on the impact of the wider determinants on health inequalities including education, employment and housing. The Review proposes the most effective evidence-based strategies for reducing health inequalities in England from 2010 and is being used by organisations across the country to help steer local planning on aims, objectives and actions to achieve the outcome of reducing health inequalities post 2010.

The key findings and recommendations from the Review can be summarised as follows:

- **Reducing health inequalities is a matter of fairness and social justice**
  The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is unfair. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health

- **Health inequalities result from social inequalities**
  Serious health inequalities do not arise by chance and they cannot be attributed simply to genetic makeup, 'bad' or unhealthy behaviour or difficulties in access to medical care. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society

- **There is a social gradient in health**
  The lower a person's social position, the worse his or her health. Action should focus on reducing the steepness of the social gradient in health. Focusing solely on the most disadvantaged will not reduce health inequalities and the social gradient sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is referred to as proportionate universalism

- **Action on health inequalities requires action across all the social determinants of health**
  Persisting inequalities across key domains provide ample explanations as to why health inequalities continue: inequalities in early child development and education, employment and working conditions, housing and neighbourhood conditions, standards of living and the freedom to participate equally in the benefits of society. Action across all these determinants of health will require the involvement of all central and local government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities

- **Reducing health inequalities is vital for the economy**
  As well as the human cost the impact of health inequalities can be measured by the cost to the economy of additional illness. Actions to raise the general level of health and flatten the social gradient will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs

- **Action taken to reduce health inequalities will benefit society in many ways**
  Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together

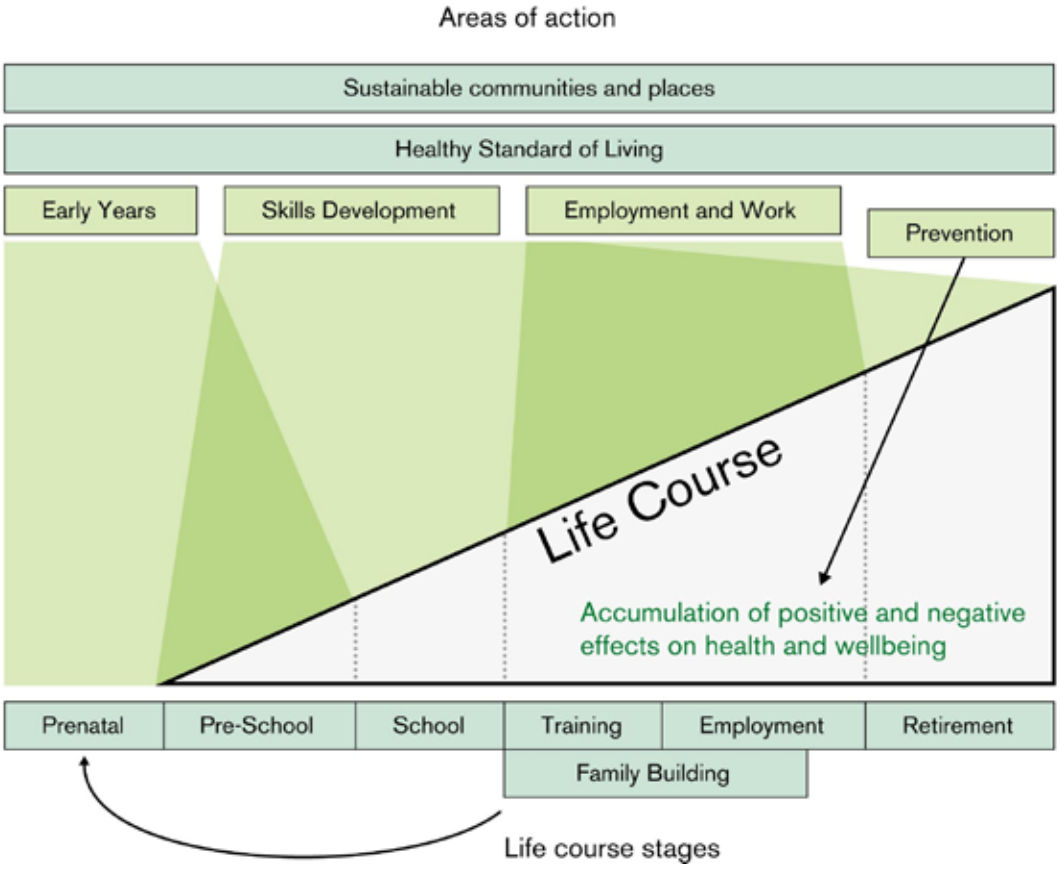
The central ambition of the Marmot Review is the creation of the conditions for people to take control over their own lives. If the conditions in which people are born, grow, live, work, and age are favourable, and more equitably distributed, then they will have more control over their lives in ways that will influence their own health and health behaviours, and those of their families.

Central to the Marmot Review is a life course perspective. The highest priority recommendation from the Review was to give **every child the best start in life**, as disadvantage starts before birth and accumulates throughout life, as shown in **Figure Two**. Give every child the best start in life was one of six policy recommendations outlined in the Review as the way to reduce health inequalities. The six include:

- ensure a healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill-health prevention
- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities and have control over their lives
- create fair employment for all

The Annual Report of the Director of Public Health 2010 for Central and Eastern Cheshire Primary Care Trust,[3] includes a chapter translating the six policy objectives into high level actions which can be taken by a range of partnerships and organisations across Cheshire East.

Figure Two: Action across the life course



Source: Fair Society, Healthy Lives[2]

3. The cost of health inequalities

The cost of health inequalities can be measured in both human and economic terms.

The Human Cost

The human cost caused by health inequalities can be seen through years of life lost and years of healthy (or active) life lost (disability free life years).

In England, people living in the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest neighbourhoods and will also spend more of their shorter lives living with a disability - an average difference in disability free life expectancy (DFLE) of 17 years. DFLE indicates the number of years a person can expect to live free from a limiting long term illness (LLTI) or disability and gives an indication of healthy life years lived.

This has important implications both for the individual concerned - in terms of working years spent with ill health, ability to earn, and quality of life years lived - and for health and social care services - in terms of increased and sustained demand for services and support. As such, DFLE is a useful measure for assessing future health and social care needs and for identifying trends and inequalities.

If everyone in England had the same death rates as the most advantaged, people who are currently dying prematurely as a result of health inequalities would, in total, have enjoyed between 1.3 and 2.5 million extra years of life.[4,5] They would, in addition, have had a further 2.8 million years free of limiting illness or disability.[6]

The majority of the population in Cheshire East can expect to live long, healthy lives however, inequalities in health do exist with variances in life expectancy, premature death (deaths under age of 75) and DFLE.

Life Expectancy

When examining life expectancy, Cheshire East males at 78.7 years and females at 82.5 years have an overall life expectancy higher than the England life expectancy for both sexes. Although this highlights that overall life expectancy is good for both sexes within Cheshire East, it also highlights that males can expect to live nearly four years less than females, mirroring the gap that exists at a national level.

When looking at life expectancy at Middle Super Output Area (MSOA) level significant variations are revealed. MSOA's are a geographic hierarchy designed to improve the collection, analysis and reporting of small area statistics in England and Wales and have an average population of 7,200. **Figure Three** and **Figure Four** show male and female life expectancy of the top (best) 10 and bottom (worst) 10 MSOA's within Cheshire East and which Local Area Partnerships (LAP's) they are located in. **Figure Five** and **Figure Six** show, in number of years, the variation from the Cheshire East male and female life expectancy for the top (best) 10 and bottom (worst) 10 MSOA's.

From **Figure Three** and **Figure Four** it can be seen that, at its worse, there is a 10.9 year gap for males and 16.8 year gap for females between the top (best) MSOA and bottom (worst) MSOA areas within Cheshire East. From **Figure Five** and **Figure Six** it can be seen that in Crewe's Central & Valley MSOA both male and female residents have a life expectancy nearly six years lower than the Cheshire East life expectancy for both sexes and around 5 years lower than the England male and female life expectancy.

At the other end at its best, male residents living in Wilmslow Town South East MSOA (83.8 years) have a life expectancy over five years higher than the Cheshire East male life expectancy and nearly six years higher than the England male life expectancy. Female residents living in Macclesfield Town Tytherington MSOA (93.8 years) have a life expectancy over 11 years higher than the Cheshire East female life expectancy and nearly 12 years higher than the England female life expectancy.

Figure Three: Top (best) and bottom (worst) Male life expectancy by middle super output area within Cheshire East, 2006-2008*

	Local Area Partnership	MSOA Name	MSOA Code	Life Expectancy (Years)
Top (Best) 10	Wilmslow	Wilmslow Town South East	E02003858	83.8
	Poynton	Disley Rural	E02003853	83.7
	Congleton	Congleton & Holmes Chapel Rural	E02003811	83.6
	Wilmslow	Wilmslow Town South West	E02003860	83.2
	Crewe	Waldron	E02003829	82.2
	Congleton	Holmes Chapel	E02003812	81.9
	Macclesfield	Macclesfield Town Tytherington	E02003866	81.5
	Congleton	Congleton West	E02003817	81.4
	Poynton	Poynton Parish West	E02003854	81.4
	Congleton	Sandbach West & Wheelock	E02003820	81.3
			Cheshire East	78.7
			CECPCT	78.5
			North West	76.3
			England	77.9
Bottom (Worst) 10	Macclesfield	Macclesfield Town Weston	E02003871	75.7
	Congleton	Middlewich West	E02003813	75.5
	Congleton	Middlewich East	E02003814	75.4
	Crewe	St Johns	E02003832	75.0
	Crewe	West Coppenhall & Grosvenor	E02003827	74.2
	Crewe	St Barnabas	E02003828	74.2
	Macclesfield	Macclesfield Town South	E02003873	73.8
	Crewe	Alexandra	E02003834	73.4
	Crewe	East Coppenhall	E02003826	73.4
	Crewe	Central & Valley	E02003830	72.9

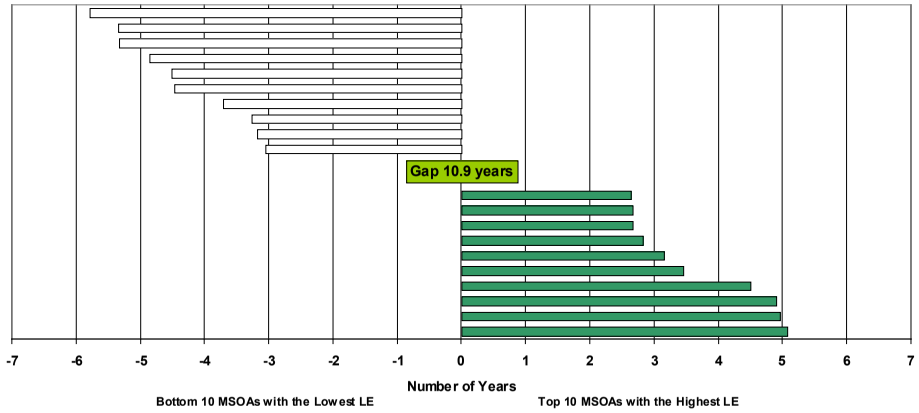
Source: SYOA Population Estimates, 2006-2008, ONS Life Table Template, Public Health Mortality File

Figure Four: Top (best) and bottom (worst) Female life expectancy by middle super output area within Cheshire East, 2006-2008*

	Local Area Partnership	MSOA Name	MSOA Code	Life Expectancy (Years)
Top (Best) 10	Macclesfield	Macclesfield Town Tytherington	E02003866	93.8
	Congleton	Congleton & Holmes Chapel Rural	E02003811	88.4
	Crewe	St Marys & Wells Green	E02003835	87.9
	Wilmslow	Wilmslow Town South East	E02003858	87.6
	Wilmslow	Wilmslow Town South West	E02003860	87.0
	Congleton	Congleton South	E02003818	86.9
	Poynton	Poynton Parish West	E02003854	86.5
	Macclesfield	Macclesfield Rural	E02003872	86.5
	Knutsford	Knutsford Town South	E02003863	86.3
	Congleton	Holmes Chapel	E02003812	85.2
			Cheshire East	82.5
			CECPCT	82.3
			North West	80.6
			England	82.0
Bottom (Worst) 10	Macclesfield	Macclesfield Town Bollinbrook & Ivy	E02003869	80.8
	Crewe	Alexandra	E02003834	80.8
	Congleton	Middlewich West	E02003813	80.5
	Congleton	Middlewich East	E02003814	80.2
	Macclesfield	Macclesfield Town South	E02003873	80.0
	Crewe	Leighton	E02003825	79.8
	Crewe	St Johns	E02003832	79.5
	Crewe	East Coppenhall	E02003826	79.2
	Crewe	St Barnabas	E02003828	78.6
	Crewe	Central & Valley	E02003830	77.0

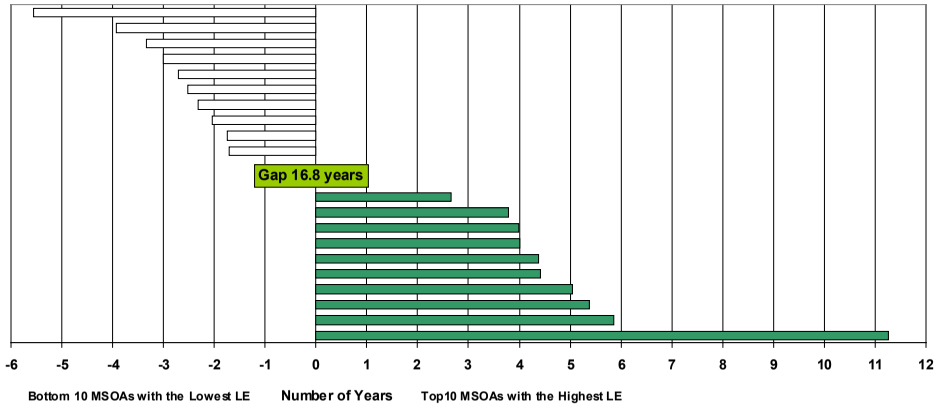
Source: SYOA Population Estimates, 2006-2008, ONS Life Table Template, Public Health Mortality File

Figure Five: Male life expectancy gap within Cheshire East, 2006-2008



Source: SYOA Population Estimates, 2006-2008, ONS Life Table Template, Public Health Mortality File

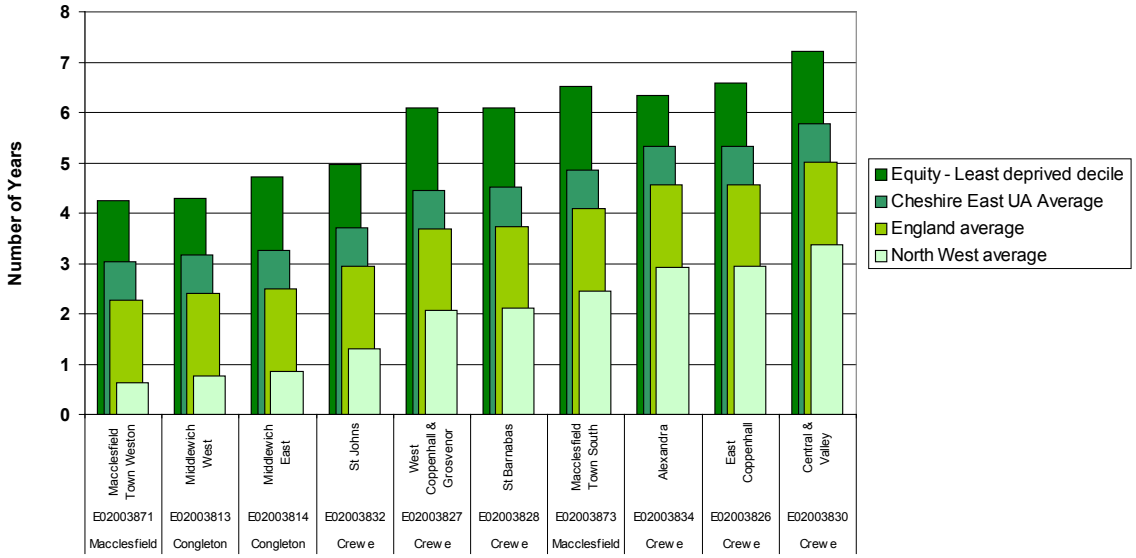
Figure Six: Female life expectancy gap within Cheshire East, 2006-2008



Source: SYOA Population Estimates, 2006-2008, ONS Life Table Template, Public Health Mortality File

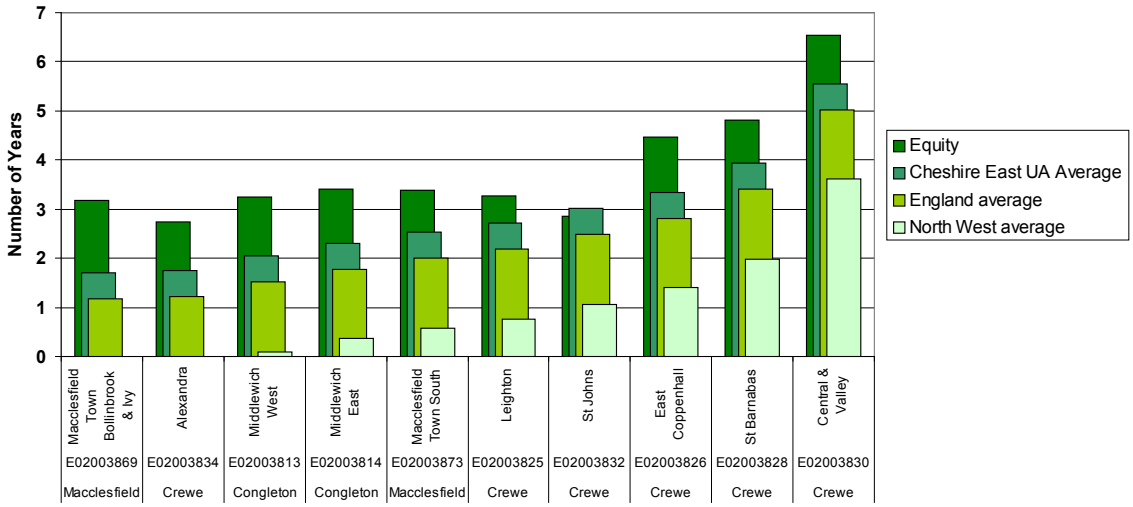
Figure Seven* and **Figure Eight*** show, for both males and females, the number of life years that each of the bottom (worst) 10 MSOA's would need to gain in order to achieve parity with the Cheshire East, North West and England life expectancy for both sexes. It also shows the number of life years that would need to be gained so that each MSOA achieved equity - that being the life expectancy achieved by the least deprived decile (ten percent) of Cheshire East. For example, male residents of Crewe's Central & Valley MSOA would need to gain over seven life years and female residents over six life years to achieve the life expectancy of the least deprived decile.

Figure Seven: Number of life years to be gained, Cheshire East Males, 2006-2008



Source: SYOA Population Estimates, 2006-2008, ONS Life Table Template, Public Health Mortality File

Figure Eight: Number of life years to be gained, Cheshire East Females, 2006-2008



Source: SYOA Population Estimates, 2006-2008, ONS Life Table Template, Public Health Mortality File

*Since calculating the 2006-08 Life Expectancies included in this report there have been several changes to some of the National reference tables used: Firstly, the Mid Year Population estimates for Lower Super Output Areas produced by Office of National Statistics were re-released in September 2010 At the time a decision was made to delay re-release of any Life Expectancy or deaths rates until the scheduled update to the Cheshire East Joint Strategic Needs Assessment in December 2010.

The NHS postcode directory Gridlink® released in August 2010 allocated some postcodes to different administrative areas than the NHSPD June 2009 release used by CECPCT Public Health Intelligence Team. This is because imputation is used to assign postcodes to administrative and electoral areas, is not an exact science and can cause postcodes to be wrongly assigned until more accurate information becomes available. Postcodes sometimes straddle administrative areas and again this can lead to postcodes being wrongly assigned. Initial analysis of the impact of this change on the Life Expectancies calculated shows that the some MSOAs will fall in and out of the Top/Bottom 10 but the overall gaps from best to worst will not change.[7]

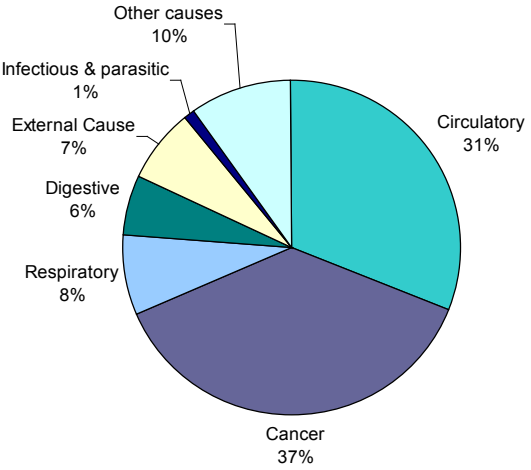
Premature death

Deaths from circulatory disease and cancer are the two main causes for premature death (death before the age of 75) within Cheshire East (**Figure Nine** and **Figure Ten**). During the period 2006-2008, 31% (n645) of male and 20% (n274) of female premature deaths were as a result of circulatory disease.

Almost a third of all premature deaths as a result of circulatory disease could be eliminated if the health experience of residents living in the worst (most deprived) MSOA was the same as the very best (least deprived) MSOA.

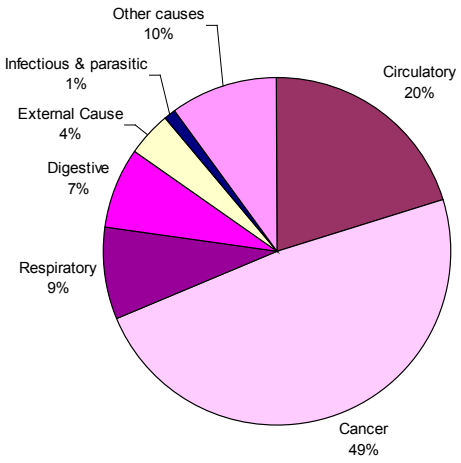
During the period 2006-2008, 37% (n768) of male and 48% (n648) of female premature deaths were as a result of Cancer. Breast, colorectal and lung cancers are the main forms of cancers that cause premature death within Cheshire East. 50% of cancers are preventable with lifestyle modification (smoking, alcohol and obesity), increased awareness, early detection and improved care.

Figure Nine: Cheshire East resident deaths 2006-2008, Males under 75 years



Source: ONS Public Health Mortality File

Figure Ten: Cheshire East resident deaths 2006-2008, Females under 75 years

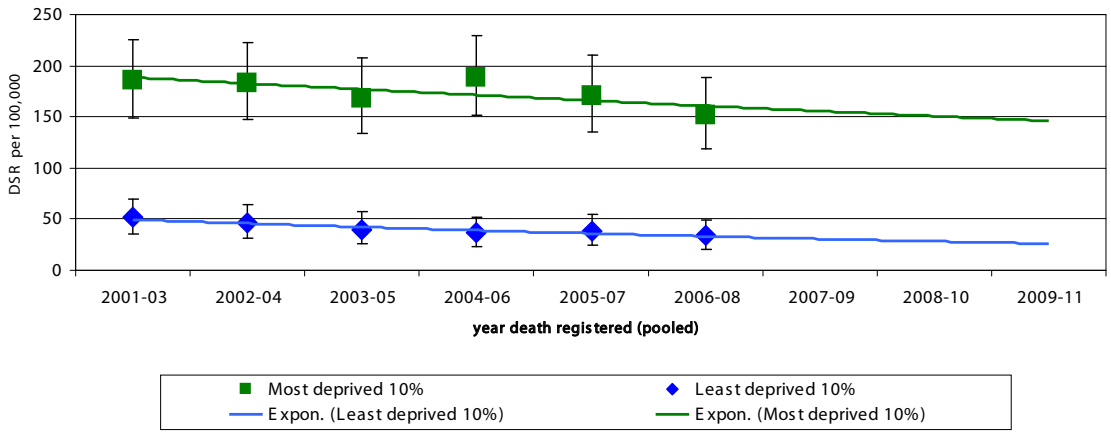


Source: ONS Public Health Mortality File

Figure Eleven indicates the reduction in the premature mortality rate from circulatory disease that has been observed during the period 2001/03 - 2006/08.

Although there has been marked reduction in premature mortality as a result of circulatory disease in our most deprived ten percent (decile) compared to the least deprived (ten percent) over the last eight years, the gap has not narrowed significantly.

Figure Eleven: Mortality from all circulatory diseases (ICD10 I00-I99), persons aged under 75 years



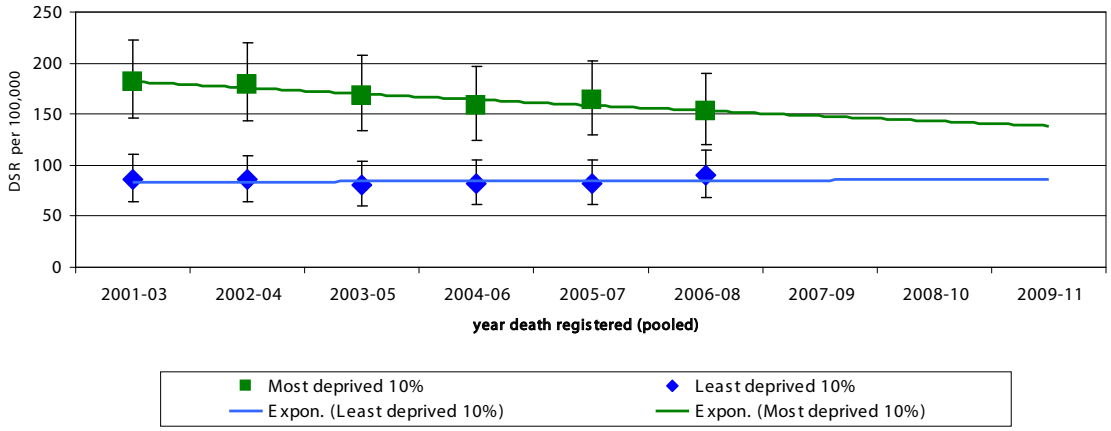
Source: ONS Public Health Mortality File, SYOA Population Estimates, Index of Multiple Deprivation

Figure Twelve indicates the reduction in the premature mortality rate as a result of all cancers that has been observed during the period 2001/03 - 2006/08.

It can be seen that the gap in premature mortality as a result of all cancers has narrowed between the most and least deprived ten percent of the Cheshire East population, with a more marked reduction observed in the most deprived ten percent.

It should be noted that there has been little movement in the premature mortality rate in the least deprived decile over this eight year period, with a slight rise observed during the period 2006-2008.

Figure Twelve: Mortality from all cancers (ICD10 C00-C97), persons aged under 75 years



Source: ONS Public Health Mortality File, SYOA Population Estimates, Index of Multiple Deprivation


Nether Alderley Mill, Nether Alderley

Healthy Life Years or Disability Free Life Expectancy

In Cheshire East male residents can expect to live until the age of 64.6 years and females residents 66.4 years before experiencing a LLTI or disability. This indicates that, on average, Cheshire East male residents will live 14.1 years with a LLTI or disability and female residents 16.1 years living with a LLTI or disability. **Figure Thirteen** and **Figure Fourteen** indicates the top (best) and bottom (worst) MSOA's for male and female DFLE and the number of years spent living with a LLTI or disability, and the proportion of their life expectancy spent free of LLTI or disability.

It can be seen from **Figure Thirteen** that male residents in MSOA areas that have the lowest (worst) DFLE rates are more likely to experience the longest period of time with a LLTI or disability and / or lowest (worst) percentage of their life expectancy free from a LLTI or disability.

It can be seen from **Figure Fourteen** that female residents in MSOA areas that have the lowest (worst) DFLE rates tend to experience a similar number of years with a LLTI or disability to that of female residents which have the highest (best) DFLE rates, however they tend to spend a lower (worst) percentage of their overall life expectancy free from a LLTI or disability. Exceptions do occur. For example, female residents of Macclesfield Town Tytherington MSOA experience the highest (best) DFLE rate but spend, on average, 22.4 years of their remaining life with a LLTI or disability - the highest number of years spent living with a

Figure Thirteen: Male disability free life expectancy and years spent living with a limiting long term illness or disability

	Local Area Partnership	MSOA Name	DFLE (Years)	Years living with a LLTI or disability	% of life expectancy spent free of LLTI or disability
Top (Best) 10 MSOAs	Knutsford	Knutsford Town South	69.5	10.9	84.3
	Congleton	Congleton & Holmes Chapel Rural	69.1	14.5	82.7
	Poynton	Adlington & Prestbury	69.0	11.5	84.7
	Macclesfield	Macclesfield Town Tytherington	68.8	12.7	84.4
	Wilmslow	Wilmslow Town South East	68.2	15.6	81.4
	Wilmslow	Wilmslow Town South West	68.2	15.0	82.0
	Congleton	Holmes Chapel	67.7	14.2	82.7
	Poynton	Poynton Parish West	67.5	13.9	82.9
	Wilmslow	Chelford & Alderley Edge	67.4	12.9	83.9
	Congleton	Sandbach West & Wheelock	67.4	11.1	85.9
Bottom (Worst) 10 MSOAs	Macclesfield	Macclesfield East	61.8	15.9	79.5
	Nantwich	West Nantwich	61.4	16.8	78.5
	Congleton	Congleton East	59.9	18.1	76.8
	Crewe	Alexandra	59.8	13.6	81.5
	Crewe	St Johns	58.9	16.1	78.5
	Macclesfield	Macclesfield Town South	57.7	18.1	76.1
	Crewe	Central & Valley	57.7	15.2	79.1
	Crewe	East Coppenhall	57.1	16.3	77.8
	Crewe	St Barnabas	55.8	18.4	75.2
	Crewe	West Coppenhall & Grosvenor	55.8	18.5	75.1

Source: Public Health Mortality File, ONS MSOA Single Year of Age Population Estimates. Disability Free Life Expectancy by Ward http://www.statistics.gov.uk/downloads/theme_health/Males_Females_Persons_%20DFLE.xls

Figure Fourteen: Female disability free life expectancy and years spent living with a limiting long term illness or disability

	Local Area Partnership	MSOA Name	DFLE (Years)	Years living with a LLTI or disability	% of life expectancy spent free of LLTI or disability
Top (Best) 10 MSOAs	Macclesfield	Macclesfield Town Tytherington	71.4	22.4	76.1
	Poynton	Adlington & Prestbury	71.2	10.2	87.5
	Congleton	Congleton & Holmes Chapel Rural	70.7	17.7	80.0
	Wilmslow	Wilmslow Town South West	70.6	16.4	81.1
	Knutsford	Knutsford Town South	70.3	16.0	81.5
	Congleton	Holmes Chapel	70.1	15.2	82.2
	Wilmslow	Wilmslow Town South East	70.0	17.6	79.9
	Macclesfield	Macclesfield Rural	69.6	16.9	80.4
	Poynton	Poynton Parish West	69.5	17.0	80.3
	Crewe	St Marys & Wells Green	68.9	19.1	78.3
Bottom (Worst) 10 MSOAs	Congleton	Middlewich East	63.4	16.8	79.0
	Crewe	St Johns	63.4	16.2	79.6
	Macclesfield	Macclesfield Town Weston	63.4	18.6	77.3
	Congleton	Congleton East	63.2	19.7	76.2
	Crewe	Alexandra	61.5	19.3	76.1
	Crewe	West Coppenhall & Grosvenor	60.7	21.5	73.8
	Crewe	St Barnabas	59.4	19.2	75.6
	Macclesfield	Macclesfield Town South	59.4	20.6	74.2
	Crewe	Central & Valley	59.2	17.8	76.9
	Crewe	East Coppenhall	59.2	20.1	74.6

Source: Public Health Mortality File, ONS MSOA Single Year of Age Population Estimates. Disability Free Life Expectancy by Ward http://www.statistics.gov.uk/downloads/theme_health/Males_Females_Persons_%20DFLE.xls

LLTI or disability experienced by female residents of any MSOA within Cheshire East - as well as spending just over 76% of their lives free from a LLTI or disability. This proportion is similar to that experienced by female residents in MSOA areas with the lowest (worst) DFLE rates.

Of note, more than three-quarters of the England population do not have a DFLE as far as the age of 68 - the pensionable age to which England is moving. If society wishes to have a healthy population, working until 68 years, it is essential that action is taken to both raise the general level of health and flatten the social gradient.[2]

The Economic Cost

It is estimated that inequality in illness experience accounts for productivity losses of £31-33 billion per year,[5] lost taxes and higher welfare payments in the range of £20-32 billion per year[5] and additional NHS healthcare costs well in excess of £5.5 billion per year. If no action is taken, the cost of treating the various illnesses that result from inequalities in obesity alone will rise from £2 billion per year to £5 billion per year in 2025.[6]

Facts of economic and health inequalities in Cheshire East

- in 2003, approximately 8,943 (6.1%) households in Cheshire East were in a state of fuel poverty in that they spent 10% or more of their income on fuel
- in 2001, 7.8% of households (11,511 households) in Cheshire East did not have central heating
- the high quality of life enjoyed by communities in Cheshire East, particularly in the Macclesfield and Congleton areas, is a significant factor in contributing to the economic success of these areas. In contrast parts of Cheshire East, particularly some wards in Crewe, are characterised by poorer quality environments and negative images together with relatively high levels of worklessness, ill health and poverty, constraining people's ability to improve their life chances
- Macclesfield has the highest median house price in the North West
- the average income of newly-forming households in 2005 / 2006 was £385 per week, or £20,020 per annum. This is well below the income needed to access either home ownership or the private rented sector in Cheshire (Survey of English Housing 2005/ 2006, CLG, 2007) Cheshire Sub-Regional Housing Strategy 2009 - 2012
- in 2007, 48% of disabled people and up to 41% of people with health problems in Cheshire East were classed as economically inactive
- the overall percentage of the working age population educated to NVQ Level 3 and above is 50%. 9.9% of the working age population of Cheshire East have no qualifications. Variation exists across Cheshire East with 45.8% of adult residents aged 16 - 74 years of Crewe's St Barnabus MSOA having no qualifications compared to 13.1% of adult residents in Wilmslow Town South MSOA
- 23% of the population (83,300) of Cheshire East experience barriers to housing and services. This includes measures of housing affordability, overcrowding, homelessness, tenure and access to local amenities and services
- as of March 2010, 6.6% of the working age population were classed as unemployed
- as of February 2010, 9.2% of the working age population were in receipt of key-out of work benefits. Job Seekers Allowance (2.8%) and Employment Support Allowance/Incapacity Benefit (5.0%) are the two main key out of work benefits claimed
- in Cheshire East every person is allocated just over £1400 per annum towards NHS costs. The equivalent of £80 per person per annum of the NHS budget is spent on treatment of alcohol related problems. This is set to rise to £100 in 2012/13
- in Cheshire East the current smoking prevalence for the adult population in 19.1%. However, there are notable inequalities across the towns in Cheshire East, with parts of Crewe having prevalence as high as 36% and parts of Macclesfield as low as 9.6%

4. Reducing health inequalities is Everybody's Business

No one agency can reduce health inequalities in isolation. This requires recognition and ownership from a range of public, private and voluntary sector organisations that reducing health inequalities is their business and that their actions, commissioning decisions and distribution of services and resources are integral to the overall work to reduce health inequalities.

The challenge:

- how can we best convey the message that 'its everyone's business' to take action post 2010 to realise the social and economic benefits of reducing health inequalities in Cheshire East?

Below we have outlined why reducing health inequalities is everybody's business.

The Business Community - Why Tackling Health Inequalities is Our Business

There is growing evidence that health, work and well-being are closely connected.

Work is known to be the best route out of poverty and is therefore of critical importance for reducing health inequalities. The 2006 report, *"Is work good for your health and well-being?"*[8] found that work is also usually good for health.

The report concludes that *"there is a strong evidence base showing that work is generally good for physical and mental health and well-being. Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment. That is true for healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. The provisos are that account must be taken of the nature and quality of work and its social context; jobs should be safe and accommodating. Overall, the beneficial effects of work outweigh the risks of work, and are greater than the harmful effects of long-term unemployment or prolonged sickness absence. Work is generally good for health and well-being"*

Patterns of employment both reflect and reinforce the social gradient and there are serious inequalities of access to labour market opportunities. Rates of unemployment are highest among those with no or few qualifications and skills, people with disabilities and mental ill-health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers, and in particular young people. When in work these same groups are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often working in conditions that are harmful to health. Insecure and poor quality employment is also associated with increased risks of poor physical and mental health.

In *Improving health and work: changing lives The Government's Response to Dame Carol Black's Review of the health of Britain's working-age population*[9] Dame Carol Black set out a number of recommendations to support employers in creating workplaces which are accommodating and safe and which can contribute to improving health - therefore helping to reduce inequalities.

The Marmot Review[2] builds on these recommendations in its Policy Objective C '**create fair employment and good work**' for all and which outlined three priority objectives:

- improve access to good jobs and reduce long-term unemployment cross the social gradient
- make it easier for people who are disadvantaged in the labour market to obtain and keep work
- improve quality of jobs across the social gradient

Figure Fifteen summarises the economic and health benefits of supporting people to be healthier and in work and provides the outline for a business case for employers to help keep their workforce healthy.

Figure Fifteen: Economic and health benefits of supporting people to be healthier and in work

For businesses
- more motivated and productive workers
- less working time lost to ill-health
- better staff retention
- greater competitiveness
- higher profits

For the regions and communities
- more social mobility
- less social exclusion
- reduction in social deprivation and child poverty
- increased productivity
- higher employment
- less burden on public services

For the economy
- assisting the conditions for business success
- higher productivity
- supporting economic performance

For the individual
- empowerment, increased self confidence, greater dignity
- better general health (mental and physical)
- financial security
- better living conditions
- opportunities for development
- more productive

For families and children
- better living conditions
- better general health (mental and physical)
- less likelihood of experiencing disadvantage in education
- greater potential for social mobility

The Annual Report of the Director of Public Health 2010 for Central and Eastern Cheshire Primary Care Trust,[3] includes a chapter that outlines further the impact that work and unemployment has on health and wellbeing and provides examples of what is being done locally to support people to stay in work, stay healthy in work and to return to work.

The challenges:

- how can the business sector in Cheshire East translate the evidence that work is good for health and wellbeing into tangible actions post 2010?
- how can the business community maximise the opportunities that work can offer to reduce the health inequalities which persist in Cheshire East?

Cheshire East Council and Cheshire East Local Strategic Partnership - Why Tackling Health Inequalities is Our Business

The report *"Valuing Health: developing a business case for health improvement"* produced for the Improvement and Development Agency (I&DeA) in 2009,[10] sets out the "co-leadership role" given to local government as well as the NHS for the delivery of strategies to reduce health inequalities. The report sets out the findings of a literature review of the health of local communities and provides good evidence supporting the effectiveness of many types of interventions which lie within the responsibilities of local authorities and their partners many of whom are active members of the LSP.

The transfer of responsibility for "health improvement" to local authorities as part of the proposed reform of the NHS (pending statute) recognises the strong role that local authorities and their partners play particularly on the wider or social determinants of health. Based on the I&DeA report, key local authority functions and activities which can impact on reducing health inequalities include:

- early child development
- older people's health and independence
- benefits and welfare
- planning
- transport
- housing - social and private, regeneration
- employment
- social inclusion
- culture and leisure
- climate change
- crime and disorder
- teenage pregnancy
- health impact assessment
- community development and empowerment

The business case for health improvement:

- the health benefits for the whole population or for targeted communities (geographical and of interest) of Cheshire East which can be produced by the work of Cheshire East Council and their key partners within the LSP
- the efficiency savings which can be made through integrated working with key partners applying models of good practice such as Total Place
- the further impacts of improved health for example in areas such as education, older people's preventative services and employment

The challenge:

- how can Cheshire East Council and its partners in the LSP realise the health benefits, the efficiency savings and the further impacts of improved health for the whole population and/or for the targeted communities of Cheshire East?

NHS Commissioners and the new local Public Health Service - Why Tackling Health Inequalities is Still Our Business

Improving health outcomes and reducing health inequalities have been at the heart of NHS commissioning strategies for many years and is well documented in the former **World Class Commissioning** (WCC) competencies. As we move into a new NHS Commissioning landscape, which includes GP consortia, it is important to retain those competencies which reflected action to reduce health inequalities, especially WCC competencies 2, 3 and 5:

- WCC 2: Working collaboratively with community partners to commission services that optimise health gains and reduce health inequalities
- WCC 3: Proactively build continuous and meaningful engagement with the public and users to shape services and improve health
- WCC 5: Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements

Whilst there has been significant improvements in life expectancy and health outcomes overall in Cheshire East, reducing the differences which exist at a smaller community and street level remains a challenge.

This challenge is critical for all those that will be involved in public health, NHS commissioning and the provision of health and health / social care services post 2010 and we must look to the evidence of what works and best practice to help shape and inform our future thinking.

A useful resource for future commissioners and providers is the Department of Health's National Support Team (NST) for Health Inequalities. The NST for Health Inequalities was set up in 2007 to provide support to local "spearhead" areas. Although Cheshire East was not one of the Spearhead areas, there are areas within it which have just as poor health outcomes as other areas within designated Spearhead areas. For example poor health outcomes in parts of Crewe are comparable to poor health outcomes for some areas within Manchester.

The NST uses a diagnostic model to help local areas identify the key interventions they can implement in order to succeed. The three categories of intervention are:

- population health - direct input at population level through legislation, regulation, taxation, mass media (e.g. preventing smoking in enclosed public spaces)
- personal health - applying effective personal health interventions (e.g. cholesterol management with statins, affordable warmth) systematically, and at a scale such that improvements add up to population-level change
- community health - engaging, developing and empowering communities effectively and systematically enough that resulting health-improving and health-seeking behaviours lead to percentage change at population level

This document endorses the best practice approach to tackling health inequalities as set out in workbooks and 'how to' guides produced by the Department of Health National Support Team for Health Inequalities.[11]

The challenge:

- how can NHS commissioners, the Public Health Service and other commissioners of health services ensure that the provision of health and social care services do not exacerbate existing inequalities in health but help to reduce the variation in health that exists at smaller community and area levels in Cheshire East?

The Voluntary Sector - Why Tackling Health Inequalities is Our Business

There are 900,000 voluntary sector organisations in the UK with a combined workforce of over 1.6 million, combined assets of £244 billion and the capacity to mobilise over a quarter of the population to volunteer formally at least once a month. It has immense associative power, has the ability to bring together coalitions for change and is at the heart of the current Governments overarching 'Big Society' vision for Britain. It's potential and ability to improve the health of the population and reduce health inequalities is based on three key roles:

- leadership, voice and advocacy. The voluntary sector plays an important role in giving voice to less well-served groups, thereby helping to reduce health inequalities
-

- informing and shaping policy and strategy. The voluntary sector brings unique expertise to population health policy making, often having a depth of understanding of particular issues or areas and an ability to produce and gather evidence in those areas that policy makers in Government themselves lack. This ability to help shape policy is particularly important in the context of ensuring that Government policy serves to reduce, rather than widen health inequalities
- designing, delivering and supporting services. The voluntary sector plays an important role in designing and delivering both front line and second-tier services which support organisations and professionals operating in population health. Working in partnership with the public and private sectors, voluntary sector brings a variety of qualities to delivering services including innovation, person-centred community rooted services, reach, building and harnessing community resources and assets, and joining up[12]

The publication *'How to deliver high-quality, patient-centred, cost-effective care: Consensus solutions from the voluntary sector'* [13] published through the Kings Fund in September 201010 sets out the collective effort of ten of the leading health and social care organisations in the voluntary sector. Each organisation submitted evidence to The King's Fund, which independently analysed and assessed each submission and worked with the organisations to establish a common position. The report identifies five key themes that the health and social care system must embrace to be sustainable and to ensure quality.

The five key themes are:

- co-ordinated care
- patients engaged in decisions about their care
- supported self-management
- prevention, early diagnosis and intervention
- emotional, psychological and practical support

Benefits cited in the report include:

- improved patient confidence and coping ability
- improved enhanced quality of life and reductions in pain, anxiety and depression
- improved health outcomes and life expectancy
- improved patient experience of care
- improved adherence to treatment
- improved health behaviours
- more streamlined care pathways that were less resource-intensive
- reduced use of both primary and secondary care and particularly urgent care
- cash savings and longer-term efficiency; and
- productivity gains including wider social and economic benefits, such as re-employment

The report adds that achieving these changes will require a number of things. It will require a policy and regulatory framework that is designed to support the delivery of patient-centred care. It will require commitment, innovation and leadership from clinicians, managers and commissioners across the system and it will require partnership in many forms; between patients and clinicians, and between different professions, organisations and sectors in health, social care, public health, wider public services, and the voluntary and private sectors.

The challenge:

- in Cheshire East how can we maximise the opportunities that the Voluntary Sector can offer, not just in terms of supporting patient centred care as described above but also in broader terms around the idea of "Big Society" and individual and community empowerment?

The Education Sector - Why Tackling Health Inequalities is Our Business

Inequalities in educational outcomes affect physical and mental health, as well as income, employment and quality of life. The graded relationship between socioeconomic position and educational outcome has significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health

People with university degrees have better health and longer lives than those without. For people aged 30 and above, if everyone without a degree had their death rate reduced to that of people with degrees, there would be 202,000 fewer premature deaths each year.[2]

The challenge:

- in Cheshire East how can we keep improving educational outcomes across the social gradient?

5. Living Well in Cheshire East - a way forward

The concept of "Living Well" as outlined in the document 'Living Well across local communities: prioritising wellbeing to reduce inequalities'[14] has been developed through a process of engagement and consultation across the North West. It describes ways of working to remove entrenched inequalities. Living Well calls for a cultural change to bring about improvements in health and wellbeing building on the findings from the Marmot Review.

A central theme is that solutions to entrenched inequalities lie mainly outside of the influence of the NHS and sit with a range of public, private and voluntary sector organisations as well as within communities themselves.

Living Well is not seen as a framework with solutions, recognising that these are for local partners and communities to work through and embed within their policies and practices.

The six statements of direction at the heart of the Living Well approach are:

- everyone see the Living Well agenda as their business
- public investment in local communities builds on the local strengths/assets to raise aspiration, build resilience and release potential
- children in all communities get the best start in life and young people are supported to become successful adults
- all organisations are tackling discrimination, poverty and social injustice
- environments and communities make it easy for people to Live Well
- all organisations invest in extending years of healthy and active life lived

In Cheshire East, we want to accept the "call to action" proposed in the North West Living Well document and build on the recommendations put forward as part of our own call to action.

Below are some key actions that all leaders, organisations and local bodies, such as the new Health and Wellbeing boards, can take to begin to deliver Living Well:

- sign up to the Living Well approach
- model the Living Well approach in decision-making
- promote understanding of Living Well and the concepts of investing for health and delivering social value among staff and with partners
- use existing powers to the full for the Living Well agenda
- assess and build on community assets - which is expanded further in the following section of this document
- adopt area-based approaches to deliver improvements
- communicate the 'Five ways to wellbeing'[15] to staff and the public and engage people in taking action

The challenge:

- how can we ensure that all leaders, organisations and local bodies, including the new Health and Wellbeing boards, sign up to the Living Well approach, translating local actions into meaningful and measurable signs of progress in reducing entrenched inequalities?

6. An asset approach to reducing health inequalities

"Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill"

Marmot, Fair Society Healthy Lives, 2010

"Many of the key assets required for creating the conditions for health lie within the social context of people's lives and therefore [the asset model] has the potential to contribute to reducing health inequities"

Morgan & Ziglio, 2007

"A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses"

Antony Morgan, National Institute for Health and Clinical Excellence, 2009

Asset based working promotes well-being by building social capital, promoting face-to-face community networks, encouraging civic participation and citizen power. High levels of social capital are correlated with positive health outcomes and well-being. It provides a source of resilience, a buffer against risks of poor health, through social support which is critical to physical and mental well-being, and through the networks that help people find work, or get through economic or other material difficulties.

It is vital to build social capital at a local level to ensure that policies are both owned by those most affected and are shaped by their experiences. In other words, effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

The asset approach is a set of values and principles and a way of thinking about the world. It:

- identifies and makes visible the health enhancing assets in a community
- sees citizens and communities as the co-producers of health and well-being, rather than the recipients of services
- promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment
- values what works well in an area
- identifies what has the potential to improve health and well-being
- supports individuals health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources
- empowers communities to control their futures and create tangible resources such as services, funds and buildings[16]

An asset approach to community wellbeing is one such approach being advocated for partners in Cheshire East to adopt and promote.

The challenge:

- how can we use an asset approach to build upon the strengths and assets of our local individuals and communities in Cheshire East to raise aspirations, build resilience and release potential?

7. Meaningful signs of future progress on addressing health inequalities

What will progress and success look and feel like for partnerships and communities in the future?

This is a question to be answered at a later date when we have clarity from central government around measuring outcomes and also through work with local communities on what is important to them. We can however aspire to the following approaches:

- setting meaningful and measurable outcome indicators at an individual, community and organisational level. Some may be prescribed centrally as national indicators; others may be left to local determination
- focusing signs of progress on outcome rather than process indicators - we want to deliver actions which show progress
- using a mix of asset and deficit indicators - the North West Living Well document describes a top ten list and which could be considered locally
- disaggregating targets to small area levels (for example to LAP or MSOA levels) proportionate to the issues and needs of these areas. This will help us to measure the extent of "levelling up" from the worst to best health status
- using the six statements of direction as described in the North West Living Well approach to set out signs of progress - as outlined below:

1. **EVERYONE SEES THE LIVING WELL AGENDA AS THEIR BUSINESS**
   Sign of progress within 1 year - Local leaders sign up to the Living Well agenda, model the approach in decision-making and promote understanding among staff. Existing powers are used to exploit Living Well opportunities across all sectors

2. **PUBLIC INVESTMENT IN LOCAL COMMUNITIES BUILDS ON LOCAL STRENGTHS/ASSETS TO RAISE ASPIRATION, BUILD RESILIENCE AND RELEASE POTENTIAL**
   Sign of progress within 1 year - Local community assets defined and assessed Joint initiatives to build local and community leadership. Promotion of the 'Five ways to wellbeing'[15] to staff and to the public

3. **CHILDREN IN ALL COMMUNITIES GET THE BEST START IN LIFE AND YOUNG PEOPLE ARE SUPPORTED TO BECOME SUCCESSFUL ADULTS**
   Sign of progress within 1 year - Coordinated effort at all levels to engage parents, schools and key organisations in exploring how to implement a Living Well approach for children and with young people

4. **ALL ORGANISATIONS ARE TACKLING DISCRIMINATION, POVERTY AND SOCIAL INJUSTICE**
   Sign of progress within 1 year - Commitment to the development of an integrated Living Well approach to addressing health and broader inequalities

5. **ENVIRONMENTS AND COMMUNITIES MAKE IT EASY FOR PEOPLE TO LIVE WELL**
   Sign of progress within 1 year - All public bodies make explicit their understanding of the relationship between health, inequality and a low carbon sustainable future, and set out actions to achieve sustainability alongside living well

6. **ALL ORGANISATIONS INVEST IN EXTENDING YEARS OF HEALTHY AND ACTIVE LIFE LIVED**
   Sign of progress within 1 year - Commitment by health providers and local government in particular to explore how health promotion and disease prevention programmes might be refocused to address social and economic factors as well as lifestyle choices and individual health awareness

The challenge:

- how can we ensure progress in reducing differences in health outcomes are demonstrated in measurable and meaningful ways to all those who have a stake in them, communities in particular?

8. Summary of our key challenges

These challenges are for consultation. We want to hear from as broad a range of people and organisations as possible.

You can respond to these challenges by emailing your responses to **livingwell@cecpct.nhs.uk** or posting responses to:
Living Well, Public Health, Central and Eastern Cheshire Primary Care Trust
Universal House, ERF Way, Off Pochin Way, Middlewich, Cheshire, CW10 0QJ

You can also respond to these challenges by completing the online consultation survey at:
www.surveymonkey.com/S9TSVF6

Responses should be received by February 14th 2011.

Our Key Challenges

- how can we best convey the message that 'its everyone's business' to take action post 2010 to realise the social and economic benefits of reducing health inequalities in Cheshire East?
- how can the business sector in Cheshire East translate the evidence that work is good for health and wellbeing into tangible actions post 2010?
- how can the business community maximise the opportunities that work can offer to reduce the health inequalities which persist in Cheshire East?
- how can Cheshire East Council and its partners in the Local Strategic Partnership realise the health benefits, the efficiency savings and the further impacts of improved health for the whole population and/or for the targeted communities of Cheshire East?
- how can NHS commissioners, the Public Health Service and other commissioners of health ensure that the provision of health and social care services do not exacerbate existing inequalities in health but help to reduce the variation in health that exists at smaller community and area levels in Cheshire East?
- in Cheshire East how can we maximise the opportunities that the Voluntary Sector can offer, not just in terms of supporting patient centred care as described above but also in broader terms around the idea of "Big Society" and individual and community empowerment?
- in Cheshire East how can we keep improving educational outcomes across the social gradient?
- how can we ensure that all leaders, organisations and local bodies, including the new Health and Wellbeing boards, sign up to the Living Well approach, translating local actions into meaningful and measurable signs of progress in reducing entrenched inequalities?
- how can we use an asset approach to build upon the strengths and assets of our local individuals and communities in Cheshire East to raise aspirations, build resilience and release potential?
- how can we ensure progress in reducing differences in health outcomes are demonstrated in measurable and meaningful ways to all those who have a stake in them, communities in particular?

9. Next Steps

The next 6 to 12 months will see significant changes and challenges that arise from major public sector reforms resulting from the publication of a number of White Papers as a result of the implications of the Comprehensive Spending Review.[17]

This should not be a cause for inaction. Now more than ever it is imperative that productive partnerships are continued and formed to find ways of engaging with those who experience inequality in health and to ensure that all strategic direction, resources and services are aligned so as to contribute to their successful reduction.

Below is outlined a short term timetable of actions that can be achieved through this period of instability, uncertainty and opportunity.

Date	Action
Nov 2010	Living Well in Cheshire East Conference One: 'a call to action to reduce differences in health'
Nov 2010	Distribution of Living Well in Cheshire East Statement of Intent and beginning of Living Well in Cheshire East Key challenges consultation
Dec 2010	Publication and dissemination of the Living well in Cheshire East Conference One Report
Dec - Jan 2010	Assess and understand the impact on Health Inequality strategic planning resulting from the Public Health Policy & Practice proposals outlined in the Public Health White Paper (to be released Dec 2010)
Jan 2011	Development of Cheshire East Health Inequalities Steering Group/Task and Finish Group
Feb 2010	Close of Living Well in Cheshire East Key challenges consultation
Feb 2011	Development of a Cheshire East Health Inequalities and Asset Based Community Development Training Programme
March 2011	Circulation of draft Cheshire East Health Inequalities Strategy 2011-2015
March - May 2011	Delivery of Cheshire East Health Inequalities and Asset Based Community Development Training Programme within all LAP areas
June 2011	Living Well in Cheshire East Conference Two: 'taking forward actions to reduce our inequalities'

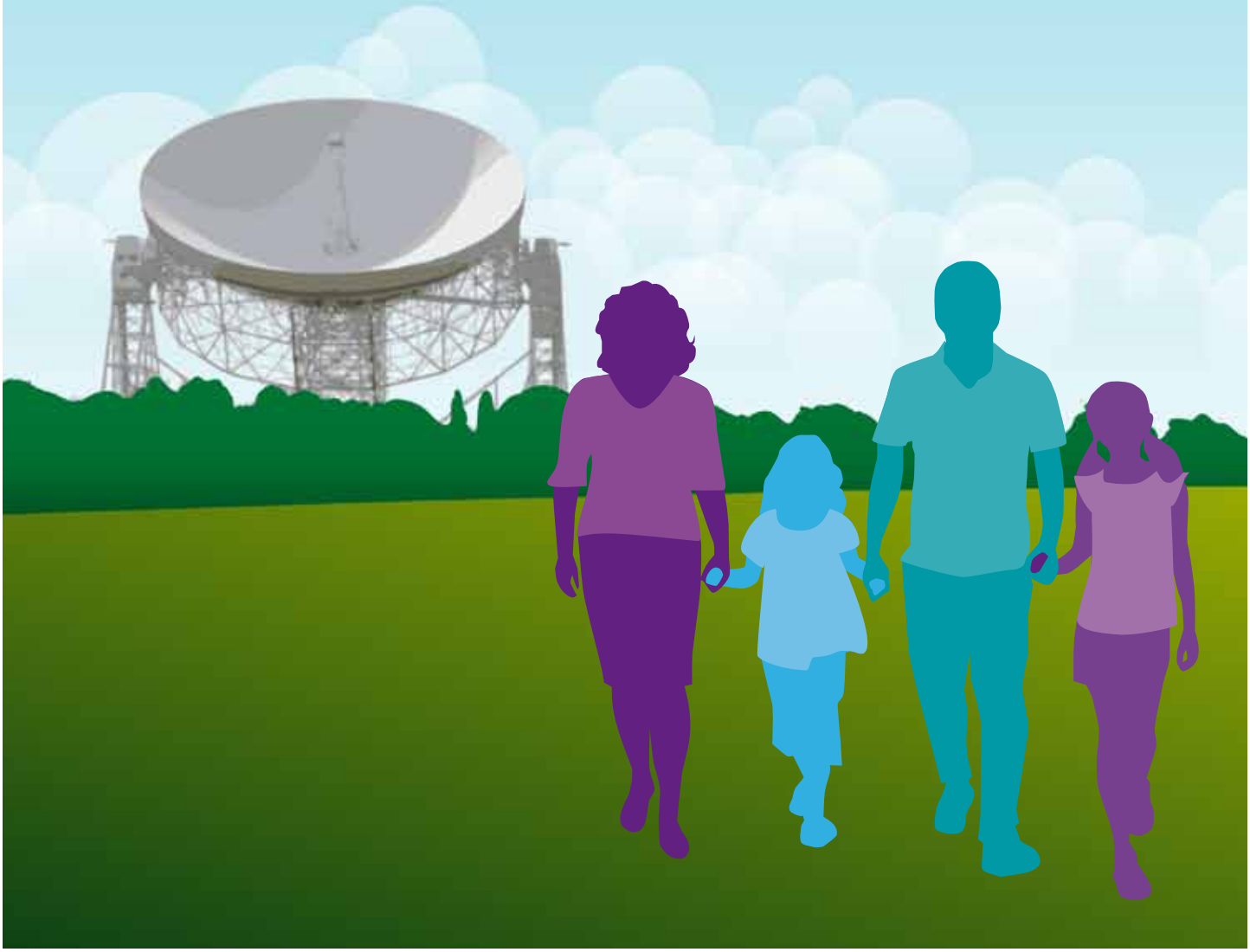
Appendix

a. Living Well in Cheshire East Statement of Intent

b. Central & Eastern Cheshire Primary Care Trust Statement of Intent

c. Cheshire East Council Statement of Intent

d. Key sources of health information in Cheshire East



Living Well in Cheshire East

STATEMENT OF INTENT

Organisation name: .....

recognise that:

- health inequalities in Cheshire East are unacceptable
- addressing health inequalities is our business
- we must work together to reduce inequalities and narrow the gap between those with the best health and the worst health
- to enable the people of Cheshire East to be living well we must endorse an approach that promotes the capacity and ability of all to improve their health and wellbeing
- we must work at individual, community and organisational levels in order to effectively address health inequalities
- we must act across the 'rainbow' (addressing lifestyle, social, economic and environmental factors that impact on health), engage and empower communities and ensure action is based on evidence

(insert organisation name) are committed to:

- reducing health inequalities by making measurable improvements and by raising aspirations in our local communities
- being active and engaged partners in the development of effective and coherent partnerships between organisations, communities and individuals, based on the principle of making the best use of their respective strengths and assets
- applying collective resources - where available - in the best way to identify and deliver on local actions to address health inequalities
- a joint approach to developing the arrangements to deliver these commitments
- signing up to the Living Well approach

Local Endorsement of Statement of Intent

We endorse this Statement of Intent and are committed to working in close partnership so as to reduce health inequalities in Cheshire East

.....	.....
Signed for	Signed for
Name:	Name: .....
Title:	Title: .....

Once completed please return to:
livingwell@cecpct.nhs.uk
or to

Public Health
Central and Eastern Cheshire Primary Care Trust
Universal House
ERF Way, off Pochin Way
Middlewich
Cheshire
CW10 0QJ

Living Well in Cheshire East

STATEMENT OF INTENT

Central and Eastern Cheshire Primary Care Trust recognise that:

- health inequalities in Cheshire East are unacceptable
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Central and Eastern Cheshire Primary Care Trust are committed to:

- reducing health inequalities by making measurable improvements and by raising aspirations in our local communities
- being active and engaged partners in the development of effective and coherent partnerships between organisations, communities and individuals, based on the principle of making the best use of their respective strengths and assets
- applying collective resources - where available - in the best way to identify and deliver on local actions to address health inequalities
- a joint approach to developing the arrangements to deliver these commitments
- signing up to the Living Well approach

Local Endorsement of Statement of Intent

We endorse this Statement of Intent and are committed to working in close partnership so as to reduce health inequalities in Cheshire East

Michael Pyrah
Chief Executive
Central & Eastern Cheshire Primary Care Trust

Dr Heather Grimbaldeston
Joint Director of Public Health
Central & Eastern Cheshire Primary Care Trust & Cheshire East Council

Living Well in Cheshire East

STATEMENT OF INTENT

Cheshire East Council recognise that:

- health inequalities in Cheshire East are unacceptable
- addressing health inequalities is our business
- we must work together to reduce inequalities and narrow the gap between those with the best health and the worst health
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- we must work at individual, community and organisational levels in order to effectively address health inequalities
- we must act across the 'rainbow' (addressing lifestyle, social, economic and environmental factors that impact on health), engage and empower communities and ensure action is based on evidence

Cheshire East Council is committed to:

- reducing health inequalities by making measurable improvements and by raising aspirations in our local communities
- being active and engaged partners in the development of effective and coherent partnerships between organisations, communities and individuals, based on the principle of making the best use of their respective strengths and assets
- applying collective resources - where available - in the best way to identify and deliver on local actions to address health inequalities
- a joint approach to developing the arrangements to deliver these commitments
- signing up to the Living Well approach

Local Endorsement of Statement of Intent

We endorse this Statement of Intent and are committed to working in close partnership so as to reduce health inequalities in Cheshire East

Councillor Andrew Knowles
Health & Wellbeing Portfolio Holder
Cheshire East Council

Erika Wenzel
Chief Executive
Cheshire East Council

Key Sources of Health Information in Cheshire East

Annual Report of the Director of Public Health 2010

The Annual Report of the Director of Public Health 2010 provides an overview of the health of the local population at Primary Care Trust and smaller area geographies. It emphasises the importance of tackling health inequalities to improve health and provides actions and recommendations to partners in health and care on how to improve the health and wellbeing of our local population.

The document can be downloaded via: **www.cecpct.nhs.uk**
Follow the route: home page > about-us > public-health > public-health-report

CECPCT Annual Report 2009/2010

This Annual Report demonstrates the achievements of Central and Eastern Cheshire Primary Care Trust during 2009-2010 including the on-going development of primary care centres and work with local people.

The document can be downloaded via: **www.cecpct.nhs.uk**
Follow the route: home page > about-us > publications > corporate-publications > Annual Reports & Accounts

Ambition for All: Cheshire East's Sustainable Community Strategy 2010 to 2025

Ambition for All, the Sustainable Community Strategy for Cheshire East, sets out a collective vision for the area and the priority actions which need to be addressed over the next 15 years to achieve that vision. The strategy will be used to influence the Local Development Framework, Local Transport Plan and other major strategies and plans.

The document can be downloaded via: **www.cheshireeast.gov.uk**
Follow the route: home page > community and living > local strategic partnership > sustainable community strategy

Joint Strategic Needs Assessment (JSNA)

Cheshire East's Joint Strategic Needs Assessment is a shared statement on the health and social care needs of people living in Cheshire East which the Council and Primary Care Trust have a legal duty to undertake, and use to develop and improve services.

The Joint Strategic Needs Assessment pulls together a range of needs assessments, and qualitative and quantitative information within a more joined up framework for commissioners to utilise to develop and improve services. It is also a source of information for the local community and Third Sector organisations to find out more about health and social care.

The JSNA can be viewed via: **www.cheshireeast.gov.uk**
Follow the route: home page > community and living > local strategic partnership > jsna

References

1. Ambition for All: Cheshire East's Sustainable Community Strategy 2010 - 2025. www.cheshireeast.gov.uk

2. Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010. www.marmotreview.org (last accessed 27.10.10)

3. The Annual Report of the Director of Public Health 2010. Central and Eastern Cheshire Primary Care Trust. www.cecpct.nhs.uk/about-us/public-health-report-2010) (Last accessed 27.10.10)

4. Mazzuco S, Meggiolaro S and Suhrcke M (2009) Submission to the Marmot Review.

5. Frontier Economics (2009) Overall costs of health inequalities. Submission to the Marmot Review.

6. McPherson K and Brown M (2009) Social class and obesity - effects on disease and health service treatment costs. Submission to the Marmot Review.

7. ONS Geography NHS Postcode Directory: 2010 User Guide v3. http://nww.connectingforhealth.nhs.uk/ods/downloads/officenatstats

8. Gordon Waddell and A Kim Burton "Is work good for your health and well-being?" The Stationary Office (2006) http://www.idea.gov.uk/idk/aio/15246941 (Last accessed 27.10.10)

9. Improving health and work: changing lives The Government's Response to Dame Carol Black's Review of the health of Britain's working-age population (November 2008). http://www.dwp.gov.uk/docs/hwwb-improving-health-and-work-changing-lives-large-print.pdf (Last accessed 27.10.10)

10. "Valuing Health: developing a business case for health improvement" produced for the Improvement and Development Agency in 2009

11. www.dh.gov.uk/en/Publicationsandstatistics/publications/PublicationsPolicyAndGuidance/DH_115113

12. The Organised Efforts of Society: the role of the voluntary sector in improving the health of the population. A report by the ACEVO Commission on Public Health. 2010. www.acevo.org.uk

13. How to deliver high-quality, patient-centred, cost-effective care: Consensus solutions from the voluntary sector published through the Kings Fund in September 2010.

14. Living Well Across Local Communities: prioritising wellbeing to reduce inequalities. 2010. NHS North West. www.nwph.net/nwcthw

15. http://www.neweconomics.org/projects/five-ways-well-being (Last accessed 27.10.10)

16. A glass half-full: how an asset approach can improve community health and well-being. 2010. Improvement and Development Agency. http://www.idea.gov.uk/idk/aio/18410498 (Last accessed 27.10.10)

17. www.hm-treasurey.gov.uk/spend_index.htm (Last accessed 27.10.10)

Notes

Living Well in Cheshire East

a call to action

If you or someone you know would like a copy of this report in a different format (ie: braille, audio, large print, different language) please call 0800 5877 888.

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