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Foreword

Annual Public Health Report 2009
I am delighted to be able to introduce the 2009 Annual Public Health Report for Central and Eastern Cheshire Primary Care Trust (CECPCT).

The Report is designed to help the 52 practices and three Practice Based Commissioning (PBC) groups across the Primary Care Trust (PCT) to identify the needs of their communities.

It sets out information on the health of the population of each practice as well as describing trends in healthcare activity by practice, between the PBC groups and across the PCT. It also provides an in-depth analysis of alcohol misuse, one of the major emerging health risks to the local population.

PBC was introduced in 2005 with the intention of putting primary care clinicians at the heart of service planning, redesign and commissioning so as to achieve the goals of ‘better clinical engagement, better services for patients and better use of resources’.

A number of national initiatives and bodies (the NHS Next Stage Review,2 the Audit Commission,3 the King’s Fund,4 the National Primary Care Research and Development Centre5 and the NHS Confederation6) have acknowledged that PBC has not yet delivered the vision of the original policy. The overall conclusion of these reviews is not to change policy but to reinvigorate PBC as a core part of PCTs and general practice work.

The ambition of this Public Health Report is to contribute to CECPCTs ‘reinvigoration’ by supporting one of the key objectives of PBC, ‘to increase the involvement of primary care clinicians in identifying the needs of their local communities’.

The report does not seek to explain fully all of its findings but asks PBC groups and practices to look at the information, review all the possible causes of the differences across the PBC and PCT and consider the suggested recommendations in light of their local knowledge and findings.

It must be re-emphasised that none of the data in this report reflects practice or PBC group ‘performance’. Many factors contribute to the differences described. The report should be used as a stimulus for discussion within practices and as a tool to engage communities, whose priorities may differ from those outlined. Only then will we be able to say that health needs are being fully addressed.

I would like to extend my thanks to all those who have all contributed to this comprehensive report, with a special mention to Jane Branson, the Editor and Sara Deakin who provided the data and intelligence support.

Dr Heather Grimbaldeston
Director of Public Health
References

Introduction

Annual Public Health Report 2009
Practice Based Commissioning (PBC) was introduced in 2005 with the intention of putting primary care clinicians at the heart of service planning, redesign and commissioning so as to achieve the goals of ‘better clinical engagement, better services for patients and better use of resources’.  

A PBC group is comprised of a number of general practices that have joined together to form a consortium, or cluster, in order to work towards the three common goals above. They do this by commissioning local health services; being the leaders of local health service re-design both in the community and in hospital settings; and being in control of their indicative budgets.

Early policy statements made it clear that whilst more decision making was to take place at a practice level this was not an invitation for individual practices to develop their own services/special interests in isolation and that practices, PBCs and Primary Care Trust’s (PCTs) must work in genuine partnership. More recently World Class Commissioning and the ‘Darzi’ NHS Next Stage Review have re-emphasised the importance of clinicians in effective strategic commissioning.

Figure 1 The Commissioning Cycle

The aim of the policy shift towards PBC was to effect an improvement in the health of the population through locally sensitive and outcome based commissioning. There is, however, a general consensus nationally that:

‘PBC has largely failed to capture the imagination of clinicians, NHS managers and the general public’ and that PCT’s and consortia need to ‘look again at the strengths and weakness of existing practice based commissioning arrangements and to explore how the policy can be re-invigorated.’  

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Introduction: Annual Public Health Report 2009
Locally PBC continues to evolve across Central and Eastern Cheshire Primary Care Trust (CECPCT) with three PBC groups in East Cheshire, South Cheshire and Vale Royal. A balance is currently being struck between local PBC group needs and priorities and cross PBC group working on PCT wide priorities.

The intention of the 2009 Annual Public Health Report is to support further development and re-invigoration of PBC in CECPCT. It is the start of setting out information on local health needs, healthcare activity and its costs by practice as well as providing some recommendations to inform decision making and to provide evidence to underpin World Class Commissioning.

The beginnings of this is to direct focus towards the:
• largest issues affecting the health of the local population
• the variation in the use of healthcare provision and;
• the differences in health experience of practice and PBC groups populations

This report does not seek to explain the observed patterns but asks PBC's and practices to look at this information, review all the possible causes of the variations across the PBC and PCT and assess the suggested recommendations in light of their findings.

Beyond this report there will be further work to continue to shape PBC priorities, increase quality and the choice of services closer to patients homes to ultimately reduce demand and associated costs. This is essential as underpinning the policy of PBC is the view that the face of healthcare needs to change from one which largely responds to ill health to one focusing on disease prevention and self managed care. This view is at the heart of the public health agenda.

The key to the success of PBC will be the reduction of health and care service demand and costs through the development of commissioning models which shifts resources from acute hospital care to a health improvement centred model of community care closer to the home. PBC is well placed to be the vehicle to move the health economy to the Wanless fully engaged scenario of:

‘…levels of public engagement in relation to their health are high. Life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.’

Delivery of this vision depends on many factors, as highlighted in Appendix One. As in any commissioning process, however, up to date detailed local information about local need is essential. This report and the linked Joint Strategic Needs Assessment (JSNA) provides this for the populations covered by the PCT.

This report complements the Cheshire East JSNA, which has been undertaken by the PCT and Cheshire East Unitary Authority as a legal duty. The JSNA is a shared statement on the health and social care needs of the population living in the Cheshire East authority geographic area. The JSNA is still in its early stages and is an ongoing continuous process.
The similarities between the JSNA and the 2009 Annual Public Health Report are that they both aim to identify the health and wellbeing needs of the local population; provide information which can be used in the planning, development and delivery of services and contribute to reducing health inequalities. The differences are that the JSNA is based on the population of Cheshire East whilst this report specifically focuses on PBC population groups, provides detailed information for each practice and provides PBC and PCT wide benchmarking data. It should be noted that the Vale Royal PBC group is geographically located in the new Cheshire West & Chester Unitary Authority. The JSNA for that area has been undertaken by this unitary authority and NHS Western Cheshire.

The information in the JSNA together with the content of this report, and subsequent updates to the Technical Appendix will help PBC groups engage with:
- Cheshire East Unitary Authority
- Cheshire West & Chester Unitary Authority
- the new Local Strategic Partnerships (LSPs) and;
- relevant Local Area Partnerships (LAPs) (localities smaller than the LSPs - there will be seven within Cheshire East Unitary Authority and two relevant LAPs within Cheshire West & Chester Unitary Authority)

This should lead to joint working and the PBCs contributing to future development of Local Area Agreements (LAA).

Chapter One of this report gives an overview of the whole population of Central and Eastern Cheshire and the main health issues affecting them.

Chapter Two focuses on the health of the resident registered patient population in the PBC groups with brief comparisons between the differences in the PBC groups and finishing with recommendations identifying key areas of development for the three PBC groups.

Chapter Three is based on the topic of alcohol. Alcohol harm reduction is a vital area in improving the health outcomes of key target groups. It is a potential area that PBC groups can work collaboratively with local partners to influence positive changes in alcohol consumption.

Chapter Four looks at local variations in demand for hospital services and illustrates a preliminary analysis of a number of selected primary and secondary care indicators, identifying ‘outliers’ in each PBC group which can be used to inform discussions with practices.

Chapter Five focus on health inequalities and practice funding in CECPCT and is a response to concerns expressed publicly that the PCT was one of the top 10 PCTs with the ‘strongest tendency to underfund poor practices’. The chapter outlines analysis using both a wider range of data sources and more directly available data and identifies that CECPCT does not under fund practices from more deprived areas.

The Report ends with an overview of recommendations from each chapter and a Technical Appendix providing more detailed information about individual practices and PBC groups.
For PBC groups to be truly health improving organisations they will have to understand the health needs of the local population, both from a data and information perspective and from taking into account patient views. There is a need for a focused drive to improve quality which includes engaging patients who are accessing services sub-optimally or not at all, and to support and champion the use of evidence based disease prevention and health promotion resources and services. PBC groups will also need to promote and support a self care approach and establish closer working partnerships with various organisations on issues that cross cut statutory agency priorities. Working together will produce solutions and impact on better health outcomes, such as in the case of alcohol harm reduction.

It must be re-emphasised that none of the data in this report reflects practice or PBC group ‘performance’. Many factors contribute to the differences described across the PCT footprint. The report should be used as a stimulus for discussion within practices and as a tool to engage communities, whose priorities may differ from those outlined. Only then will we be able to say that the health needs of the population are being fully addressed.

References
8 NHS Confederation 2008.
10 Local Government Review from 1st April 2009 creates the new Cheshire East Authority, a unitary authority, which covers the foot print of Congleton, Crewe & Nantwich and Macclesfield. Vale Royal Borough Council and hence Vale Royal PBC will sit in the newly created Cheshire West and Chester Authority.
Central and Eastern Cheshire Primary Care Trust (CECPCT) has the fastest growing ageing population in the North West of England.

The population of CECPCT has one of the highest life expectancy rates in the North West and a slightly higher life expectancy rate than the England average, however this masks the gaps in life expectancy rates in individual towns.

Linked to life expectancy and health inequalities cardiovascular disease (CVD) and cancer are the greatest cause of early death within CECPCT.

Smoking is one of the highest contributors to morbidity and early death. CECPCT smoking rates are similar to the England average however rates are significantly higher in Crewe, Winsford and Northwich.

Reported levels of binge drinking amongst adults in CECPCT is higher than the national average, with levels reported as 23% higher in Crewe & Nantwich Borough. Hazardous drinking is significantly worse than England and the North West and averages 7th highest in the country. The cost of emergency admissions for alcohol are growing by over £1m per year.

Current estimates of the prevalence of obesity suggest that 23.3% of the adult population of CECPCT are obese which is equivalent to the England average, with significant variation from town to town.

In the CECPCT area more than one in five 4-5 year olds are overweight or obese and more than one in three 10-11 year olds are overweight or obese. This is significantly better than the national average.

Breastfeeding initiation rates are lower than the national average and are much lower than those Primary Care Trust’s (PCTs) with similar populations (60% v 77%).

Uptake of vaccination in CECPCT is generally good however measles, mumps and rubella (MMR) vaccination has been historically low over the past 10 years and has led to sporadic outbreaks of disease, with a recent significant outbreak of measles between October 2008 and January 2009.

There is a high rate of teenage conception with approximately 50% leading to abortions. Crewe & Nantwich has the highest rate of teenage pregnancy at 43.9 per 1,000.

The increase in the number of older people and those with health conditions that reduce independence will result in a proportionate increase in the number of fallers (26,040 by 2011) and associated fractures (1,302 by 2011) in those aged 65 and over.

The numbers of emergency ambulance call outs within CECPCT due to a fall are significant (6,332 in 2007). The cost to the PCT for ambulance call related to falls is approximately £2 million per annum.

The number of admissions to hospital for fractured proximal femur is just slightly above (2%) the England rate in 2006/07.

Within CECPCT 17% of the population report having a limiting long-term illness which will increase roughly in line with the growing ageing population.
Our Population
Central and Eastern Cheshire Primary Care Trust (CECPCT) has a population of 453,000 residents spread over rural and urban communities. Figure 1.1 illustrates that the PCT has fewer young adults and a correspondingly higher proportion of people in all age groups over forty than the national age distribution.

Figure 1.1 Population Pyramid for Central and Eastern Cheshire Primary Care Trust

Source: Exeter download mid 2008 for CECPCT residents

CECPCT has the fastest growing ageing population in the North West. The overall population is predicted to increase by 16% (70,200 people) by 2031. Over 80% of the overall increase is predicted to occur in those aged 65 and over. Initially the population aged under 44 is predicted to decline but all age groups will increase over the total time period from 2006 to 2031.

Some of our towns have experienced recent migration from Eastern European countries however this is a constantly changing picture as the national and international economic situation shifts. The proportion of non-white ethnic groups has risen from 1.6% (7,700) in 2001 to 2.8% (13,600) in 2005. This population is distributed in the urban centres of Wilmslow, Crewe and Winsford as well as a relatively high percentage (1%) in the rural areas surrounding Crewe, Nantwich and Macclesfield.

Birth Projections
Nationally there has been a rise in fertility in all age groups since 2001. Similar increases have also been taking place in CECPCT where between 2002 and 2006 the number of live births rose from 4,413 to 5,064. CECPCT birth rates vary by age; with the highest rates being seen in women aged 25 to 34.
Child and Family Health

Childhood Immunisation
Childhood immunisation uptake is generally good. MMR uptake however has remained at or below 88% for the last seven years. This uptake level has been insufficient to prevent sporadic cases or clusters of disease. Approximately 340 more infants need to be immunised each year to achieve the target uptake of 95% that is required to prevent outbreaks of disease. In 2007 there were 16 notifications of measles, 46 of mumps and 8 of rubella in CECPCT. We have recently had a significant outbreak of measles with approximately 146 notifications of measles between October 2008 and 31st January 2009 and which required a mass immunisation programme to bring under control.

Breastfeeding
Breastfeeding rates are lower than the national average and lower than expected when compared with levels achieved by similar PCTs. CECPCT achieved a 59.5% initiation rate in 2007/08, compared to 76.8% achieved by the best performing PCT within the same Office for National Statistics (ONS) grouping ‘Prospering Smaller Towns (c)’. Breastfeeding significantly reduces occurrences of certain childhood illnesses such as otitis media (ear infection), gastroenteritis, asthma and reduces the likelihood of obesity later on in life. Breastfeeding also protects mothers from a wide range of illnesses such as breast and ovarian cancers, reduction in type 2 diabetes and an increased likelihood of returning to pre-pregnancy weight.

Teenage Pregnancy
The predicted trend in teenage pregnancies means that the 2010 target may not be met. This target is a 50% reduction from the 1998 rate to 20.2 per 1,000 or 179 pregnancies for the PCT. Crewe & Nantwich has the highest rate at 43.9 per 1,000 (or 95 per annum in this borough). Teenage pregnancy shows the traditional links with deprivation, with the deprived wards of Coppenhall, Delamere, Grosvenor, Maw Green and St Barnabas in Crewe all having significantly higher rates of teenage pregnancy. There is a high rate of conceptions leading to abortion (approximately 50%), particularly in Macclesfield and Congleton Boroughs.

Lifestyle
Many of the major causes of premature death are influenced by individual health behaviours and lifestyle issues. A persons decision or ability to adopt and follow a healthy or unhealthy lifestyle is influenced by a number of factors such as social and environmental influences, family income and size, age, area of residence, access to physical activity opportunities and healthy food options as well as the availability and opportunity of cheap alcohol, tobacco and illicit drugs.

PBC clusters can be part of creating healthy local environments by engaging with Local Strategic Partnerships and the Local Area Agreement on areas of primary prevention as well as reducing the burden of ill health caused by lifestyle issues through secondary interventions such as prescribing cholesterol lowering drugs, referring to stop smoking services, and coronary heart disease (CHD) clinics. The main lifestyles issues are outlined as follows:

Tobacco
Smoking remains the greatest preventable causes of morbidity and early death. In England it is estimated that 87,000 people per year die due to smoking related illness. Nationally and locally significant progress has been made to decrease the number of smokers. In CECPCT there are estimated to be around 76,800 adult smokers equating to 20.1% of the adult population compared with the national
average of 21.0\%\textsuperscript{13}. Smoking prevalence is highest in urban areas and appears to be linked to high deprivation. West Coppenhall and Grosvenor Middle Super Output Area (MSOA) in Crewe has an estimated smoking prevalence of 36.2\%, whereas smoking prevalence in the more affluent Adlington and Prestbury areas may be as low as 9.6\% (at MSOA).

Smoking in pregnancy is a particular issue for CECPCT. Our current rate of smoking during pregnancy is 19.6\%. National targets for smoking during pregnancy have been set at 15\% by 2009/10. CECPCT is already carrying out work to address this and further work is planned to make further impacts on this target.

Both the effectiveness and the cost effectiveness of behavioural and pharmacological stop smoking interventions are well documented\textsuperscript{12}. All health professionals and particularly those in primary care have a vital role in assisting smokers to quit, especially through asking patients their smoking status and recording the prevalence of smokers in their practice, advising smokers to quit, referring to specialist stop smoking services and providing encouragement during quit attempts.

More work needs to be done with partnerships to promote the importance of being smoke free, especially in hard to reach communities where a reduction in prevalence of smoking (through less younger people taking up smoking and more smokers quitting), is part of the strategy to close the life expectancy gap.

**Alcohol**

The impact of alcohol misuse in CECPCT occurs at all levels of society and has a major impact on the healthcare system including general practice consultations, attendance at A&E, ambulance call outs, and outpatient and hospital admissions. The chronic effects of alcohol use includes liver cirrhosis, CHD, cancer and stroke. 5.1\% (18,317) of the CECPCT adult population are estimated to be harmful drinkers (drinking above ‘safe limits’ - drinking more than 50 units per week for males or 35 units for females). The reported level of binge drinking amongst adults in CECPCT is 21.4\%, higher than the national average of 18.0\%.\textsuperscript{14} There is further detailed information about the impact of alcohol in CECPCT in Chapter Three. The importance of the health system and in particular primary care in assisting people to moderate the excessive but now normalised alcohol intake is understated.

**Obesity**

In CECPCT children have their height and weight measured within school in Reception Year (aged 4-5) and Year 6 (aged 10-11). In 2007/08 more than one in five of the children measured in reception year were either overweight or obese (20.4\%). In Year 6 children this rate was nearly one in three (29.5\%). This is significantly better than the national average of overweight and obese children in the same comparative age groups.

Current estimates of the prevalence of obesity amongst our adult population suggest that 89,200 (23.3\%) of the adult population of CECPCT are obese, equivalent to the national rate (23.6\%). There is significant variation at town level ranging from 28.3\% in Winsford to 19.5\% in Wilmslow.

Overweight and obesity are complex conditions closely linked to the wider determinants of health. Obesity is responsible for over 30,000 deaths in England each year.\textsuperscript{15} The impact that overweight and obese patients have on local NHS services and resources can be estimated by using National Institute for Health and Clinical Excellence (NICE) Guidance calculations.\textsuperscript{16}
Using the calculation template, it can be estimated that the obese subset of the local CECPCT population is responsible for more than 200,000 extra GP appointments over the expected consultation rates per year. This is the equivalent of 3-4 GP appointments per GP per day, or 5,000 GP appointments per year for a practice of 10,000 patients, or one full time doctor. In addition, this population subset consumes an extra 2% of the total local prescribing budget for all medical conditions, compared to those patients who are classed as having a healthy weight. This equates to £50,000 for a practice of 10,000 patients.

The benefits of health professionals promoting a healthy diet through increased consumption of fruit and vegetables, reduced salt and saturated fat intake is imperative. Almost 70,000 premature deaths could potentially be prevented each year if UK diets matched nutritional guidelines. Encouraging increased physical activity participation would also make a significant difference, as it not only contributes to wellbeing, but is also essential for good health. People who are regularly physically active reduce their risk of developing major chronic diseases such as CHD, stroke and type 2 diabetes by up to 50%, and the risk of premature death by about 20-30%. The estimated direct healthcare cost of physical inactivity to this PCT is £7.5m per annum.

Main Causes of Early Death
Nearly 37% of all deaths within CECPCT are a result of cardiovascular disease (CVD). During the three years from 2005-07 there were 4,780 deaths, approximately 1,600 deaths from CVD per annum. CVD is the biggest contributor to the life expectancy gaps experienced within all CECPCT areas in both males and females (range 25.6% - 48.1%). 26.4% (3,473) of deaths are a result of cancer (1,157 per annum).

Approximately 26% (1,245) of deaths are premature and could be preventable with lifestyle modification. Almost a third (31%) of these premature deaths would be eliminated if the health experience of the worst MSOA were the same as the very best.

Cancer deaths are one of the main causes of death and therefore have a considerable impact on life expectancy. 50% of cancers are preventable with lifestyle modification (smoking, obesity and alcohol), early detection of cancer and improved care.

Life Expectancy
CECPCT has a life expectancy that is just higher than England. The latest data between 2005-07 is indicated in Table 1.1:

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>77.7 years</td>
<td>81.8 years</td>
</tr>
<tr>
<td>North West</td>
<td>76.0 years</td>
<td>80.5 years</td>
</tr>
<tr>
<td>Central and Eastern Cheshire PCT</td>
<td>78.1 years</td>
<td>81.8 years</td>
</tr>
</tbody>
</table>
There are large differences within CECPCT. Life expectancy calculated at MSOA level for 2005-07 showed a gap of:

- **13.5 years in men**
  Range: 71.6 years East Coppenhall (C&N) to 85.1 years Wilmslow Town West

- **15.5 years in women**
  Range: 77.9 years Central and Valley (C&N) to 93.5 years Wilmslow Town South East

The largest gap inside a borough is 14 years for women in Macclesfield.

When 95% Confidence Intervals are calculated there is still a significant difference in males (7.9 years) and females (9.7 years) between the highest and lowest life expectancy.

To inform priority setting and to identify the geographical areas of concern regarding male and female low life expectancy and the factors that influence it, CECPCT has combined MSOA's into five equal groups based on the overall life expectancy. This approach has:

- created a local CECPCT spearhead MSOA group which identifies those MSOA areas where there is low life expectancy for either male or females whose poor health experience will be the focus of further attention and;
- enabled CECPCT, and its partners, to look at the various factors that influence life expectancy such as deprivation, poor lifestyles and access to services

Table 1.2 identifies the CECPCT spearhead MSOA group with male and female life expectancy.

<table>
<thead>
<tr>
<th>MSOA Code</th>
<th>MSOA Name</th>
<th>Male Life Expectancy</th>
<th>Female Life Expectancy</th>
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<tbody>
<tr>
<td>E02003813</td>
<td>Middlewich West</td>
<td>78.8</td>
<td>79.8</td>
</tr>
<tr>
<td>E02003821</td>
<td>Sandbach South</td>
<td>74.3</td>
<td>80.0</td>
</tr>
<tr>
<td>E02003826</td>
<td>East Coppenhall</td>
<td>71.6</td>
<td>78.7</td>
</tr>
<tr>
<td>E02003827</td>
<td>West Coppenhall &amp; Grosvenor</td>
<td>73.0</td>
<td>83.0</td>
</tr>
<tr>
<td>E02003828</td>
<td>St Barnabas</td>
<td>73.6</td>
<td>78.3</td>
</tr>
<tr>
<td>E02003830</td>
<td>Central &amp; Valley</td>
<td>72.2</td>
<td>77.9</td>
</tr>
<tr>
<td>E02003832</td>
<td>St Johns</td>
<td>76.6</td>
<td>79.0</td>
</tr>
<tr>
<td>E02003833</td>
<td>Wistaston Green</td>
<td>78.1</td>
<td>79.5</td>
</tr>
<tr>
<td>E02003834</td>
<td>Alexandra</td>
<td>75.0</td>
<td>81.3</td>
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<td>E02003839</td>
<td>West Nantwich</td>
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<td>80.9</td>
</tr>
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<td>E02003882</td>
<td>Leftwich, Rudheath &amp; Witton</td>
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Patterns of Deprivation and Health Inequalities
Across CECPCT most of the local ‘town’ areas have relatively less people affected by income deprivation than the national average, except in Winsford where it affects both children and older people and in Crewe where children are affected. More significantly, there are three fold percentage differences in income deprivation between our ‘town’ areas. This contributes to poor health and health inequalities which are closely linked to life expectancy.

Figure 1.2 Central and Eastern Cheshire PCT LSOAs by IMD 2007 Quintile with spearhead MSOAs labelled

Our Life in the Northwest (2008) provides a framework to tackle health inequalities. One of its main action points is to improve the quality and quantity of primary care in disadvantaged areas and recommends that practices meet local needs and be well organised, with activity in place to seek out people who already have a disease or are at high risk but are accessing services sub-optimally or not at all. See Appendix Two.

Consequences of Population Ageing
Falls
Falls are common occurrences with increasing age and are strongly associated with chronic/long-term conditions. In the UK falls are the major cause of disability and the leading cause of mortality due to injury in older people aged over 75 years of age. Death rates are higher in men than women. There are significant costs to individuals, their families and public services due to hospitalisation, social care, repeated falls, loss of independence, impaired mobility and isolation.

National evidence predicts that each year 30% of people aged 65 and over and 50% of people aged 80 years and over will fall. Half of these people will fall twice.
Chapter One: Annual Public Health Report 2009

Approximately 10% of all falls in older people will result in an injury of which half will have a fracture with the most common fractures being wrist, spine, hip, humerus and pelvis.

Table 1.3 shows the population forecast for people aged 65 and over in CECPCT and the estimated number of fallers. In 2007 it was estimated that there were 23,601 fallers and of these 2,360 had an injury and half of these had a fracture.

Table 1.3  Forecast of falls for Central and Eastern Cheshire 2007 - 2021

<table>
<thead>
<tr>
<th>Year</th>
<th>Population Forecast 65+</th>
<th>Estimate of Fallers @30%</th>
<th>Falls with injury @10%</th>
<th>Falls with fracture @5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>78,670</td>
<td>23,601</td>
<td>2,360</td>
<td>1,180</td>
</tr>
<tr>
<td>2011</td>
<td>86,800</td>
<td>26,040</td>
<td>2,604</td>
<td>1,302</td>
</tr>
<tr>
<td>2016</td>
<td>100,100</td>
<td>30,030</td>
<td>3,003</td>
<td>1,502</td>
</tr>
<tr>
<td>2021</td>
<td>109,000</td>
<td>32,700</td>
<td>3,270</td>
<td>1,635</td>
</tr>
</tbody>
</table>

National evidence would suggest that approximately 10% of all ambulance call outs are for people aged 65 and over who have fallen, of which approximately 60% are taken to hospital. Figure 1.3 demonstrates the top five ambulance call outs (taken from a spot week comparator) for the North West for November 2007 and November 2008. Falls is the greatest reason for call outs with 14% in 2008 and 13.8% in 2007. This is greater than the nationally suggested 10% ambulance call outs for people over 65.

Figure 1.3  Top 5 Reasons for an Ambulance Call Out in the North West

Local data suggest that around 3,500 to 4,000 older people attend A&E each year as a result of a fall. Out of a total of 55,103 people attending A&E at East Cheshire NHS Trust between April 2007 and March 2008, 1,484 (2.7%) were fallers over the age of 70 and 51% of these were admitted onto a ward, 22% to fracture clinic, A&E review or GP follow up. 20% had no follow up.

Nationally, hospital admission rates increase for accidental falls with increasing age. In England 60% of admissions for falls in 2005/06 were over the age of 65 and 40% were over the age of 80.22

In 2006/07 the England rate of emergency admission for fracture of the proximal femur (all ages) was 100.15 per 100,000 and for CECPCT in the same year it was slightly higher at 102.08 per 100,000. Table 1.4 shows that since 2002/03 the CECPCT rate has been converging with the England rate and has moved from being statistically significantly higher than England in 2002/03 and 2003/04 to just slightly above. A large decline was seen in 2005/06.
Table 1.4  Number of Fractured Proximal Femur

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>CECPCT Rate</th>
<th>England Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>503</td>
<td>102.08</td>
<td>100.15</td>
</tr>
<tr>
<td>2005/06</td>
<td>463</td>
<td>96.15</td>
<td>101.19</td>
</tr>
<tr>
<td>2004/05</td>
<td>516</td>
<td>110.04</td>
<td>101.38</td>
</tr>
<tr>
<td>2003/04</td>
<td>537</td>
<td>115.98</td>
<td>102.67</td>
</tr>
<tr>
<td>2002/03</td>
<td>541</td>
<td>118.23</td>
<td>103.44</td>
</tr>
</tbody>
</table>

Source: nww.nchod.nhs.uk emergency hospital admissions for fractured proximal femur.  
*This data is not available separately for older people and the figures given are for all ages. Indirectly age and sex standardised rate per 100,000 population.

Table 1.5 shows the number of CECPCT emergency admissions to hospital for both females and males receiving timely surgery for a proximal fractured femur. The data suggests that females are more likely to receive timely surgery than males.

Table 1.5  Timely Surgery: fractured proximal femur 2002-2007 CECPCT population

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of admissions</th>
<th>Number with selected procedure within 2 days of admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>2006/07</td>
<td>390</td>
<td>113</td>
</tr>
<tr>
<td>2005/06</td>
<td>345</td>
<td>118</td>
</tr>
<tr>
<td>2004/05</td>
<td>403</td>
<td>113</td>
</tr>
<tr>
<td>2003/04</td>
<td>404</td>
<td>133</td>
</tr>
<tr>
<td>2002/03</td>
<td>404</td>
<td>137</td>
</tr>
</tbody>
</table>

Source: nww.nchod.nhs.uk timely surgery: fractured proximal femur  *This data is not available separately for older people and the figures given are for all ages. Age standardised percentages.

Table 1.6 shows the number of deaths within 30 days of emergency admission to hospital as a result of a fracture of the proximal femur. Nationally, the risk of death following an accidental fall steeply increases with age and is higher in men than women. On average the risk of death following a fracture of the proximal femur is about 10% within 30 days of the fracture and around 30% at one year.22

Table 1.6  Deaths within 30 days of emergency admissions to hospital: fractured proximal femur CECPCT population

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of completed inpatient spells</th>
<th>Number of deaths</th>
<th>Percentage of deaths</th>
<th>Percentages of deaths England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>462</td>
<td>60</td>
<td>12.9%</td>
<td>10.0%</td>
</tr>
<tr>
<td>2004/05</td>
<td>516</td>
<td>43</td>
<td>8.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>2003/04</td>
<td>530</td>
<td>67</td>
<td>12.6%</td>
<td>10.0%</td>
</tr>
<tr>
<td>2002/03</td>
<td>537</td>
<td>51</td>
<td>9.4%</td>
<td>9.9%</td>
</tr>
<tr>
<td>2001/02</td>
<td>500</td>
<td>37</td>
<td>7.4%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

Source: nww.nchod.nhs.uk deaths within 30 days emergency admissions.  *This data is not available separately for older people and the figures given are for all ages.
In 2006/07 there were approximately 1,879 finished consultant episodes linked to a fall (a 7% increase on 2005/06) leading to 24,182 occupied bed days with an average 19.9 days length of stay (a 2% increase on 2005/06). CECPCT had a higher than average length of stay for injury other than fracture and other primary diagnosis of 4.46 days and 18.83 days respectively when compared to neighbouring PCTs.

Many of the risk factors associated with falling can be potentially modified through multi-factorial risk assessments and interventions targeted at those at risk. The most successful are those which address multiple risks which includes exercise programmes, environmental modifications in the home or institution, education programmes, medication reviews and nutritional or hormonal supplementation.

**Long-Term Illness**

Table 1.7 shows the number of people affected by poor health with limiting long-term illness (LLTI) and Table 1.8 shows the number of people aged 65 and over ‘Not in Good Health’ with a LLTI within CECPCT. The numbers will increase roughly in line with the growing ageing population. Of the total population, over 17% have an LLTI. There is variation again between the old local authority districts within CECPCT both for the total population and for those aged 65 or more. Vale Royal has the estimated highest proportions and Macclesfield the lowest.

<table>
<thead>
<tr>
<th>All Age Groups</th>
<th>Total Population in 2005</th>
<th>Not in Good Health and with Limiting Long-Term Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vale Royal</td>
<td>124,600</td>
<td>10,100</td>
</tr>
<tr>
<td>Crewe &amp; Nantwich</td>
<td>113,600</td>
<td>9,000</td>
</tr>
<tr>
<td>Congleton</td>
<td>91,700</td>
<td>6,400</td>
</tr>
<tr>
<td>Macclesfield</td>
<td>150,500</td>
<td>10,000</td>
</tr>
<tr>
<td><strong>4 Districts</strong></td>
<td><strong>480,500</strong></td>
<td><strong>35,500</strong></td>
</tr>
</tbody>
</table>

Source: Cheshire Council, Forecast of Health of Older People (2005-2021)

<table>
<thead>
<tr>
<th>Age Group 65 or more</th>
<th>Total Age 65+ in 2005</th>
<th>Not in Good Health and with Limiting Long-Term Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vale Royal</td>
<td>20,300</td>
<td>4,600</td>
</tr>
<tr>
<td>Crewe &amp; Nantwich</td>
<td>19,100</td>
<td>4,300</td>
</tr>
<tr>
<td>Congleton</td>
<td>15,700</td>
<td>3,200</td>
</tr>
<tr>
<td>Macclesfield</td>
<td>28,500</td>
<td>5,300</td>
</tr>
<tr>
<td><strong>4 Districts</strong></td>
<td><strong>83,600</strong></td>
<td><strong>17,400</strong></td>
</tr>
</tbody>
</table>

Source: Cheshire Council, Forecast of Health of Older People (2005-2021)
Conclusions and Recommendations

This chapter summarizes the size of the major health needs of the local population. Many of the issues raised here will be covered in Chapter Two on the PBC footprint. It is important to note that on a PCT footprint:

- patients receive the same level and quality of service wherever they live and whichever general practice they are registered with
- practices, CECPCT and PBCs work together in genuine partnership to improve local health experience. Innovation in and through PBCs must not widen current inequalities
- identified clusters and groupings in practices can provide leadership on behalf of colleagues particularly in specialist areas of commissioning
- PBC groups should follow the 'Tackling Health Inequalities Locally; a self assessment framework' to assist in addressing health inequalities. See Appendix One

References

12 NICE 2008 - National Institute for Health and Clinical Excellence. NICE Public Health Guidance 10: Smoking cessation services in primary care, pharmacies, local authorities and workplace, particularly for manual working groups, pregnant women and hard to reach groups. NICE. London www.nice.org.uk/guidance/PH10
13 CECPCT 2007 Stop Smoking Service Health Equity Audit. Central and Eastern Cheshire Primary Care Trust
14 North West Alcohol Profiles; 2003-05.
This chapter provides an overview of the health and health needs of Central and Eastern Cheshire Primary Care Trust's (CECPCT) residents who attend general practices within the three Practice Based Commissioning (PBC) groups - East Cheshire, South Cheshire and Vale Royal. This information along with the Technical Appendix can be used to help the groups to achieve 'better clinical engagement, better services for patients, better patient health and better use of resources.' The Technical Appendix should allow practices and PBC groups to accurately benchmark themselves against other practices, PBC and Primary Care Trust (PCT) rates.

Each PBC section gives information about the individual PBC group, with the differences compared with the PCT and key outliers or areas of exception on (i) the population and population trends; (ii) self reported health status; (iii) patient health as defined by life expectancy, all cause mortality and death by major disease; (iv) lifestyles, for example, healthy eating, smoking, alcohol consumption, physical activity and obesity; and (v) patient disease and lifestyle recording within practices comparing what is recorded with what could be expected for the demographics of that PBC and the practices within it.

It should be noted that:
- life expectancy data relates to Middle Super Output Area (MSOA) level (in most instances);
- health deprivation data is at the Lower Super Output Area (LSOA) level;
- lifestyle data is at PBC and PCT level, with a view to look at practice to practice comparison and causes in future publications. This data will be available at MSOA level in the future;
- the data does not include the patients registered with practices who reside outside of the PCT boundaries;
- data is not exhaustive and topic areas, such as child health, sexual health, teenage conceptions, breastfeeding and mental health are not covered due to data currently not being available at practice or PBC group level. This information is available at PCT or Local Authority level in other reports such as the Joint Strategic Needs Assessment. This data at practice and PBC group level will be available when analysis has been completed;
- this is a snap shot and this information will be monitored over time.

The three PBC Groups: East Cheshire, South Cheshire and Vale Royal
The three PBC groups cover a geographical area of Cheshire covering 1,223 sq km, stretching from the southern Pennines in the east and across the central Cheshire plain. It includes both urban and rural areas.

The North East of the PCT, within the East Cheshire PBC group, is a commuter belt for Greater Manchester and contains the affluent towns of Wilmslow, Alderley Edge and Prestbury. Winsford in Vale Royal was an overflow town from Liverpool and Manchester in the 1960’s. All three groups contain post industrial towns such as Macclesfield, Congleton, Northwich, Winsford and Crewe which are regenerating themselves with new industries.
All three have their own areas of deprivation - smaller pockets in East (parts of Macclesfield town, Handforth); a larger area in South (west end of Crewe); the town of Winsford and an area in East Northwich in Vale Royal. All three contain villages still engaged in agriculture and although not designated as areas of deprivation they have their own rural issues such as access to local services and amenities, transport and social isolation.

It should be noted that the PBC groups do not correspond directly with the four former local authority boundaries (Congleton, Crewe & Nantwich, Macclesfield and Vale Royal). Vale Royal is the only one which does not cross a former borough boundary and the PBC group does not cover the whole of the borough of Vale Royal with part of it (Frodsham, Helsby and Tarporley) sitting within a different PCT area (NHS Western Cheshire). It is worth noting that even if the boundaries were coterminous the populations would potentially differ as the building blocks of PBCs are people registered with general practices residing in Cheshire as opposed to persons from defined geographical boundaries.

The local Government Review from 1st April 2009 created a new Cheshire East Unitary Authority, a unitary authority, which covers the foot print of Congleton, Crewe & Nantwich and Macclesfield. Vale Royal Borough Council and hence Vale Royal PBC will sit in the newly created Cheshire West and Chester Unitary Authority.
Geography and Population
The East Cheshire PBC group consists of 23 GP practices with a total practice patient population who are resident within the PCT boundaries of 195,107. The group covers the population bases of:

- Macclesfield
- Congleton
- Knutsford
- Wilmslow and;
- the surrounding rural areas.

Within the geographical boundaries of this PBC group there are three CECPCT spearhead MSOA areas:

- Macclesfield Town Bollinbrook Ivy (Female only)
- Macclesfield Town East (Male only)
- Macclesfield Town South (Male only)

Spearhead MSOA areas are where the life expectancy for either male or females fall within the lowest 20% life expectancy for CECPCT.

There is one GP practice (Handforth Health Centre) which is in the top ten most deprived practices in CECPCT.

Figure 2.1 is a population pyramid for the PBC group. The group has a higher percentage of people in all age groups over 45 than that of the PCT average. This is particularly apparent in the 65 and over age group. In contrast there are fewer younger adults aged between 20 to 35 years and children aged under 5 years than that of the PCT.

Figure 2.1 Population pyramid for East Cheshire PBC Group

Source: Exeter download mid 2008 for CECPCT residents

This pattern can be most clearly seen:

- with the highest percentage of children under 5 for the PBC group in Wilmslow Health Centre at 6.6%. This is only 1.2% higher than the PCT average
Correspondingly:

- the highest percentage (27.7%) of patients in the 65 and over age group is at Hawthorn Lane Practice (Wilmslow), 10.6% higher than the PCT percentage, however being a small practice this equates only to 329 people. Readsmoor Medical Centre (Congleton) has the highest number of patients aged 65 and over at 2,642 people (20.5%)

and

- Broken Cross Surgery (Macclesfield) has the lowest percentage (11.7%) of patients aged 65 and over in the PBC group

**Predicted Population Trends**

Office for National Statistics (ONS) produce projected population estimates by age for local authorities. These have been used to give an indication of the future age structure of the PBC group. Between 2006 and 2016 the number of people aged 65 and over living in (what was) Congleton Borough is set to rise by 6,400. This equates to a 39.8% increase, higher than the predicted increase for England (22.3%). Although the predicted increase in (what was) Macclesfield Borough (22.2%) is slightly lower than the England increase, this still means an additional 6,300 people of pensionable age.

The number of ‘older old’ i.e. people aged 85 and over in both former boroughs is predicted to increase by a higher percentage than England (32.1%). There is a predicted increase of 35.9% for Macclesfield Borough, meaning an additional 1,400 potentially vulnerable people. A further 1,000 people aged 85 and over are predicted for Congleton Borough, a 50% increase on the 2006 figure.

Despite the predicted increases in people of pensionable age the old age dependency ratio for Macclesfield Borough is predicted to increase slightly (2%) and then plateau at 39%. Congleton Borough’s old age dependency ratio is expected to steadily rise from 32% to 42% over the same period.

It should be noted that East Cheshire PBC group (Congleton and Holmes Chapel) and South Cheshire PBC group (Middlewich, Sandbach and Alsager) straddle across Congleton Borough. The predicted population trends are for the whole borough and cannot be split between the two PBC groups.

**Patient Self Reported Health**

By apportioning Census 2001 data on patient self reported health to a GP practice via a patient postcode, estimates have been calculated for each practice. It is important to understand when interpreting that these are not true values.

These estimates suggest that the proportion of patients reporting their health to be ‘Not Good’ over the previous 12 months was 7.8%, compared to 8.5% for the PCT. Within the PBC group there is a minor variation between practices. 9% of patients at both Handforth Health Centre, the most deprived practice within the PBC group, and Annandale Medical Centre (Knutford), the 20th least deprived, report themselves to be in ‘Not Good’ health. This implies that a person’s perception of their health may not necessarily be linked to their experienced level of deprivation and that other lifestyle and external factors, such as poor mental health, may be a more prominent cause.
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16.4% of patients within the PBC group stated they have a Limiting Long-Term Illness (LLTI), slightly lower than that for the PCT average (17.2%). There is not, however, a significant variation between the individual practices or a definite indication that a higher percentage of patients within the most deprived practices reported a LLTI compared to those patients registered with the least deprived. For example:

- 13.9% of patients at The Health Centre (Holmes Chapel), the 22nd least deprived practice, reported having an LLTI.

This compares with:

- 20% of patients at Annandale Medical Centre (Knutsford) the 20th least deprived.

**Patient Health**

**Life Expectancy**

The life expectancy for both male (80.3 years) and female patients (83.4 years) within the PBC group is higher than the PCT (78.1 years and 81.8 years respectively). Although both male and female life expectancy seem to decrease with increasing deprivation the relationship is weak and there are a number of outliers. For example:

- Broken Cross Surgery (Macclesfield) has the lowest male (74.0 years) and female (78.0 years) life expectancy within PBC group, yet it is ranked in the middle in terms of its deprivation.

In comparison:

- male and female patients of Handforth Health Centre, which is the most deprived practice within the PBC group, live an additional 6.7 years and 4.3 years respectively.

There are notable differences in the life expectancy between males and females. For example:

- female life expectancy for patients registered at Broken Cross Surgery (Macclesfield) is 78.0 years compared to 90.6 years at Chelford Surgery. This equates to a life expectancy gap of 12.6 years.

Compared with:

- a life expectancy gap of almost 12.8 years for males across the PBC group. Males registered at Broken Cross Surgery (Macclesfield) have a life expectancy of 74.0 years compared to 86.8 years at Kenmore Medical Centre (Wilmslow).

**All Age All Cause Mortality**

Only Broken Cross Surgery (Macclesfield) at 950.7 per 100,000 (Confidence Interval (CI) 799.3 - 1121.1) has a significantly higher directly standardised rate (DSR) for all age all cause mortality than the PCT (552.9 per 100,000, CI 542.8 - 563.2). This practice has been identified in previous analysis and the high rate is due to the practice being responsible for a nursing home. A further four practices; Lawton House Surgery (Congleton), High Street Surgery (Macclesfield), Park Green Surgery (Macclesfield) and Park Lane House Medical Centre (Macclesfield) all have significantly higher rates than the PBC rate of 502.0 per 100,000 (CI 487.8 - 516.5).
Although the most deprived practice, Handforth Health Centre, has a higher rate at 522.1 per 100,000 than The Health Centre (Holmes Chapel) (369.3 per 100,000), the second least deprived, there is no correlation between all cause all age mortality and deprivation within the PBC.

Deaths by Major Diseases
Figure 2.2 shows the percentage of deaths by major disease categories for the PBC group between 2005 and 2007 compared to the PCT. The percentage split is not dissimilar to that of the PCT.

Figure 2.2 Major causes of death within East Cheshire PBC Group (all persons, all ages)

Of the 5342 deaths in the PBC group over this period, the main causes were:
• circulatory diseases 1,886 (35.3%) (including coronary heart disease (CHD)) 306 (5.7%) and stroke 528 (9.9%)
• cancer 1,443 (27.0%) (including lung 281 (5.3%) breast 108 (2.0%) and colorectal 154 (2.9%)
• respiratory 790 (14.8%)
• digestive 269 (5.0%) (including liver cirrhosis) and;
• external causes 174 (3.3%) (including road traffic accidents and suicide)

The PBC group has a slightly higher percentage of deaths from colorectal, oesophageal and other cancers; respiratory disease and infectious and parasitic diseases.

To understand some of the true differences between the practices the DSR for the main causes of death, all cancers and cardiovascular disease (CVD) have been examined. Standardising enables you to examine different geographies by adjusting for any underlying differences in the populations in terms of age and sex.

Table 2.1 summaries the differences in DSR for all age all cause mortality, CVD and all cancers, showing the highest and lowest practices and whether higher, lower or the same as the PCT.
Further analysis shows that for:

Male CVD all ages:
• there are few statistical differences between the practices. Only Kenmore Medical Centre (Wilmslow) at 131.8 per 100,000 (CI 92.3 - 182.0) is significantly lower than the Macclesfield practices of Park Green Surgery, Cumberland House and Broken Cross Surgery
• Broken Cross Surgery (Macclesfield) (379.8 per 100,000, CI 247.4 - 556.2) has a significantly higher rate than both the PBC group (198.8 per 100,000, CI 185.4 - 212.8) and the PCT (233.8 per 100,000, CI 223.8 - 244.1) rates
• there is no relationship between practice death rates and deprivation

Female CVD all ages:
• no practices are significantly higher than either the PBC group (139.2 per 100,000, CI 129.9 - 148.9) or the PCT (154.2 per 100,000, CI 147.6 - 161.1) rates. There are few statistical differences between the practices. Only Wilmslow Health Centre at 72.8 per 100,000 (CI 40.7 - 118.0) and Alderley Edge Medical Centre at 101.6 per 100,000 (CI 74.5 - 135.0) are significantly lower than Park Green Surgery (Macclesfield) at 183.3 per 100,000 (CI 138.7 - 236.8)
• there is no relationship with deprivation
Male cancer all ages:
• there are no significant differences between most of the practices, however, Annandale Medical Centre (Knutsford) (337.1 per 100,000, CI 240.1 - 459.0) has a significantly higher rate than seven of the other practices within the PBC group as well as being significantly higher than both the PBC group (183.3 per 100,000, CI 170.3 - 197.0) and the PCT (198.3 per 100,000, CI 189.0 - 207.9) rates.
• there is no relationship between practice death rates and deprivation.

Female cancer all ages:
• there are no significant differences between the practices.
• there is no relationship between practice death rates and deprivation.

Examining the percentage of deaths by cause at a practice level may highlight other areas for further analysis.

Lifestyles
In comparison to the PCT rate, estimates indicates that a higher proportion of the PBC group follow a healthy lifestyle. This is demonstrated by higher prevalence rates for healthy ‘Good’ lifestyle indicators - healthy eating (26.8%) and physical activity participation (25.6%) combined with lower prevalence rates of unhealthy ‘Bad’ lifestyle indicators - adults who smoke (17.2%) and who drink excess amounts of alcohol (20.6%). The obesity rate of 21.3% is also lower than the PCT rate.

Within the PBC group, the prevalence of ‘Good’ and ‘Bad’ lifestyle indicators for all practices generally follows the relationship of high deprivation equals poor or ‘Bad’ health. In other words, in comparison to those patients registered with the least deprived practices, the more deprived practices have a higher percentage of patients who smoke, drink excessively and are obese, as well as a lower percentage of patients who achieve healthy eating and physical activity participation guidelines.

Table 2.2 summarises the variation between the practices in regard to patient’s lifestyles - alcohol, healthy eating, obesity, physical activity and smoking and showing whether higher, lower or the same as the PCT. For example, High Street Surgery (Macclesfield) has the highest percentage of smokers (22.6%) and Alderley Edge Medical Practice the lowest (11.0%); however, both are lower than the PCT average.
Table 2.2  Lifestyle Measures

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
</table>
| Alcohol Misuse (as measured by % adults binge drinking) | **Highest:** High Street Surgery, Macclesfield 22.9%  
**Lowest:** The Schoolhouse Surgery, Disley 17.4% | ☺          |
| Healthy Eating (as measured by % adult fruit and veg consumption) | **Highest:** Chelford Surgery, Chelford 31.6%  
**Lowest:** Lawton House Surgery, Congleton 23.4% | ☺          |
| Obesity (as measured by adults with BMI 30+) | **Highest:** Lawton House Surgery, Congleton 24.2%  
**Lowest:** Alderley Edge Medical Practice, Alderley Edge 17.4% | ☺          |
| Physical Activity (as measured by % adults achieving 5 x 30 mins) | **Highest:** Alderley Edge Medical Practice, Alderley Edge 28.2%  
**Lowest:** Lawton House Surgery, Congleton 23.9% | ☻          |
| Smoking (as measured by % adults smoking) | **Highest:** High Street Surgery, Macclesfield 22.6%  
**Lowest:** Alderley Edge Medical Practice, Alderley Edge 11.0% | ☻          |

😊 PBC group is better than PCT average  
😊 PBC group is the same as or similar to PCT average  
😊 PBC group is worse than PCT average

**Expected Disease Prevalence**

Disease prevalence modelling has been used to calculate the expected number of registered CECPCT resident patients in a practice with a particular disease based on that practice’s population structure. It should be noted that the models must be used with caution and can only indicate what would be expected based on a particular population’s characteristics. They cannot definitively say how many cases of a particular disease or risk factor will exist within each practice population.
Table 2.3 shows a comparison of the highest and lowest expected disease prevalence within the PBC group as well as how the PBC group compares to the PCT. For example, Lawton House Surgery (Congleton) has the highest expected prevalence of diabetes at 5.2% and Wilmslow Health Centre the lowest (3.6%).

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td><strong>Highest:</strong> Hawthorn Lane Surgery, Wilmslow 5.8%</td>
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</tr>
<tr>
<td></td>
<td><strong>Lowest:</strong> Broken Cross Surgery, Macclesfield 3.1%</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td><strong>Highest:</strong> Park Lane Surgery, Macclesfield 3.5%</td>
<td>😊</td>
</tr>
<tr>
<td></td>
<td><strong>Lowest:</strong> The Schoolhouse Surgery, Disley 1.8%</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td><strong>Highest:</strong> Lawton House Surgery, Congleton 5.2%</td>
<td>😓</td>
</tr>
<tr>
<td></td>
<td><strong>Lowest:</strong> Wilmslow Health Centre, Wilmslow 3.6%</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td><strong>Highest:</strong> Hawthorn Lane Surgery, Wilmslow 31.0%</td>
<td>😞</td>
</tr>
<tr>
<td></td>
<td><strong>Lowest:</strong> Broken Cross Surgery, Macclesfield 20.9%</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td><strong>Highest:</strong> Hawthorn Lane Surgery, Wilmslow 3.3%</td>
<td>😞</td>
</tr>
<tr>
<td></td>
<td><strong>Lowest:</strong> Broken Cross Surgery, Macclesfield 1.5%</td>
<td></td>
</tr>
</tbody>
</table>

😊 PBC group is better than PCT average
😊 PBC group is the same as or similar to PCT average
😊 PBC group is worse than PCT average

**Case Finding**

Practices record the actual number of patients with a given condition for example, CHD or behaviours such as smoking, in order to produce an observed ‘register’ of those patients with that condition. This can be compared with the ‘expected’ number of patients with a given condition or behaviour, usually calculated using models based on the given characteristics of that area (demographic and social characteristics).

This allows practices to check whether the number of patients they have observed/recorded is what is expected and if it is not then it will inform the practice as to the need to take measures to address this. It also allows practices to benchmark themselves against the PBC group average. For example:

- if the observed number of adults patients who are obese is low compared to what is expected, are practices weighing their patients every 15 months?; if observed CHD rate is higher than the expected what is causing this?
Table 2.4 shows a comparison of the highest and lowest observed/expected case findings within the PBC group as well as how the PBC group compares to the PCT.

### Table 2.4 Observed over Expected Case Finding

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
</table>
| Asthma        | **Highest:** Lawton House Surgery, Congleton 87.1%  
**Lowest:** Bollington Medical Centre, Bollington 35.7% | 😞          |
| CHD           | **Highest:** The Schoolhouse Surgery, Disley 129.6%  
**Lowest:** Alderley Edge Medical Practice, Alderley Edge 68.8% | 😞          |
| COPD          | **Highest:** The Schoolhouse Surgery, Disley 125.0%  
**Lowest:** Alderley Edge Medical Practice, Alderley Edge 23.5% | 😄          |
| Dementia      | **Highest:** Hawthorn Lane Surgery, Wilmslow 107.5%  
**Lowest:** Chelford Surgery, Chelford 12.8% | 😞          |
| Diabetes      | **Highest:** Priorsleigh Medical Centre, Poynton 117.7%  
**Lowest:** Alderley Edge Medical Practice, Alderley Edge 64.9% | 😞          |
| Hypertension  | **Highest:** The Schoolhouse Surgery, Disley 73.5%  
**Lowest:** Park Lane House Medical Centre, Macclesfield 38% | 😞          |
| Learning      | **Highest:** Meadowside Medical Centre, Congleton 31.2%  
**Lowest:** Alderley Edge Medical Practice, Alderley Edge 2.3% | 😞          |
| Disability    | **Highest:** Hawthorn Lane Surgery, Wilmslow 57.8%  
**Lowest:** Park Lane House Medical Centre, Macclesfield 16.6% | 😞          |
| Obesity       | **Highest:** Hawthorn Lane Surgery, Wilmslow 129.0%  
**Lowest:** High Street Surgery, Macclesfield 59.4% | 😞          |

- 😊 PBC group is better than PCT average
- 😐 PBC group is the same as or similar to PCT average
- 😞 PBC group is worse than PCT average

Overall, the PBC group case finding for the main disease groups is under the PCT average observed/expected rate. PBC values are: CHD (86.7%), heart failure (53.8%), stroke (97.5%), diabetes (88.6%), obesity (32.7%) and learning disability (13.5%). When broken down at practice level it can be seen that a number of practices bring down the PBC group average observed/expected rate. For example:
- for CHD, High Street Surgery (Macclesfield) (72.8%), Kenmore Medical Centre (Wilmslow) (74.7%) and Alderley Edge Medical Practice (68.8%) have the lowest observed/expected.
The most likely reasons for practices being under the PCT average observed/expected ratio are patients not being screened/diagnosed, diagnosed but not on a register or not being recorded. The implications of this is that patients are being missed. Where earlier disease detection could have an impact on life expectancy this is important as earlier detection could/would enable patients to make lifestyle choice changes, enable self care and can contribute to better management of long-term conditions and hospital admission avoidance.

Summary
This summary identifies the similarities and differences between the PBC group and the PCT. It should be recognised that in all aspects there are differences across the practices with some above and some below the PBC group and PCT averages.

In comparison with the PCT, East Cheshire PBC group has:
• a higher percentage of people in all age groups over 45. This is particularly apparent in the 65 and over age group
• a lower percentage of younger adults aged between 20 to 35 years
• a lower percentage of children aged under 5 years
• a slightly lower percentage of patients reporting their health to be ‘Not Good’ over the previous 12 months at the time of the 2001 Census
• a slightly lower percentage of patients stating they have a LLTI
• a higher life expectancy
• lower all age all cause mortality rates
• comparable percentages for all the main causes of death
• a higher proportion of the PBC patient population follow a healthy lifestyle
• a higher expected disease prevalence for hypertension and stroke
• lower than expected case recording

In comparison with England, the PBC group has:
• a higher percentage predicted increase of people 65 and over
• a higher than the predicted increase in ‘older old’ i.e. 85 and over

Within the PBC group:
• there is a weak link between life expectancy and deprivation, but with outliers
• the majority of the projected population increase is estimated to come in all age bands 65 and over
• there is no relationship between all age all cause mortality and deprivation
• there is no relationship between death rates and deprivation
• there are three local spearhead MSOA areas and one practice in the top 10 deprived practices in the PCT
• the practice in the top 10 deprived practices in CECPCT is not within a spearhead MSOA area

The PBC group should consider these findings and, along with the Technical Appendix and local knowledge, explore the relationship between the age, disease, deaths and lifestyles of its patient population.

For example, from the provided information above the following conclusions can be made:
• the higher rate of the patient population following a healthy lifestyle will contribute towards the reasons as to why the patient population has a higher life expectancy than the PCT, as well as contributing towards the lower than the
PCT DSR for all age all cause mortality

- the projected increase in the older population will have a significant health impact on the PBC group with possible increases in the number of older people with LLTIs as well as other complex health needs which develop in old age, such as dementia
- life expectancy seems to decrease with increasing deprivation (although the relationship is weak)
- patients with diseases that are preventable, managed and in some cases treated by following a healthy lifestyle for example, hypertension, stroke, CHD and diabetes should be offered targeted lifestyle advice and access to healthy lifestyle services

**Recommendations**

- Practices to analyse their own data and information, develop and implement operational plans to improve health of their own patients against an agreed timetable
- PBC to develop a Commissioning Plan to:
  - continue to improve life expectancy across the PBC
  - address lifestyle choices to improve health across the PBC
  - address issues related to the predicted increase in the ageing population
  - address identified health inequalities and target the populations from spearhead MSOAs and the most deprived practices
  - identify and plan further work to understand children and young family’s health needs and requirements
  - improve data collection in all practices to improve the observed/expected rates
  - develop a working and collaborative relationship with Cheshire East Local Strategic Partnership and share information to assist in the development of future joint plans, and in particular form relationships with relevant Local Area Partnerships
  - ensure achievable and measurable targets are included in each part of the work to improve the health of the patient population
Geography and Population
The South Cheshire PBC group consists of 17 GP practices with a total practice patient population who are resident within the PCT boundaries of 162,800. The group covers the population bases of:
- Crewe
- Nantwich
- Sandbach
- Middlewich
- Alsager and:
  - the surrounding rural areas

Within the geographical boundaries of this PBC group there are 10 CECPCT spearhead MSOA areas:
- Alexandra, Crewe (Male only)
- St Barnabas, Crewe (Male & Female)
- West coppenhall & Grosvenor, Crewe (Male only)
- Central & Valley, Crewe (Male & Female)
- East Coppenhall, Crewe (Male & Female)
- St Johns, Crewe (Female only)
- Wistaston Green (Female only)
- West Nantwich (Female only)
- Middlewich West (Female only)
- Sandbach South (Male & Female)

Spearhead MSOA areas are where the life expectancy for either male or females fall within the lowest 20% life expectancy for CECPCT.

There are four practices, Grosvenor, Delamere, Earnswood and Millcroft (all in Crewe) in the top ten most deprived in CECPCT.

Figure 2.3 is a population pyramid for the PBC group. The PBC group, compared to the PCT average has a higher percentage of young people and adults aged between 10 to 39 years.

Figure 2.3 Population pyramid for South Cheshire PBC Group

This pattern can be most clearly seen:
- with the highest percentage of children aged under 5 for the PBC group at Delamere Surgery (Crewe) at 7.4%. This is reflected in the high child dependency ratio of 30.7% compared to the PBC ratio of 26.7%.
There are variations across the PBC:
- with Merepark Medical Centre (Alsager) having the lowest percentage for children aged under 5 at 3.5% and a child dependency ratio of 22.0%. This is lower than the PCT average of 5.4% and child dependency ratio of 26.7%.

Also:
- The Cedars Medical Centre (Alsager) has the highest percentage of patients aged 65 and over (21.9%), 5.4% higher than the PBC average and 4.8% higher than the PCT average.

In contrast:
- The Acorns Surgery (Middlewich) at 11.9% has the lowest percentage of patients aged 65 and over in the PBC.

**Predicted Population Trends**
Office for National Statistics (ONS) produce projected population estimates by age for local authorities. These have been used to give an indication of the future age structure of the PBC group. Between 2006 and 2016 the predicted increases in people 65 and over in (what was) both Crewe & Nantwich Borough (30.1%) and Congleton Borough (39.8%) are higher than the predicted increase for England (22.3%). This means an additional 6,400 people aged 65 and over in Congleton Borough and an additional 5,800 in Crewe & Nantwich Borough. The number of ‘older old’ i.e. aged 85 and over in both former boroughs is predicted to increase by a higher percentage than England (32.1%). Crewe & Nantwich Borough is predicted to increase by 43.5% meaning an additional 1,000 potentially vulnerable people. A further 1,000 people aged 85 and over are predicted in Congleton Borough, a 50% increase on the 2006 figure.

Despite the predicted increases in people of pensionable age the old age dependency ratio for Crewe & Nantwich Borough is predicted to remain fairly stable at 34% between 2006 and 2016. Congleton Borough’s old age dependency ratio is expected to steadily rise from 32% to 42% over the same period.

It should be noted that South Cheshire PBC group (Middlewich, Sandbach and Alsager) and East Cheshire PBC group (Congleton and Holmes Chapel) straddle across Congleton Borough. The predicted population trends are for the whole borough and cannot be split between the two PBC groups.

**Patient Self Reported Health**
By apportioning Census 2001 data on patient self reported health to a GP practice via a patient postcode, estimates have been calculated for each practice. It is important to understand when interpreting that these are not true values.

These estimates suggest that the proportion of patients reporting their health to be ‘Not Good’ over the previous 12 months was 8.6%, slightly higher than the PCT average of 8.5%. Within the PBC group there is minor variation between practices but practices that are more deprived have higher percentages compared to the least deprived practices. For example, Grosvenor Medical Centre (Crewe) has the highest percentage at 10.2%. This practice is the most deprived practice within the PBC group. The Acorns Surgery (Middlewich), the least deprived practice, has 7.2%.
17.2% of patients within the PBC group stated they have a Limiting Long-Term Illness (LLTI), equivalent to that for the PCT as a whole. Again, increased deprivation results in a higher percentage. Grosvenor Medical Centre (Crewe) is higher at 19.2% and The Acorns Surgery (Middlewich) is lower at 14.3%.

**Patient Health**

**Life Expectancy**
The life expectancy for males (78.1 years) within the PBC group is the same as the PCT overall. Female life expectancy (82.1 years) is slightly higher than the PCT average of 81.8 years. There is a notable difference in the life expectancy between practices for males and females. For example:

- female patients registered at Earnswood Medical Centre, (Crewe) have a life expectancy of 79.9 years compared to 86.9 years at Scholar Green Practice; a gap of 7 years

Compared with:

- male life expectancy at Delamere Surgery (Crewe) is 75.0 years compared to 82.1 years at The Acorns Surgery (Middlewich), equating to a 7.1 year gap

Overall both the male and female life expectancy within the PBC group follows the high deprivation equals lower life expectancy paradigm with no significant deviations. For example

- Delamere Surgery (Crewe) has the lowest male (75.0 years) life expectancy whilst Earnswood Medical Centre (Crewe) has the lowest female (79.9 years) life expectancy and these practices are the second and third most deprived respectively in the PBC group

In comparison:

- The Acorns Surgery (Middlewich) has the highest male (82.1 years) life expectancy and is the least deprived. Scholar Green Surgery has the highest female (86.9 years) and is the second least deprived

**All Age All Cause Mortality**
The Crewe practices of Grosvenor Medical Centre at 703.9 per 100,000 (Confidence Interval (CI) 635.2 - 777.7), Delamere Surgery at 757.2 per 100,000 (CI 669.8 - 852.4) and Earnswood Medical Centre at 752.5 (CI 686.9 - 822.4) all have all age all cause mortality rates significantly higher than the PBC group (586.9 per 100,000, CI 569.0 - 506.1) and PCT (552.9 per 100,000, CI 542.8 - 563.2). Although the least deprived practice of The Acorns (Middlewich) at a rate of 482.5 (CI 379.0 - 604.6) per 100,000 is not significantly lower than the most deprived (Grosvenor Medical Centre (Crewe)), there is a weak relationship with deprivation.

**Deaths from Major Diseases**
Figure 2.4 shows the percentage of deaths occurring in all major disease groups for the PBC group and the PCT between 2005 and 2007.
Figure 2.4 Major causes of death within South Cheshire PBC Group (all persons, all ages)

This shows that of the 4427 deaths within the PBC group during this period:
- 1,613 (36.4%) were attributable to circulatory diseases such as coronary heart disease (CHD) 292 (6.6%) and stroke 416 (9.4%)
- 1,193 (26.9%) were due to cancer such as lung cancer 228 (5.2%), breast cancer 100 (2.3%) and colorectal cancer 130 (2.9%)
- 599 (13.5%) were due to respiratory disease
- 241 (5.4%) to digestive diseases, including liver cirrhosis, and;
- 148 (3.3%) were due to external causes which include road traffic accidents and suicide

The PBC group has a greater percentage of deaths from CHD, breast cancer and digestive diseases than the PCT as a whole and a lower percentage of deaths from respiratory diseases.

To understand some of the true difference between the practices the Directly Standardised rates (DSR) for the main causes of death, cancer and cardiovascular disease (CVD) have been examined. Standardising enables you to examine different geographies by adjusting for any underlying differences in the populations in terms of age and sex.

Table 2.5 summaries the differences in DSR for all age all cause mortality, CVD and all cancers, showing the highest and lowest practices and whether higher, lower or the same as the PCT.
Table 2.5  DSR for All Age All Cause Mortality, CVD and Cancer

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
</table>
| All Age All Cause Mortality DSR | Highest: Delamere Surgery, Crewe 757.2 per 100,000  
Lowest: Kiltearn Medical Centre, Nantwich 481.5 per 100,000 | 🥰         |
| CVD all ages Males DSR      | Highest: Delamere Surgery, Crewe 386.4 per 100,000  
Lowest: The Acorns Surgery, Middlewich 112.6 per 100,000 | 😞         |
| CVD all ages Females DSR    | Highest: Delamere Surgery, Crewe 204.3 per 100,000  
Lowest: Scholar Green Surgery, Scholar Green 101.5 per 100,000 | 😞         |
| Cancer all ages Males DSR    | Highest: Earnswood Medical Centre (Crewe) 304.4 per 100,000  
Lowest - Merepark Medical Centre (Alsager) 153.8 per 100,000 | 😞         |
| Cancer all ages Females DSR  | Highest: Merepark Medical Centre, Alsager 192.3 per 100,000  
Lowest: Ashfields Primary Care Centre, Sandbach 113.0 per 100,000 | 😞         |

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😊 PBC group is worse than PCT average

Further analysis shows that for:

Male CVD all ages:
- only Delamere Surgery (Crewe) (386.4 per 100,000, CI 247.4 - 556.2) has a significantly higher rate than both the PBC group (260.4 per 100,000, CI 242.5 - 279.2) and the PCT (233.8 per 100,000, CI 223.8 - 244.1) rates
- death rates increase with increasing deprivation

Female CVD all ages:
- there is no significant difference between practices
- there is no relationship with deprivation

Male cancer all ages:
- Earnswood Medical Centre (Crewe) (304.4 per 100,000, CI 242.4 - 377.1) has a significantly higher rate than both the PBC group (210.8 per 100,000, CI 197.5 - 228.0) and the PCT (198.3 per 100,000, CI 189.0 - 207.9) rates
- there are few statistical differences between the practices. Only Earnswood Medical Centre (Crewe) is significantly higher than the practices of Rope Green and Kiltearn Medical Centre (Nantwich)
- there is no relationship between practice death rates and deprivation

Female cancer all ages:
- there are no significant differences between the practices
- there is no relationship between practice death rates and deprivation

Examining the percentage of deaths by cause at a practice level may highlight other areas for further analysis.
**Lifestyles**

In comparison to the PCT rate, estimates indicate that a higher proportion of the PBC group follow an unhealthy lifestyle. This is demonstrated by lower prevalence rates for healthy ‘Good’ lifestyle indicators - healthy eating (24.1%) and physical activity participation (22.6%) and a higher prevalence rate of unhealthy ‘Bad’ lifestyle indicators - adults who smoke (21.2%), who drink excess amounts of alcohol (22.1%) and who are obese (24.3%) than the PCT.

Table 2.6 shows a comparison of the highest and lowest prevalence of lifestyle measures within the PBC, identifying practices that have the highest or lowest prevalence of ‘Good’ or ‘Bad’ lifestyle measures within the PBC group as well as indicating how the PBC group compares to the PCT. For example Delamere Surgery (Crewe) has the highest percentage of smokers at 29.2% and Scholar Green Surgery the lowest at 15.4%.

**Table 2.6  Lifestyle Measures**

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
</table>
| Alcohol Misuse (as measured by % adults binge drinking) | Highest: Delamere Surgery, Crewe 25.0%  
Lowest: Scholar Green Surgery, Scholar Green 18.8% | 😞          |
| Healthy Eating (as measured by % adult fruit and veg consumption) | Highest: Merepark Medical Centre, Alsager 27.7%  
Lowest: Grosvenor Medical Centre, Crewe 20.0% | 😞          |
| Obesity (as measured by adults with BMI 30+) | Highest: Grosvenor Medical Centre, Crewe 26.6%  
Lowest: Merepark Medical Centre, Alsager 21.2% | 😞          |
| Physical Activity (as measured by % adults achieving 5 x 30 mins) | Highest: Merepark Medical Centre, Alsager 26.3%  
Lowest: Delamere Surgery, Crewe 19.4% | 😞          |
| Smoking (as measured by % adults smoking) | Highest: Delamere Surgery, Crewe 29.2%  
Lowest: Scholar Green Surgery, Scholar Green 15.4% | 😞          |

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**Expected Disease Prevalence**

Disease prevalence modelling has been used to calculate the expected number of registered patients in a practice with a particular disease based on that practice’s population structure. It should be noted that the models must be used with caution and can only indicate what would be expected based on a particular population’s characteristics. They cannot definitively say how many cases of a particular disease or risk factor will exist within each practice population.
Table 2.7 shows a comparison of the highest and lowest expected disease prevalence within the PBC group as well as how the PBC group compares to the PCT. For example Tudor Surgery (Nantwich) has the highest expected prevalence of CHD at 5.3% and The Acorns Surgery (Middlewich) the lowest at 3.2%.

Table 2.7  Expected Disease Prevalence

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td><strong>Highest:</strong> Tudor Surgery, Nantwich 5.3%</td>
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<tr>
<td></td>
<td><strong>Lowest:</strong> The Acorns Surgery, Middlewich 3.2%</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td><strong>Highest:</strong> Earnswood Medical Centre, Crewe 4.0%</td>
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<tr>
<td></td>
<td><strong>Lowest:</strong> Haslington Surgery, Crewe 1.9%</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
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<tr>
<td></td>
<td><strong>Lowest:</strong> The Acorns Surgery, Middlewich 3.3%</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td><strong>Highest:</strong> Cedars Medical Centre, Alsager 28.4%</td>
<td>😊</td>
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<tr>
<td></td>
<td><strong>Lowest:</strong> Millcroft Medical Centre, Crewe 20.7%</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td><strong>Highest:</strong> Tudor Surgery, Nantwich 2.4%</td>
<td>😊</td>
</tr>
<tr>
<td></td>
<td><strong>Lowest:</strong> The Acorns Surgery, Middlewich 1.5%</td>
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</tbody>
</table>

😊 PBC group is better than PCT average  
😊 PBC group is the same as or similar to PCT average  
😊 PBC group is worse than PCT average

Case Finding

Practices record the actual number of patients with a given condition for example, diabetes, COPD, CHD or behaviours such as smoking, in order to produce an observed ‘register’ of those patients with that condition. This is compared with the ‘expected’ number of patients with a given condition or behaviour usually calculated using models based on the given characteristics of that area (demographic and social characteristics).

This allows practices to check whether the number of patients they have observed/recorded is what is expected and if it is not then it will inform the practice as to the need to take measures to address this. It allows also practices to benchmark themselves against the PBC group average. For example:

- if the observed number of adults patients who are obese is low compared to what is expected, are practices weighing their patients every 15 months?; if observed CHD rate is higher than the expected what is causing this?
Table 2.8 shows a comparison of those practices that have the highest or lowest observed over expected rates as well as indicating how the PBC group compares to the PCT.

### Table 2.8 Observed over Expected Case Finding

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asthma</strong></td>
<td><strong>Highest</strong>: Scholar Green Surgery, Scholar Green 76.4%&lt;br&gt;<strong>Lowest</strong>: Delamere Street Surgery, Crewe 50.5%</td>
<td>☺</td>
</tr>
<tr>
<td><strong>CHD</strong></td>
<td><strong>Highest</strong>: Merepark Medical Centre, Alsager 110.8%&lt;br&gt;<strong>Lowest</strong>: The Acorns Surgery, Middlewich 74.6%</td>
<td>☺</td>
</tr>
<tr>
<td><strong>COPD</strong></td>
<td><strong>Highest</strong>: Oaklands Medical Centre, Middlewich 83.4%&lt;br&gt;<strong>Lowest</strong>: Beam St Surgery, Nantwich 21.9%</td>
<td>☹</td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td><strong>Highest</strong>: Delamere Street Surgery, Crewe 57.4%&lt;br&gt;<strong>Lowest</strong>: Tudor Surgery, Nantwich 8.0%</td>
<td>☺</td>
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<tr>
<td><strong>Diabetes</strong></td>
<td><strong>Highest</strong>: Oaklands Medical Centre, Middlewich 131.0%&lt;br&gt;<strong>Lowest</strong>: Kiltearn Medical Centre, Nantwich 84.6%</td>
<td>☺</td>
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<tr>
<td><strong>Hypertension</strong></td>
<td><strong>Highest</strong>: Tudor Surgery, Nantwich 74.5%&lt;br&gt;<strong>Lowest</strong>: Millcroft Medical Centre, Crewe 48.2%</td>
<td>☺</td>
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<tr>
<td><strong>Learning Disability</strong></td>
<td><strong>Highest</strong>: Beam St Surgery, Nantwich 32.9%&lt;br&gt;<strong>Lowest</strong>: Haslington Surgery, Haslington 5.1%</td>
<td>☹</td>
</tr>
<tr>
<td><strong>Obesity</strong></td>
<td><strong>Highest</strong>: Scholar Green Surgery, Scholar Green 58.4%&lt;br&gt;<strong>Lowest</strong>: Haslington Surgery, Haslington 26.3%</td>
<td>☺</td>
</tr>
<tr>
<td><strong>Stroke</strong></td>
<td><strong>Highest</strong>: Merepark Medical Centre, Alsager 136.6%&lt;br&gt;<strong>Lowest</strong>: Haslington Surgery 66.8%</td>
<td>☺</td>
</tr>
</tbody>
</table>

- ☺ PBC group is better than PCT average
- ☹ PBC group is the same as or similar to PCT average
- ☹️ PBC group is worse than PCT average

Overall, the PBC group case finding for the main disease groups is good but is slightly under the PCT average observed/expected rate for COPD (PBC 47.3%, PCT 51.1%) and learning disability (PBC 14.7%, PCT 15.0%). When broken down to practice level a number of practices bring down the PBC observed/expected rate. For example:

- for COPD Nantwich Health Centre at 21.9%, Earnswood Medical Centre (Crewe) at 32.3%, Ashfields Primary Care Centre (Sandbach) at 39.1% and Millcroft Medical Centre (Crewe) at 40.4% have the lowest average observed/expected rate.
There are also stark differences between the highest and lowest average observed/expected rate. For example:

- for dementia Delamere Street Surgery (Crewe) has the highest at 57.4% compared to Tudor Surgery (Nantwich) with the lowest at 8.0%.

The most likely reasons for practices being under the PCT average observed/expected rate could be due to patients not being screened and/or diagnosed, diagnosed but not on a register or recorded. The implications of this is that patients are being missed. Where earlier disease detection could have an impact on life expectancy this is important as earlier detection could/would enable patients to make lifestyle choice changes, enable self care and can contribute to better management of long-term conditions and hospital admission avoidance.

**Summary**

This summary identifies the similarities and differences between the PBC and the PCT. It should be recognised however that in all aspects there are differences across the practices with some above and some below PBC and PCT averages.

In comparison with the PCT, South Cheshire PBC group has:

- a higher percentage of young people and adults aged between 15 to 29 years
- a higher percentage of adults in all age groups over 60 years
- a slightly higher percentage of patients reporting their health to be ‘Not Good’ over the previous 12 months at the time of the 2001 Census
- life expectancy for males is similar
- life expectancy for females is slightly higher
- a lower percentage of deaths from respiratory diseases
- a greater percentage of deaths from CHD, breast cancer, and digestive diseases
- higher proportions of patients follow an unhealthy lifestyle
- good case finding

In comparison with England, the PBC group has:

- a higher than the predicted increase in people aged 65 and over between 2006 - 2016
- higher increase in number of ‘older old’ i.e. aged 85 and over

In addition within the PBC group:

- there is a weak relationship between rates of all age all cause mortality and deprivation
- male CVD death rates increase with increasing deprivation
- a higher expected disease prevalence for COPD
- there are 10 local spearhead MSOA areas (in Crewe, Nantwich, Middlewich and Sandbach)
- there are four practices in the top 10 deprived practices in CECPCT, all in Crewe
The PBC group should consider these findings and, along with the Technical Appendix and local knowledge, explore the relationship between the age, disease, deaths and lifestyles of its patient population.

For example, from the provided information above the following conclusions can be made:

- the projected increase in the older population will have an impact on the PBC group with possible increases in the number of people with long-term conditions and LLTI as well as other complex health needs such as dementia;
- the higher proportions following an unhealthy lifestyle will contribute towards the reasons why patients within the PBC group have a lower life expectancy than the PCT, as well as contributing towards the higher than PCT death rate;
- patients with diseases that are preventable, managed and in some cases treated by following a healthy lifestyle for example, hypertension, stroke, CHD and diabetes should be offered targeted lifestyle advice and access to healthy lifestyle services.

**Recommendations**

- Practices to analyse their own data and information, develop and implement operational plans to improve health of their own patients against an agreed timetable;
- PBC to develop a Commissioning Plan to:
  - continue to improve life expectancy across the PBC
  - address lifestyle choices to improve health across the PBC
  - address issues related to predicted increase in the ageing population
  - address identified health inequalities and target the population from spearhead MSOAs and the most deprived practices
  - identify and plan further work to understand children and young family’s health needs and requirements
  - improve data collection in all practices to improve the observed/expected rates
  - develop a working and collaborative relationship with Cheshire East Local Strategic Partnership (LSP) and share information to assist in the development of future joint plans, and in particular form relationships with relevant Local Area Partnerships
  - ensure achievable and measurable targets are included in each part of the work to improve the health of the patient population
Geography and Population
The Vale Royal PBC group consists of 13 GP practices with a total practice patient population who are resident within the PCT boundaries of 100,965. This group covers the population bases of:

- Winsford
- Northwich and;
- the surrounding rural areas

Within the geographical boundaries of this PBC group there are five CECPCT spearhead MSOA areas:
- East Winsford (Male & Female)
- West Winsford (Male & Female)
- North Winsford (Male only)
- Winsford Central (Male & Female)
- Leftwich, Rudheath & Witton (Male & Female)

Spearhead MSOA areas are where the life expectancy for either male or females fall within the lowest 20% life expectancy for CECPCT.

There are five GP practices (the five practices in Winsford) which are in the top ten most deprived practices in CECPCT.

Figure 2.5 is a population pyramid for the PBC group. The PBC group, as compared to the PCT average, has a higher proportion of children and adults aged up to 44 years of age.

Figure 2.5 Population pyramid for Vale Royal PBC Group

This pattern can be seen:
- where Willow Wood Surgery (Winsford) has the highest percentage of children aged under 5 (7.5%). This is reflected in the high child dependency ratio (32.7%). Willow Wood Surgery (Winsford) also has the lowest percentage of patients aged under 65 (5.9%) and lowest old age dependency ratio (17.3%).

Source: Exeter download mid 2008 for CECPCT residents
In contrast:

- Weaverham Surgery (Weaverham) has the highest percentage of patient aged 65 and over (18.2%) and the highest old age dependency ratio (35.2%) within the PBC group.

Predicted Population Trends
Office for National Statistics (ONS) produce projected population estimates by age for local authorities. These have been used to give an indication of the future age structure of the PBC group. Between 2006 and 2016 the number of people aged 65 and over living in (what was) Vale Royal Borough is set to rise by 7300. This equates to a 35.4% increase, higher than the predicted increase for England (22.3%).

The number of ‘older old’ i.e. aged 85 and over is predicted to increase by a higher percentage than England (32.1%). A further 1,100 people aged 85 and over are predicted for the borough, a 42.3% increase on the 2006 figure.

The old age dependency ratio for Vale Royal Borough is predicted to increase by 4% by 2010 and then remain steady at 35%.

It should be noted that Vale Royal Borough straddles across Vale Royal PBC (Northwich and Winsford) and NHS Western Cheshire (Helsby, Frodsham and Tarporley). The predicted population trends are for the whole borough and cannot be split between the two areas.

Patient Self Reported Health
By apportioning Census 2001 data on patient self reported health to a GP Practice via a patient postcode, estimates have been calculated for each practice. It is important to understand when interpreting that these are not true values.

These estimates suggest that the proportion of patients reporting their health to be ‘Not Good’ over the previous 12 months was 9.4%, higher than the PCT average of 8.5%. Within the PBC group there is little variation between practices. However, practices with high deprivation have higher estimates of self-reported ‘Not Good’ health. For example, the highest estimate at 10.9% occurs at High Street Medical Practice (Winsford), the second most deprived practice within the PBC group. Only 8% of patients registered at Danebridge Medical Practice (Northwich), the third least deprived practice, report their health as ‘Not Good’.

18.6% of patients within the PBC group stated they have a Limiting Long-Term Illness (LLTI), an estimated value higher than that for the PCT as a whole. There is not, however, a significant variation between the individual practices. Deprivation does not appear to influence the response.

For example:

- 18.9% of patients at Launceston Surgery (Winsford), the most deprived practice, reported having an LLTI

This compares with:

- 18.9% of patients at Weaverham Surgery, the least deprived practice, reported having an LLTI
Patient Health

Life Expectancy
The average life expectancy for both male patients (78.0 years) and female patients (81.5 years) within the PBC group are lower than the PCT average (78.1 years and 81.8 years respectively). Overall both the male and female patient populations within Vale Royal PBC group practices follow the lower life expectancy equals high deprivation paradigm with the exception of males at Firdale Practice (Northwich) and females at Riverside Medical Practice (Northwich).

For example:
- High Street Practice (Winsford) has the lowest male (73.5 years) life expectancy and Willow Wood Surgery (Winsford) has the lowest female (78.4 years) life expectancy which are the second and fourth most deprived respectively in the PBC group.

In comparison:
- Firdale Practice (Northwich) has the highest male (80.6 years) life expectancy and Riverside Medical Practice (Northwich) has the highest female (86.4 years) which are the sixth and fifth least deprived respectively.

There is also a notable difference in the life expectancy variation between males and females. For example:
- female life expectancy for patients at Launceston Close Surgery (Winsford) is 80.1 years compared to 83.5 years at Weaverham Surgery which is the least deprived practice in the PBC group;
- male life expectancy for patients at Launceston Close Surgery (Winsford) is 75.5 years compared to 79.0 years at Weaverham Surgery.

All age All Cause Mortality
Both the High Street Practice (Winsford) at 820.5 per 100,000 (Confidence Interval 676.3 - 986.1) and Willow Wood Surgery (Winsford) at 880.1 per 100,000 (CI 713.0 - 1073.8) have significantly higher rates for all age all cause mortality than the PBC group (613.3 per 100,000, CI 589.5 - 637.8) and PCT (552.9 per 100,000, CI 542.8 - 563.2) rates. A further four practices (Swanlow Medical Centre (Winsford), Weavervale Surgery (Winsford), Witton Street Surgery (Northwich) and Middlewich Road Surgery (Northwich) have rates significantly higher than the PCT rate.

Although the least deprived practice of Weaverham Surgery at a rate of 540.9 (CI 467.6 - 621.9) per 100,000 is not significantly lower than the most deprived (Launceston Close Surgery (Winsford)), there is a relationship with deprivation.
Deaths by Major Diseases
Figure 2.6 shows the percentage of deaths occurring in all major disease groups for the PBC group and the PCT between 2005 and 2007.

Of the 2659 deaths in the PBC group over this period the main causes were:
- 1,010 (38.0%) were attributable to circulatory diseases - such as coronary heart disease (CHD) 209 (7.9%) and stroke 244 (9.2%)
- 684 (25.7%) were due to cancer such as lung cancer 161 (6.1%), breast cancer 45 (1.7%) and colorectal cancer 71 (2.7%)
- 377 (14.2%) were due to respiratory disease
- 147 (5.5%) to digestive diseases, including liver cirrhosis, and;
- 94 (3.5%) were due to external causes which include road traffic accidents and suicide

The PBC group shows a higher percentage of deaths from circulatory disease, respiratory disease, lung cancer and digestive diseases than the PCT.

To understand some of the true difference between the practices the Directly Standardised rates (DSR) for the main causes of death, cancer and cardiovascular disease (CVD) were examined. Standardising enables you to examine different geographies by adjusting for any underlying differences in the populations in terms of age and sex.

Table 2.9 summarises the differences in DSR for all age all cause mortality, CVD and all cancers showing the highest and lowest practices and whether higher, lower or the same as the PCT.
Table 2.9  DSR for All Age All Cause Mortality, CVD and Cancer

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Age All Cause Mortality DSR</td>
<td>Highest: Willow Wood Surgery, Winsford 880.1 per 100,000  Lowest: Firdale Practice, Northwich 527.3 per 100,000</td>
<td>😞</td>
</tr>
<tr>
<td>CVD all ages Males DSR</td>
<td>Highest: High Street Medical Practice, Winsford 435.5 per 100,000  Lowest: Firdale Practice, Northwich 204.0 per 100,000</td>
<td>😞</td>
</tr>
<tr>
<td>CVD all ages Females DSR</td>
<td>Highest: High Street Medical Practice, Winsford 292.8 per 100,000  Lowest: Weaverham Surgery, Weaverham 148.7 per 100,000</td>
<td>😞</td>
</tr>
<tr>
<td>Cancer all ages Males DSR</td>
<td>Highest: Willow Wood Surgery, Winsford 341.7 per 100,000  Lowest: Firdale Practice, Northwich 160.9 per 100,000</td>
<td>😞</td>
</tr>
<tr>
<td>Cancer all ages Females DSR</td>
<td>Highest: Willow Wood Surgery, Winsford 246.5 per 100,000  Lowest: Riverside Medical Practice, Northwich 75.5 per 100,000</td>
<td>😞</td>
</tr>
</tbody>
</table>

😊 PBC group is better than PCT average  
😊 PBC group is the same as or similar to PCT average  
😊 PBC group is worse than PCT average

Further analysis shows:
Male CVD all ages:
• there are no significant differences between the practices. Both High Street Practice (Winsford) (435.5 per 100,000, CI 255.7 - 686.6) and Witton Street Surgery (Northwich) (348.1 per 100,000, CI 257.4 - 459.5) have significantly higher rates than the PCT rate (233.8 per 100,000, CI 223.8 - 244.1)  
• there is no relationship between practice death rates and deprivation

Female CVD all ages:
• there is no significant difference between practices  
• there is no relationship with deprivation

Male cancer all ages:
• there are no significant differences between most of the practices. Willow Wood Surgery (Winsford) (341.7 per 100,000, CI 208.2 - 528.2) has a significantly higher rate than the PCT rate (198.3 per 100,000, CI 189.0 - 207.9)  
• there is no relationship between practice death rates and deprivation

Female cancer all ages:
• there are no significant differences between the practices  
• there is no relationship between practice death rates and deprivation

Examining the percentage of deaths by cause at a practice level may highlight other areas for further analysis.
Lifestyles
In comparison to the PCT rate, data indicates a higher proportion of the PBC group patient population follow an unhealthy lifestyle, as demonstrated by lower prevalence rates for healthy ‘Good’ lifestyle indicators - healthy eating (23.7%) and physical activity participation (22.0%) and a higher prevalence rate of unhealthy ‘Bad’ lifestyle indicators - adults who smoke (24.0%), who drink excess amounts of alcohol (22.5%) and who are obese (25.7%).

Within the PBC group, the rate of ‘Good’ prevalence and ‘Bad’ prevalence for lifestyle indicators for all practices follows the relationship of high deprivation equals poor or ‘Bad’ health. In other words, in comparison to those patients registered with the least deprived practices, the more deprived practices have a higher percentage of patients who smoke, drink excessively and are obese, as well as lower percentage of patients who achieve healthy eating and physical activity participation guidelines.

Table 2.10 summarises the variation between the practices in regard to patient's lifestyles - alcohol, healthy eating, obesity, physical activity and smoking. For example, Willow Wood Surgery (Winsford) has the highest percentage of smokers (29.0%) and Danebridge Medical Practice (Northwich) the lowest (18.7%).

Table 2.10  Lifestyle Measures

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
</table>
| Alcohol Misuse (as measured by % adults binge drinking) | Highest: Launceston Surgery, Winsford 24.3%  
Lowest: Weaverham Surgery, Weaverham 19.3% | 😞         |
| Healthy Eating (as measured by % adult fruit and veg consumption) | Highest: Danebridge Medical Practice, Northwich 27.6%  
Lowest: Willow Wood Surgery, Winsford 20.3% | 😞         |
| Obesity (as measured by adults with BMI 30+) | Highest: Willow Wood Surgery, Winsford 28.8%  
Lowest: Weaverham Surgery, Weaverham 22.6% | 😞         |
| Physical Activity (as measured by % adults achieving 5 x 30 mins) | Highest: Danebridge Medical Practice, Northwich 24.8%  
Lowest: Willow Wood Surgery, Winsford 19.8% | 😞         |
| Smoking (as measured by % adults smoking) | Highest: Willow Wood Surgery, Winsford 29.0%  
Lowest: Danebridge Medical Practice, Northwich 18.7% | 😞         |

😊 PBC group is better than PCT average  
🙂 PBC group is the same as or similar to PCT average  
😞 PBC group is worse than PCT average
Expected Disease Prevalence

Expected disease prevalence modelling has been used to calculate the expected number of registered patients in a practice with a particular disease based on that practice’s population structure. It should be noted that the models must be used with caution and can only indicate what would be expected based on a particular population’s characteristics. They cannot definitively say how many cases of a particular disease or risk factor will exist within each practice population.

Table 2.11 shows a comparison of the highest and lowest expected disease prevalence between practice and whether it is above, the same or below the PCT average.

For example, Danebridge Medical Centre (Northwich) has an expected disease prevalence for diabetes of 5.2%, the highest in the PBC group and Willow Wood Surgery (Winsford) has the lowest at 3.2%.

Table 2.11 Expected Disease Prevalence

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
</table>
| CHD  | Highest: Weaverham Surgery, Weaverham 5.0%  
      | Lowest: Willow Wood Surgery, Winsford 3.2% | 😞 |
| COPD | Highest: Weavervale Surgery, Winsford 4.0%  
      | Lowest: Swanlow Medical Centre, Winsford 2.3% | 😞 |
| Diabetes | Highest: Danebridge Medical Centre, Northwich 5.2%  
      | Lowest: Willow Wood, Winsford 3.2% | 😞 |
| Hypertension | Highest: Weaverham Surgery, Weaverham 26.5%  
      | Lowest: Willow Wood Surgery, Winsford 18.3% | 😊 |
| Stroke | Highest: Weaverham Surgery, Weaverham 2.3%  
      | Lowest: Willow Wood Surgery, Winsford 1.1% | 😊 |

😊 PBC group is better than PCT average  
😊 PBC group is the same as or similar to PCT average  
😊 PBC group is worse than PCT average

Case Finding

Practices record the actual number of patients with a given condition, for example, COPD, CHD or behaviours such as smoking in order to produce an observed ‘register’ of those patients with that condition. This is compared with the ‘expected’ number of patients with a given condition or behaviour based on the given the characteristics of that area (demographic and social characteristics).

This allows practices to check whether the number of patients they have observed/recorded is what is expected and if it is not then it will inform the practice as to the need to take measures to address this. It also allows practices to benchmark themselves against the PBC group average. For example:

- if the observed number of adults patients who are obese is low compared to what is expected, are practices weighing their patients every 15 months?; if observed CHD rate is higher than the expected what is causing this?
Chapter Two: Annual Public Health Report 2009

### Table 2.12 Observed over Expected Case Finding

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Features</th>
<th>PBC vs PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Highest - Launceston Surgery, Winsford 81.7%</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>Lowest - Watling Street Surgery, Northwich 45.6%</td>
<td>☹️</td>
</tr>
<tr>
<td>CHD</td>
<td>Highest - Weaver Vale Surgery, Winsford 115.6%</td>
<td>☹️</td>
</tr>
<tr>
<td></td>
<td>Lowest - Oakwood Medical Centre, Northwich 72.3%</td>
<td>☑️</td>
</tr>
<tr>
<td>COPD</td>
<td>Highest - Swanlow Medical Centre, Winsford 105.9%</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>Lowest - Watling Street Surgery, Northwich 33.8%</td>
<td>☹️</td>
</tr>
<tr>
<td>Dementia</td>
<td>Highest - High Street Medical Practice, Winsford 68.8%</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>Lowest - Willow Wood Surgery, Winsford 16.0%</td>
<td>☹️</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Highest - Launceston Surgery, Winsford 124.0%</td>
<td>☹️</td>
</tr>
<tr>
<td></td>
<td>Lowest - Riverside Medical Practice, Northwich 68.7%</td>
<td>☑️</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Highest - Weaver Vale Surgery, Winsford 73%</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>Lowest - Willow Wood Surgery, Winsford 43.4%</td>
<td>☹️</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>Highest - Weaver Vale Surgery, Winsford 29.4%</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>Lowest - Watling Street Surgery, Northwich 6.4%</td>
<td>☹️</td>
</tr>
<tr>
<td>Obesity</td>
<td>Highest - Middlewich Road Surgery, Northwich 66.4%</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>Lowest - Oakwood Medical Centre, Northwich 29.6%</td>
<td>☑️</td>
</tr>
<tr>
<td>Stroke</td>
<td>Highest - High Street Medical Practice, Winsford 121.8%</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>Lowest - Watling Street Surgery, Northwich 45.6%</td>
<td>☹️</td>
</tr>
</tbody>
</table>

- ☑️ PBC group is better than PCT average
- ☑️ PBC group is the same as or similar to PCT average
- ☹️ PBC group is worse than PCT average

Overall, the PBC group case finding for the main disease groups is good but asthma (61.7%), CHD (89.7%), diabetes (90.7%) and stroke (94.0%) are all slightly under the PCT average observed/expected rate for . When broken down to practice level a number of practices bring down the PBC group average observed/expected rate. For example:

- for asthma, Watling Street Medical Practice (Northwich) (45.6%), Oakwood Medical Centre (Barnton) (48.9%) and Riverside Medical Practice (Northwich) (50.1%) have the lowest average observed/expected rate

There are also stark differences between the highest and lowest average observed/expected rate. For example:

- for dementia, High Street Medical Centre (Winsford) has the highest 68.8% compared to Willow Wood Surgery (Winsford) lowest at 16.0%
The most likely reason why practices are under the PCT average observed/expected rate could be due to patients not being screen/diagnosed, diagnosed but not on a register or recorded. The implications of this is that patients are being missed. Where earlier disease detection could have an impact on life expectancy, this is important as earlier detection could/would enable patients to make lifestyle choice changes, enable self care and can contribute to better management of long-term conditions and hospital admission avoidance.

Summary
This summary identifies the similarities and differences between the PBC group and the PCT. It should be recognised however that in all aspects there are differences across the practices with some above and some below PBC group and PCT averages.

In comparison with the PCT, Vale Royal PBC group has:
- a higher proportion of children aged under five years of age
- a higher proportion of young children and adults aged between 10 to 29 years
- a higher proportion of adults in all age groups over 60
- a higher than the PCT average of patients reporting their health to be ‘Not Good’ over the previous 12 months at the time of the 2001 Census
- a higher proportion of patients stating they have a LLTI
- a lower life expectancy
- a higher percentage of deaths from circulatory disease, respiratory disease, lung cancer and digestive diseases
- a higher disease prevalence for COPD and diabetes
- a higher proportion of patients following an unhealthy lifestyle
- good overall case finding

In comparison with England, the PBC group has:
- a higher percentage predicted increase of people aged 65 and over
- a higher increase of ‘older old’ i.e. aged 85 and over

Within the PBC group:
- there is a relationship between lower life expectancy and high deprivation practices have significantly higher DSR for all age all cause mortality
- there is a relationship between high DSR for all age all cause mortality with deprivation
- there are five local spearhead MSOA areas and five practices in the top 10 deprived practices in the CECPCT, all in Winsford

The PBC group should consider these findings and along with the Technical Appendix and local knowledge explore the relationship between the age, disease, deaths and lifestyles of its patient population. For example, from the provided information above the following conclusions can be made:
- the projected increase in the older population will have an impact on the PBC group with possible increases in the number of people with long-term conditions, LLTI as well as other complex health needs such as dementia
- the higher proportions following an unhealthy lifestyle will contribute towards the reasons why patients within the PBC group have a lower life expectancy than the PCT, as well as contributing towards the higher than PCT death rate
- patients with diseases that are preventable, managed and in some cases treated by following a healthy lifestyle for example, hypertension, stroke, CHD and diabetes should be offered targeted lifestyle advice and access to healthy lifestyle services
Recommendations

- Practices to analyse their own data and information, develop and implement operational plans to improve health of their own patients against an agreed timetable

- PBC to develop a Commissioning Plan to:
  - continue to improve life expectancy across the PBC
  - address lifestyle choices to improve health across the PBC
  - address issues related to predicted increase in the ageing population
  - address identified health inequalities and target the population from spearhead MSOAs and the most deprived practices

- identify and plan further work to understand children and young family’s health needs and requirements

- improve data collection in all practices to improve the observed/expected rates

- develop a working and collaborative relationship with Cheshire West and Chester Local Strategic Partnership. Share information to assist in the development of future joint plans, in particular form relationships with Local Area Partnerships

- ensure achievable and measurable targets are included in each part of the work to improve the health of the patient population
Chapter Two identified a number of lifestyle choices, including alcohol, which have an impact on the health of an individual. Alcohol is enjoyed by many people with few, if any, ill effects. Problem drinking however, is increasing in our society and it creates both health and social effects. This chapter explores in more detail alcohol consumption and the impact this choice has on health.

Definitions

**Sensible drinking** is drinking in a way that is unlikely to cause harm either to the drinker or to other people. Current advice is that:

- adult women should not regularly drink more than 2-3 units \(^{25}\) of alcohol a day
- adult men should not regularly drink more than 3-4 units of alcohol a day
- pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby they should not drink more than 1-2 units of alcohol once or twice a week and should not get drunk

**Binge drinking** involves drinking too much alcohol over a short period of time, typically leading to drunkenness. It has immediate and short-term risks to the drinker and to those around them. It is defined as consuming more than twice the recommended maximum amount of alcohol, which is 6 units for women and 8 units for men.\(^ {26}\)

**Hazardous drinking** occurs when people consume alcohol at levels between sensible and harmful drinking. This is between 15-35 units per week for women and 22-50 units per week for men.

**Harmful drinking** leads to significant damage to physical and mental health. Women who regularly drink 6 or more units a day (over 35 units a week) and men who regularly drink 8 or more units a day (over 50 units a week) are at risk of alcohol-related harm.

Alcohol is recorded as one of the five leading causes of disease and injury in Europe and is responsible for 7% of the overall disease burden. Irrespective of the direct effects of intoxication and addiction, alcohol causes around half of the disease burden from cirrhosis of the liver, oesophageal cancers and epilepsy and around a third of the disease burden from liver cancers, road traffic accidents, hypertensive disease and homicide.

Recent decades have seen a shift in social norms and levels of alcohol consumption have risen due to a number of factors including increased availability, decrease in retail price and diversity of products. The consumption of alcohol within the home is also of concern. More alcohol is being bought from off-licences as opposed to public houses.\(^ {27}\)

Alcohol consumption by young people increased significantly during the 1990’s, but this trend has recently reversed and the proportion of young people aged 11-15 who have never drunk alcohol has risen from 38% to 46% between 2001 and 2006. Although the proportion of young adolescents who are drinking has declined in recent years, those who do drink are consuming more alcohol, more often.\(^ {28}\)
Central and Eastern Cheshire Primary Care Trust (CECPCT) Position

Out of all the 152 Primary Care organisations in England, CECPCT currently ranks 108th for binge drinking, 146th for hazardous drinking and 73rd for harmful drinking (where rank 1 is the lowest value and rank 152 the highest).29

Within CECPCT:
- the binge drinking level is high but is slightly better than the North West level
- hazardous drinking is significantly worse than both the England and North West averages and is the seventh highest rate in the country
- the level of harmful drinkers is comparable to the England average and significantly better than the North West average

Figure 3.1 demonstrates the percentage prevalence of binge, hazardous and harmful adult drinkers by the former borough council areas that were within CECPCT geographical boundaries.

Table 3.1 demonstrates the estimated number of problem drinkers by borough area.

In each of these local authority areas, 29% of adults drink too much alcohol (hazardous plus harmful) compared to 25% of adults nationally. In total 24-25% (95,000 people) drink excessively but not harmfully, with an additional 4-5% (20,000 people) drinking at harmful levels.
Hospital Admissions for Alcohol Related Harm

Local health services and their partners such as local authorities are now required to work together to deliver better services with improved outcomes for local people. Progress is assessed using a set of National Indicators (NI), one of which (NI 39) measures the age-standardised rate of admissions to hospital for alcohol related harm per 100,000 population.

The number of admissions shown in the alcohol related harm indicator is an artificial representation of the size of the problem as only about 20% of the admissions are ‘alcohol specific’ and can be fully attributed to alcohol (for example, alcoholic liver disease). The other 80% are added together from fractions of admissions where each fraction represents the proportion of an actual admission that can be attributed to alcohol (for example, up to 8% of colorectal cancer admissions are ‘alcohol attributable’). The total number of actual admissions that this indicator is based on is therefore much greater.

The regional alcohol indicators\(^{29}\) show that within this part of Cheshire that alcohol is a particular problem area on both a PCT and former local authority level. The levels of:

- alcohol specific hospital admissions for males and females
- alcohol attributable hospital admissions for males and females and;
- alcohol specific hospital admissions for under 18’s

are almost all significantly worse than the England average.

Figure 3.2 demonstrates the number of hospital admissions and admission rate per 100,000 of the population for alcohol related harm for CECPCT and England. The numbers increased in CECPCT by 63% from 5039 in 2002/03 to 8207 admissions in 2006/07. Throughout this period the hospital admission rate for local people remained above that for England with an increased gap from 2005/06 onwards.

Table 3.2 demonstrates the number of persons admitted for alcohol attributable conditions by PCT and Practice Based Commissioning (PBC) group area. There are geographical variations in admissions due to alcohol related harm with the borough of Vale Royal having a similar admission rate to nationally in 2006/07, Macclesfield and Congleton 6-8% higher and Crewe & Nantwich 29% higher.

If this upward trend continues the PCT’s trajectory for admissions for alcohol related harm will increase from 1,550 (2006/07) to 2,587 per 100,000 population by 2013.

Due to the way this indicator is constructed it is not possible to give the precise cost of these admissions, but in many cases these patients will have long hospital stays and the total costs to general practice budgets that can be directly attributed to alcohol is likely to be up to £10 million annually and growing by £1 million each year. The PCT has obtained person-based information about these admissions which has been used to create a practice level indicator of the number of people admitted over this five year period and the age/sex-standardised rate. There are marked variations between practices, whose individual rates range from 69% to 152% of the PCT rate.
Chapter Three: Annual Public Health Report 2009

Primary Care Interventions

It has been estimated that general practitioners are only aware of 8% of people with alcohol dependency and an even smaller proportion of those with harmful/hazardous drinking. Simple screening tools in the form of questionnaires (FAST, AUDIT-C, PAT) have been nationally recommended to help practice staff identify people who may have an alcohol problem.

There is evidence to show that the provision of screening and brief interventions results in a reduction in the amount of alcohol consumed.® For every eight hazardous or harmful drinkers given brief intervention advice, one will reduce consumption to low risk levels. Therefore the public health impact of widespread implementation of brief interventions in primary healthcare is potentially very large.

CECPCT has commissioned practices through the national GP contract to identify harmful drinkers, deliver brief interventions to them and refer dependent drinkers to specialist services. However, this national agreement for 2008/09 and 2009/10 requires practices to screen only newly registered patients rather than their existing patients. If practices screened all their patients we could anticipate some reduction

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Table 3.2 Persons admitted for Alcohol Attributable Conditions by PCT and PBC Group Area

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCT Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>3702</td>
<td>3995</td>
<td>4265</td>
<td>4947</td>
<td>5297</td>
</tr>
<tr>
<td>DSR</td>
<td>673.2</td>
<td>720.13</td>
<td>766.40</td>
<td>906.92</td>
<td>963.24</td>
</tr>
<tr>
<td><strong>East PBC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>1613</td>
<td>1772</td>
<td>1904</td>
<td>2191</td>
<td>2278</td>
</tr>
<tr>
<td>DSR</td>
<td>667.59</td>
<td>720.81</td>
<td>777.07</td>
<td>913.83</td>
<td>943.31</td>
</tr>
<tr>
<td><strong>South PBC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>1281</td>
<td>1374</td>
<td>1455</td>
<td>1708</td>
<td>1906</td>
</tr>
<tr>
<td>DSR</td>
<td>667.34</td>
<td>714.60</td>
<td>747.90</td>
<td>898.73</td>
<td>998.85</td>
</tr>
<tr>
<td><strong>Vale Royal PBC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>807</td>
<td>849</td>
<td>906</td>
<td>1048</td>
<td>1112</td>
</tr>
<tr>
<td>DSR</td>
<td>702.28</td>
<td>732.78</td>
<td>782.19</td>
<td>913.53</td>
<td>957.82</td>
</tr>
</tbody>
</table>

Source: North West Public Health Observatory

---

Figure 3.2 Hospital Admission for Alcohol Related Harm
in consumption, a reduction in inappropriate referrals into the specialist alcohol treatment services (who could then focus on harmful and dependent drinkers) and the information could be used to develop comparable data to monitor the progress of alcohol harm reduction.

**The Big Drink Debate**

In the summer of 2008 the Big Drink Debate\(^\text{31}\) survey asked North West residents about how alcohol affects their health, safety and wellbeing. Although the proportion of people covered by this survey in the four former local borough council areas in CECPCT was slightly lower than in other areas in the North West, the views of 1,462 local people formed part of the overall 24,085 responses to the survey. Generally people's views were comparable to elsewhere in the North West (as measured by the proportion of people expressing concern about particular issues).

The three strongest held views about access and availability of alcohol locally were that alcohol use is increased by:

- low prices and discounts (79%)
- serving large measures (74%) and;
- allowing street drinking (68%)

In terms of the impact of alcohol on the community the two main concerns expressed by people living within CECPCT were about:

- children drinking in streets and parks (75%) and;
- the behaviour exhibited by people who were drunk (70%)

Both issues were of particular importance to people living within Congleton Borough where they were of concern to 83% and 77% of people respectively. Other differences in Congleton Borough were that 63% of people believed that extended licensing hours increase alcohol use and 53% said that they avoided town centres at night because of the drunken behaviour of others. On these two issues the level of concerns from Congleton Borough was about 10% higher than in the other three boroughs.

Approximately 50% of men and women questioned revealed that they believe that GP advice would encourage reduced alcohol consumption compared with only 37% who thought that people would reduce their consumption following simple information.

Local initiatives carried out by the local authority and the police in Congleton may explain some of the differences in people's perceptions of alcohol use in this borough. Congleton has a very successful Pub Watch scheme in place and individuals who cause problems in and around licensed premises are subsequently banned from all premises within the Pub Watch area.

**Summary and Recommendations**

The National Alcohol Strategy identifies the priorities for action as being to target:

- young people under 18 who drink alcohol (in particular 11-15-year olds). Many of this group are drinking more than they used to only a few years ago
- 18-24 year old binge drinkers. A minority of this group are responsible for the majority of alcohol related crime and disorder in the night-time economy, and;
- the harmful drinkers - this group's patterns of drinking damage their physical or mental health and who may be causing substantial harm to others
CECPCT must also address the needs of the very large numbers of hazardous drinkers who without support may progress to become harmed by alcohol and whose care requirements will continue to grow by over £1m per annum.

CECPCT have developed a World Class Commissioning strategy and an alcohol harm reduction commissioning strategy which aims to:

- improve access for people with alcohol related problems to appropriate services
- increase the proportion of hazardous/harmful drinkers being given a brief intervention to reduce their drinking
- improve the awareness of alcohol related ill-health and its prevention
- reduce alcohol related A&E attendances
- reduce alcohol related hospital admissions

This is being organised into a number of work programmes which require the support of PBC groups and practitioners to:

- increase targeted primary prevention - screening and brief interventions in health settings and then widening out into other areas
- increase quality and quantity of treatment services throughout the PCT area - equality of services from basic advice to specialist treatment by assessing existing services and addressing potential gaps
- reinforce partnerships with criminal justice and licensing partners - support of already existing arrest referral project within custody suite and Crime Disorder Reduction Partnership (CDRP) initiatives maintaining Section 17 responsibility

In particular it is recommended that:

- general practices should set up a practice register of all harmful drinkers using the new ‘Read’ codes for identification, screening and brief advice issued to practices in May and October 2008
- practices should monitor alcohol related harm admissions (including their costs) and target relevant individuals to support them to reduce their alcohol use

References

25 One unit is 10ml or 8g of pure alcohol. The number of units in a drink depends on how strong it is and how much there is. Half a pint of 3.5% beer, lager or cider is one unit, one small glass (125ml) of wine at 9% is one unit


28 Safe. Sensible. Social. The next steps in the National Alcohol Strategy. 2007

29 Local Alcohol Profiles for England. 2008 www.nwph.net/alcohol.lape

30 Kaner EF et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database of Systematic Reviews 2007

31 http://www.nwph.net/alcohol/bigdrinkdebate/index.aspx
This chapter explores local variations in demand for hospital services. It is a preliminary analysis of a number of selected primary and secondary care indicators to identify ‘outliers’ in each Practice Based Commissioning (PBC) group. This can be used to inform practices and guide the future commissioning of services.

To ensure best use of NHS resources and enable the achievement of key targets, commissioners of local health services require an understanding of variations in referral rates and hospital activity.

Rates of GP referrals and hospital admissions have generally shown a rising trend in recent years. This can be for a number of reasons, such as population ageing, release of built up demand, patients returning from the private sector, changes in consultant to consultant referrals or lower referral thresholds. This can lead to increased costs and in some cases decreased efficiency if patients admitted to hospital could have been managed in a less acute setting, nearer to their homes. The introduction of PBC offers an opportunity for commissioners to explore the reasons for the apparent local increase in demand and find alternative ways of managing some cases that are currently referred directly to secondary care.

In order to understand the local variations in demand for health services, commissioners need to analyse patient activity data (indicators) at practice level and benchmark this against other practices, Central and Eastern Cheshire Primary Care Trust (CECPCT) and national averages. This should allow areas requiring further discussion to be identified. It is important to note however that the analysis and interpretation of these indicators is not straightforward for a number of reasons:

• a certain amount of random year to year variation in practice indicators is inevitable and where the numbers involved are small year to year changes may appear dramatic even when the underlying average rate is constant. It is not unusual for a practice to appear to be an outlier on one indicator one year and then to be average again the next. Confidence intervals can sometimes help the interpretation of this type of variation
• data quality issues may limit the interpretation of some indicators
• practice populations differ in their health needs. This is related to differences such as age structure (practices with a greater proportion of elderly patients are likely to have greater health needs) or deprivation or other social issues (residents of deprived areas are more likely to develop heart disease and several other conditions than those residents of more well-off areas). This means that referral rates should not be compared between practices without due consideration of all the possible explanations for the differences observed. The use of rates standardised for age, sex and deprivation allows a fairer comparison to be made between practices
• a referral to secondary care is only one step in a complex patient journey, and a fuller understanding of the factors leading to increased referrals and hospital activity requires mapping of the overall process, which has not been attempted here
A preliminary analysis of a number of selected primary and secondary care indicators is presented below which can be used to inform discussions with practices. Two time periods are compared: April to October 2007 and April to October 2008. The main three conclusions that can be drawn from these graphs are:

- there is variation between practices which may be considerable for some indicators
- for most indicators there is a trend of increasing activity, and;
- for most indicators CECPCT is not dissimilar to the overall national picture, when compared to the national median or quartiles\textsuperscript{32}

Recommendation
Each PBC cluster should develop and agree a Demand Management Plan using the information in this chapter, the Technical Appendix and additional data acquired through further analysis.

References
\textsuperscript{32} The median, where indicated on the graphs, shows the average level of performance for practices in England and Wales. The upper and lower quartiles, where indicated on the graphs, show the cut-offs for the top and bottom 25% of performance respectively.
### Chapter Four: Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>PBC Cluster</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP referrals to hospital</td>
<td>East</td>
<td>Mostly rising, Hawthorne Lane Surgery, Wilmslow has a notably lower number of GP referrals as a proportion of the practice population (Figure 401)</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>Mostly rising, The Acorns Surgery, Middlewich has seen the largest rise (Figure 4.2)</td>
</tr>
<tr>
<td></td>
<td>Vale Royal</td>
<td>Mostly rising (Figure 4.3)</td>
</tr>
<tr>
<td>Elective day cases</td>
<td>East</td>
<td>Rise in overall numbers between two time periods (Figure 4.4)</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>Rise in overall numbers between two time periods (Figure 4.5)</td>
</tr>
<tr>
<td></td>
<td>Vale Royal</td>
<td>Rise in overall numbers between two time periods (Figure 4.6)</td>
</tr>
<tr>
<td>Admission rate standardised (SAR) for age, sex and deprivation</td>
<td>East</td>
<td>Rising for most practices, although all practices are still below the national median. Rates for Hawthorne Lane Surgery, Wilmslow are notably low and have also fallen between the two periods (Figure 4.7)</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>Rising for most practices Rates appear to cluster around the national median 2 practices (Milicraft Medical Centre, Crewe and The Acorns Surgery, Middlewich) are above the national upper quartile (Figure 4.11)</td>
</tr>
<tr>
<td></td>
<td>Vale Royal</td>
<td>Rising for most practices Rates appear to cluster around the national median (Figure 4.12)</td>
</tr>
<tr>
<td>Non elective actual admissions</td>
<td>East</td>
<td>Rise in overall numbers between two time periods for most practices (Figure 4.8)</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>Rise in overall numbers between two time periods for most practices (Figure 4.9)</td>
</tr>
<tr>
<td></td>
<td>Vale Royal</td>
<td>Rise in overall numbers between two time periods for most practices (Figure 4.10)</td>
</tr>
<tr>
<td>Frequent users (&gt; = 3 admissions in a year)</td>
<td>East</td>
<td>Most practices have seen a rise. Similar to the country as a whole (Figure 4.13)</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>Most practices have seen a fall. Half or more of the practices are above the national median (Figure 4.14)</td>
</tr>
<tr>
<td></td>
<td>Vale Royal</td>
<td>Similar to the country as a whole (Figure 4.15)</td>
</tr>
<tr>
<td>Non elective admissions for 0 to 1 day</td>
<td>East</td>
<td>Proportions of non-elective admissions for 0 to 1 day are generally below those of the country as a whole, particularly for Hawthorne Lane Surgery, Wilmslow (Figure 4.16)</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>Generally high compared to the country as a whole (Figure 4.17)</td>
</tr>
<tr>
<td></td>
<td>Vale Royal</td>
<td>Generally high compared to the country as a whole (Figure 4.18)</td>
</tr>
<tr>
<td>% of Ambulatory Care Sensitive diagnoses (ACS) admissions by total admissions</td>
<td>East</td>
<td>Most practices have seen a fall, especially Hawthorne Lane Surgery. Similar to the national median as a whole (Figure 4.19)</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>Most practices have seen a fall. Most practices are less than the national median (Figure 4.20)</td>
</tr>
<tr>
<td></td>
<td>Vale Royal</td>
<td>Most practices have seen a fall. Most practices are less than the national median (Figure 4.21)</td>
</tr>
</tbody>
</table>

This graph shows the number of GP referrals to hospital relative to the size of each practice population, demonstrating the variation between practices and a rising trend between the two time periods. Further investigation of the possible outliers identified would first require examination of longer-term trend data to confirm that these practices are outliers.

There is a notable rise in the number of elective day cases between the two time periods, particularly in the East and South consortium areas. As this is consistently seen across practices, it is likely to reflect changes at local trusts rather than in local practices.

There has been a rise in numbers of non elective actual admissions between the two time periods for most practices.

Standardised admission rates have increased between the two time periods for most practices in the three consortium areas. The East consortium area appears to have lower admission rates after adjustment for age, sex and deprivation. The outlying practices may be worthy of closer attention.

On this indicator, there appear to be differences between clusters which may warrant further investigation.

The East consortium area differs from the other two areas on this indicator, and this may partly explain the variation between clusters in standardised admissions rate noted above. This may warrant further investigation.

Ambulatory Care Sensitive diagnoses (ACS) represents avoidable admissions and therefore a lower proportion of admissions may indicate better management. A falling trend is encouraging.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>PBC Cluster</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of elective admissions / first outpatient attendances</td>
<td>East: Notably higher than for the country as a whole (Figure 4.22)</td>
<td>Compared to the country as a whole, numbers of WTE GPs per 1,000 weighted population in all three consortium areas are relatively low for most practices. Only a minority exceed the national median value. There is also marked variation in GP provision between practices and further work could investigate how this relates to referral rates.</td>
</tr>
<tr>
<td></td>
<td>South: Notably higher than for the country as a whole (Figure 4.23)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vale Royal: Notably higher than for the country as a whole (Figure 4.24)</td>
<td></td>
</tr>
<tr>
<td>GP WTE per 1,000 weighted population</td>
<td>East: Low compared to the country as a whole (Figure 4.25)</td>
<td>CECPCT appears to be well provided for in terms of district nurses compared to the rest of the country.</td>
</tr>
<tr>
<td></td>
<td>South: Low compared to the country as a whole (Figure 4.26)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vale Royal: Low compared to the country as a whole (Figure 4.27)</td>
<td></td>
</tr>
<tr>
<td>District nurses per 100,000 weighted population (Figure 4.28)</td>
<td>East: Above the national upper quartile</td>
<td>CECPCT appears to have below average provision of health visitors in many areas compared to the rest of the country.</td>
</tr>
<tr>
<td></td>
<td>South: Above the national upper quartile</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vale Royal: Above the national upper quartile</td>
<td></td>
</tr>
<tr>
<td>Health visitors per 100,000 weighted population (Figure 4.29)</td>
<td>East: Below the national median</td>
<td></td>
</tr>
<tr>
<td></td>
<td>South: Below the national median</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vale Royal: Above the national median</td>
<td></td>
</tr>
<tr>
<td>Ratio of follow up appointments to first outpatient appointments</td>
<td>East: Most practices are below the national lower quartile. Generally there has been a small fall between the two periods (Figure 4.30)</td>
<td>The East consortium area appears to have a lower ratio of follow up appointments to first outpatient appointments, which may indicate greater follow up of chronic conditions in primary care instead of at hospital outpatient clinics.</td>
</tr>
<tr>
<td></td>
<td>South: Similar to the country as a whole. Generally there has been a small fall between the two periods (Figure 4.31)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vale Royal: Similar to the country as a whole. Generally there has been a small fall between the two periods (Figure 4.32)</td>
<td></td>
</tr>
<tr>
<td>% of surgical admissions with primary procedure on day of admission</td>
<td>East: Similar to the country as a whole. A small rise is seen for most or all practices (Figure 4.33)</td>
<td>A small rise is seen in this indicator for most or all of the practices in the three areas.</td>
</tr>
<tr>
<td></td>
<td>South: Similar to the country as a whole. A small rise is seen for most or all practices (Figure 4.34)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vale Royal: Similar to the country as a whole. A small rise is seen for most or all practices (Figure 4.35)</td>
<td></td>
</tr>
</tbody>
</table>
**Indicator**  
GP referrals to hospital

**Definition**  
Number of written referrals from General Practitioners, whether doctors or dentists, for first consultant outpatient appointment direct or indirect to a Consultant. All should be recorded, regardless of whether they result in an outpatient attendance. The referral request received date should be used to identify referrals to be included in the return. General & Acute specialists include: 100-192, 300-460, 502, 800-831, 900 and 901 exclude: 501, 560, 700-715

**Source**  
Dr Foster & Statutory returns

**Date range**  

**Comments**  
This is one of the measures which forms part of plans to sustain 18 week referral to treatment national target (the patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point). If activity increases above the targets set within the vital signs this affects the ability to sustain 18 weeks.

**Footnotes**  
Figure 4.1 GP Referrals - East

Figure 4.2 GP Referrals - South

Figure 4.3 GP Referrals - Vale Royal
Indicator: Elective day cases

Definition: Number of elective first finished consultant episodes (FFCEs) for G&A specialties include: 100-192, 300-460, 502, 800-831, 900 and 901 exclude: 501, 700-715

Exclude “well babies”.

Source: Dr Foster & Statutory returns


Comments: This is one of the measures which forms part of plans to sustain 18 week referral to treatment national target (the patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point). If activity increases above the targets set within the vital signs this affects the ability to sustain 18 weeks.
**Figure 4.7** Non elective actual - East

**Figure 4.8** Non elective actual - South

**Figure 4.9** Non elective actual - Vale Royal

**Indicator** Non-elective day cases

**Definition** Number of non-elective (emergency admission, maternity admission, other admission (codes 21-83)) first finished episodes (FFCEs) for the G&A specialties include: 100-192, 300-460, 502, 800-831, 900 and 901 exclude: 501, 700-715 Exclude "well babies".

**Source** Dr Foster & Statutory returns

**Date range** April 2007 - Oct 2007, April 2008 - Oct 2008

**Comments** This is one of the measures which forms part of plans to sustain 18 week referral to treatment national target (the patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point). If activity increases above the targets set within the vital signs this affects the ability to sustain 18 weeks.

**Footnotes**
**Figure 4.10** Admission rate standardised for age, sex, deprivation - East

- **Indicator**: Standardised admission rates (SAR)
- **Definition**: Admission rates standardised for age, sex, deprivation
- **Source**: Dr Foster
- **Comments**: This is the ratio of observed number of admissions to expected. Values greater than 100 suggest a higher than expected number of admissions, while values less than 100 suggest fewer admissions than expected.

**Figure 4.11** Admission rate standardised for age, sex, deprivation - South

**Figure 4.12** Admission rate standardised for age, sex, deprivation - Vale Royal
Figure 4.13  Frequent users (>=3 admissions in 1 year) - East

Indicator: Percent admissions Frequent Users
Definition: Frequent Users defined as >=3 admissions in a year/12 months
Source: Dr Foster
Comments: A low percentage of patients suggest effective systems for supporting patients with long term conditions.

Figure 4.14  Frequent users (>=3 admissions in 1 year) - South

Figure 4.15  Frequent users (>=3 admissions in 1 year) - Vale Royal
Figure 4.16  Non elective admissions for 0 and 1 LOS - East

Figure 4.17  Non elective admissions for 0 and 1 LOS - South

Figure 4.18  Non elective admissions for 0 and 1 LOS - Vale Royal

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Percent admissions 0 and 1 day length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Non-elective admissions for 0 and 1 day LOS - selected HRG (list from Tariff guidance)</td>
</tr>
<tr>
<td>Source</td>
<td>Dr Foster</td>
</tr>
<tr>
<td>Comments</td>
<td>A high percentage may indicate patients being admitted unnecessarily, possibly to achieve 4-hour A&amp;E targets. A low percentage suggests good practice.</td>
</tr>
</tbody>
</table>

| Footnotes          |                                                                 |

Chapter Four: Annual Public Health Report 2009
**Figure 4.19** % of ACS admissions by total admissions - East

- **Indicator:** Percent admissions for Ambulatory Care Sensitive diagnoses (ACS)
- **Definition:** Non-elective admissions for 0 and 1 day LOS - selected HRG (list from Tariff guidance)
- **Source:** Dr Foster
- **Date range:** April 2007 - Oct 2007, April 2008 - Oct 2008
- **Comments:** This indicator shows the number of avoidable admissions per PCT. A low percentage represents good practice.

**Figure 4.20** % of ACS admissions by total admissions - South

**Figure 4.21** % of ACS admissions by total admissions - Vale Royal
Indicator: First OP to Elective Inpatient or daycase Conversion Rate

**Definition:** Number of elective admissions/first OP attendances

**Source:** Dr Foster

**Date range:** April 2007 - Oct 2007, April 2008 - Oct 2008

**Comments:** This rate shows the conversion of OP to IP care. A high rate could indicate a low threshold for admission. A low rate could indicate inappropriate referrals to OP clinics.

**Footnotes**
Figure 4.25  GP WTE per 1,000 weighted population - East

Indicator  GP per 1,000 weighted population
Definition  GP WTE per 'Primary Care' 1,000 weighted population

Source  Exeter GP population and finance
Date range  April 2007, April 2008
Comments  Provides an estimate of the coverage of Gp services across the PCT.

Footnotes  Date on GPs WTE is as per April. Weighted population is for 2008
### Figure 4.28 District Nurse per 100,000 weighted population (Dec 2008)

**Indicator**: District nurses per 100,000 weighted population

**Definition**: District Nurses FTE as of December 2008

**Source**: Finance Department, CECPCCT

**Date range**: December 2008

**Comments**: Provides an estimate of the overall Community services workforce.

**Footnotes**: The date supplied is based on 2008 WTE for district nurses and 2008 weighted population.

### Figure 4.29 Health Visitor per 100,000 weighted population (Dec 2008)

**Indicator**: Health visitors per 100,000 weighted population

**Definition**: Health Visitors FTE as of September

**Source**: Finance Department, CECPCCT

**Date range**: December 2008

**Comments**: Provides an estimate of the overall Community services workforce.

**Footnotes**
Figure 4.30  Number of follow up appointments/first OP appointments - East

Figure 4.31  Number of follow up appointments/first OP appointments - South

Figure 4.32  Number of follow up appointments/first OP appointments - Vale Royal

Indicator: Follow up ratio: 1st Outpatient Appointments

Definition: Number of follow up appointments/first outpatient appointments

Source: Dr Foster


Comments: The First to Follow-up Ratio is calculated from patient attendances where the appointment type is known. A low number to follow ratio could indicate good practice.

Footnotes: The WCC data packs indicate the ratio of 1st outpatient attendances to inpatients and day cases. The information from Dr Foster using this criteria gives a high % compared to the median and upper quartiles.
Figure 4.33  % or surgical admissions with Primary Procedure on day on admission - East

Figure 4.34  % or surgical admissions with Primary Procedure on day on admission - South

Figure 4.35  % or surgical admissions with Primary Procedure on day on admission - Vale Royal

Indicator Surgical admissions with primary procedure on admission

Definition Percent of surgical admissions with primary procedure on day of admission

Source Dr Foster


Comments Day Of Surgical Admission rate (DOSA) refers to the number of admitted elective patients that have their operation on the day that they are admitted to hospital. A high percentage represents good practice.

Footnotes
Chapter Five
Health Inequalities and Practice Funding

Annual Public Health Report 2009
Over four-fifths of government funding for the NHS is channelled through Primary Care Trust's (PCT’s) in the form of annual financial allocations. PCT’s in different areas receive differing levels of funding according to the estimated level of need for health services in the populations they serve. For example, a PCT serving a deprived population would need to receive a larger financial allocation to cover the costs of the greater health needs of a deprived population.

The Advisory Committee on Resource Allocation, an independent panel which advises the government on how to allocate resources within the NHS, has recently altered the formula it uses to decide how much each PCT should receive, with the aim of targeting resources better at areas of greatest need. The new formula (known as the ‘fair shares’ formula) takes account of a number of factors, including the size of a population, demographic factors such as age and sex, and other predictors of need such as level of deprivation. An additional formula takes health inequalities into account and the unavoidable differences in the costs of providing health services in different areas are taken into account by a new ‘market forces factor’.

The level of funding required by a PCT that is predicted by this formula often does not correspond to the level of funding that was provided in the past. Some PCT’s have previously received levels of funding that are higher than those indicated by the ‘fair shares’ formula (and could therefore be considered to be ‘overfunded’) and some PCT’s have previously received levels of funding that would appear to be insufficient to cover the health needs of their population. For some PCT’s the difference is substantial and a rapid change to funding PCT’s entirely according to the ‘fair shares’ formula would risk bringing instability to a number of PCT’s. To avoid this the government alters PCT financial allocations over a period of several years to bring funding into line with the level of funding predicted by the ‘fair shares’ formula (commonly referred to as the ‘target’ funding).

Funding for Central and Eastern Cheshire Primary Care Trust (CECPCT) has increased as a result of the new formula, having moved from 1.2% above target in 2007/08 to 0.7% for 2008/09. This equates to an increase in revenue of approximately £30 million. CECPCT received £1,352 per head of weighted population in 2007/08, which is still less per head than many other PCT’s in the region.

Since 2005, the majority of a PCT’s budget has been devolved to individual general practices for GPs to commission health services for their patients (known as ‘practice-based funding’). Initially, practices agreed budgets with their PCT that were based on previous levels of referral activity, however as there may be significant differences in referral activity between different practices that are not explained by differences in health needs between the populations served, from 2007 the government has begun to introduce a ‘fair shares’ approach to determining the ‘indicative’ commissioning budget for individual general practices (so called because although the commissioning decisions are made by practices, the actual financial transfers are handled by the PCT).

This uses a formula based on age, deprivation and the health needs of the population registered to a general practice to estimate a ‘fair shares’ funding target, towards which the indicative budget will gradually move, at a rate to be no greater than 1% per year. Compared to the new target for practice funding, some practices will appear to be overfunded and some underfunded.
In October 2008, the Health Service Journal (HSJ) published an analysis of differences in practice funding between PCT’s and described CECPCT as one of the top ten PCT’s with ‘the strongest tendency to underfund poor practices’. The HSJ analysis looked at how closely individual practices were funded to their target and found that where a practice was located in a poorer area it was more likely to receive less than target funding. In other words those practices serving poorer populations were more likely to be insufficiently funded relative to need.

A weakness of this approach is that the level of deprivation of a practice population was assumed to be reflected in the deprivation score for the postcode of the practice, when a typical postcode only covers an area containing on average about 15 households. Most of the practice population will actually live elsewhere and so this may not be a valid measure of their level of deprivation.

In order to verify the findings of the HSJ article CECPCT undertook its own analysis using a measure of practice deprivation which is directly based on local 2001 UK census data relating to employment, education, health/disability and housing. Figure 5.1 shows the results of this exercise.

**Figure 5.1 Distance from target by practice deprivation decile for Central and Eastern Cheshire Primary Care Trust, 2008**

Each vertical bar represents one-tenth (one decile) of local practices ranked in order of increasing deprivation. A negative value for a bar indicates ‘underfunding’. It is clear from the figure there is no systematic underfunding of the more deprived practices to the benefit of less deprived practices. In marked contrast to the HSJ analysis there was no significant overall relationship between deprivation and level of funding.
For CECPCT the most deprived practices tend to be better funded relative to need than the least deprived although statistically the difference was not significant. This finding was confirmed by a further analysis using a different measure of deprivation.

The difference in findings between the HSJ article and local analysis could be due to the different choice of deprivation measure - practice postcode versus practice population. The CECPCT analysis is based on actual data rather than an indirect proxy measure of deprivation.

**Summary and Conclusion**

Transferring budgets to PBC groups/practices (either actual or indicative) is one way of engaging primary care clinicians in commissioning. However, as commented on by the recent NHS Confederation Publication: ‘we should judge PBC by the degree to which commissioning is genuinely clinically led and to which clinicians feel ownership and comply with commissioning outcomes, rather than the number that hold budgets. This is not to say that budget holding is not a legitimate means of achieving this engagement. However it is important that it is not seen as a means rather than an end’.

The PCT would hope to support this approach.

**Recommendation**

- the financial support and information given to PBC groups will enable them to take robust commissioning decisions and achieve health improvement and value for money in the service for their population

**References**


35 Linear regression of distance to target against UV67 score for practices did not show any significant association (P=0.41).

Summary of Recommendations

Chapter One
Overview of Health in Central and Eastern Cheshire Primary Care Trust
- Patients receive the same level and quality of service wherever they live and whichever general practice they are registered with
- practices, CECPCT and Practice Based Commissioning (PBC) groups work together in genuine partnership to improve local health experience. Innovation in and through PBC groups must not widen current inequalities
- identified clusters and groupings in practices can provide leadership on behalf of colleagues particularly in specialist areas of commissioning
- PBC groups should follow the ‘Tackling Health Inequalities Locally: a self assessment framework’ to assist in addressing health inequalities. See Appendix One

Chapter Two
Health of the Patient Population for Practice Based Commissioning Groups
- Practices to analyse their own data and information, develop and implement operational plans to improve the health of their own patients against an agreed timetable
- PBC to develop a Commissioning Plan to:
  - continue to improve life expectancy across the PBC
  - address lifestyle choices to improve health across the PBC
  - address issues related to the predicted increase in the ageing population
  - address identified health inequalities and target the populations from spearhead MSOA’s and the most deprived practices
- identify and plan further work to understand children and young family’s health needs and requirements
- improve data collection in all practices to improve the observed/expected rates
- for East and South PBC group: develop a working and collaborative relationship with Cheshire East Local Strategic Partnership (LSP) and share information to assist in the development of future joint plans, and in particular form relationships with relevant Local Area Partnerships. For Vale Royal PBC group; develop a working and collaborative relationship with Cheshire West and Chester LSP and share information to assist in the development of future joint plans, in particular form relationships with Local Area Partnerships
- ensure achievable and measurable targets are included in each part of the work to improve the health of the patient population
Chapter Three
Alcohol: A Lifestyle Choice
• increase targeted primary prevention - screening and brief interventions in health settings and then widening out into other areas

• increase quality and quantity of treatment services throughout the PCT area - equality of services from basic advice to specialist treatment by assessing existing services and addressing potential gaps

• reinforce partnerships with criminal justice and licensing partners - support of already existing arrest referral project within custody suite and Crime Disorder Reduction Partnership initiatives maintaining Section 17 responsibility; general practices should set up a practice register of all harmful drinkers using the new ‘Read’ codes for identification, screening and brief advice, issued to practices in May and October 2008

• practice’s should monitor alcohol related harm admissions (including their costs) and target relevant individuals to support them to reduce their alcohol use

Chapter Four
Local variations in demand for Hospital Services
• each PBC group should develop and agree a Demand Management Plan using the information in this chapter, the Technical Appendix and additional data acquired through further analysis

Chapter Five
Health Inequalities and Practice Funding
• the financial support and information given to PBC groups will enable them to take robust commissioning decisions and achieve health improvement and value for money in the service for their population
Glossary

Annual Public Health Report 2009
Age Standardised Rate: see Directly Standardised Rate.


Binge Drinking: a pattern of heavy drinking that occurs during an extended period of time set aside for drinking. Binge drinking is generally defined as ‘men consuming at least eight, and women at least six standard units of alcohol in a single day. That is double the maximum recommended ‘safe limit’ for men and women respectively.’ One unit is 10ml or 8g of pure alcohol. The number of units in a drink depends on how strong it is and how much there is. Half a pint of 3.5% beer, lager or cider is one unit, one small glass (125ml) of wine at 9% is one unit. Also see safe limits of alcohol drinking.

Body Mass Index (BMI): BMI is a tool that can be used to check how healthy a person’s weight is. BMI is calculated by dividing a person’s weight by their height in metres squared. BMI is a scientific measure that is used to indicate whether a person is underweight, a healthy weight, overweight or obese. Also see obesity and overweight.

Cardiovascular Disease (CVD): refers to those diseases affecting the circulation of the blood in the heart, arteries, capillaries or veins and includes heart disease and stroke. CVD is the leading cause of death in the UK. Cardiovascular disease is defined by the ICD-10 codes I00-I99 (see ICD-10 Codes).

Central and Eastern Cheshire Primary Care Trust (CECPCT): is the health service commissioner for the central and eastern areas of Cheshire. CECPCT’s overall commissioning aim is to improve the health of the population and reduce health inequalities. In carrying out its commissioning responsibilities it is expected to work in partnership with other agencies. Also see Commissioning.

Chronic Obstructive Pulmonary Disease (COPD): is characterised by airflow obstruction, which is usually progressive and does not improve significantly over time. It is generally linked to smoking. Symptoms include coughing, wheezing and breathlessness.

Circulatory disease: see Cardiovascular Disease.

Clinicians: qualified healthcare professionals - doctors, nurses and members of the allied health professions, for example, dietitians, occupational therapists, physiotherapists, podiatrists and speech and language therapists.

Coronary Heart Disease (CHD): encompasses sudden cardiac collapse, acute coronary syndromes, exertional angina, non-fatal arrhythmias, and heart failure. The major lifestyle causes of CHD are diet, smoking and physical inactivity. Coronary Heart Disease is defined by the ICD-10 codes I20-I25 (See ICD-10 Codes).

Confidence Intervals (CI): a confidence interval is a range of values that is used to quantify the imprecision in the estimate of a particular value. Specifically it quantifies the imprecision that results from random variation in the estimation of the value. The wider the CI, the greater the uncertainty in the estimate. The CI can be used to compare the estimates against a target or benchmark or to compare
estimates for different geographies or time periods. Non-overlapping CIs would indicate a statistical significant difference.

**Commissioning:** in health terms commissioning is the process of deciding which health services are needed for a given population, acquiring them and ensuring that the services meet the defined needs. The process ranges from assessing population needs, agreeing priorities, setting targets and outcomes, to procuring services and monitoring the service providers. Also see Central and Eastern Cheshire PCT.

**Dependency Ratios:** dependency ratios provide simple summary measures of age composition, with respect to relative numbers of people in ‘dependent’ and ‘productive’ groups. The ratios are typically based on a division of the age range into three broad, somewhat crude groupings: children (0-14), working ages (15-59/64), and older people (60/65+ years). Dependency ratios are normally expressed as a percentage, with the numerator being the dependent population and the denominator being the ‘productive’ population.

Common dependency ratios used to measure support needs of a population include:

- the dependency ratio for all children
- the dependency ratio for those of pensionable age

**Directly Standardised Rate (DSR):** this calculation provides a single, summary rate for each population adjusted to take account of age structure. This enables easily interpretation comparisons between geographies or organisation that may have very different age structures. Any DSRs in this Annual Report have been standardised to the European Standard Population.

**Disease Prevalence Modelling:** calculates the expected number of people with a given condition or risk factor within a certain area based on that area’s population structure. The models must be used with caution and can only indicate what would be expected based on a particular population’s characteristics. They cannot definitively say how many cases of a particular disease or risk factor will exist within each population.

Hypertension, CHD, COPD and diabetes models use the mid-2007 registered resident practice populations and 2007/08 QOF data. All other models use mid-2006 registered resident practice populations and 2006/07 QOF data.

The Hypertension model used is from the Association of Public Health Observatories, February 2007 and takes into account age, sex and ethnicity. It uses hypertension rates taken from the Health Survey for England 2003 and 2004 to calculate expected prevalence. (http://www.apho.org.uk/resource/view.aspx?QN=DPMLDP)

The CHD model used is from the Association of Public Health Observatories (APHO) March 2006 and uses age, sex, ethnicity and deprivation to calculate expected CHD, using rates from the Health Survey for England 2003. The Hypertension and CHD models are currently being revised by APHO and cannot be accessed from their website. (http://www.apho.org.uk/resource/view.aspx?QN=DPMLDP)
The COPD model is from Eastern Region Public Health Observatory 2007 (http://tools.erpho.org.uk/copdprev.aspx). The model uses age, sex, ethnicity, deprivation, smoking status and rurality and Health Survey for England 2001 prevalence rates.


All other modelled estimates use the Synthetic Estimates of Prevalence of Chronic Diseases and Risk Factors with Observed Data from the Quality Management and Analysis System, April 2007 (http://www.doncasterpct.nhs.uk/phiu-resources.asp?ArticleID=100173). This takes account of the practice age and sex structure and deprivation score, calculated from the 2001 Census UV67 score. The model uses a number of different sources for prevalence rates, including the Health Survey for England 2003 and 2004.

**Harmful Drinking:** harmful drinking is defined as drinking at levels which can cause harm to physical and mental health, for example, liver damage or cirrhosis, alcohol dependence and stress and aggression. Women who regularly drink over 6 units a day (or over 35 units a week) and men who regularly drink over 8 units a day (or over 50 units a week) are drinking at harmful levels.

**Health Inequalities:** the gap between the health experience of different population groups such as the well-off compared to poorer communities or people from different ethnic backgrounds. The Department of Health is committed to reducing health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

**ICD-10 Codes:** ICD-10 codes refer to the World Health Organisation International Statistical Classification of Diseases and Related Health Problems. The ICD-10 codes are used to classify diseases and related health problems recorded on health and vital records, including death certificates. These can be used to compile morbidity and mortality statistics.

**Index of Multiple Deprivation (IMD):** national measure of social deprivation published every few years by (what is now) the Department for Communities and Local Government. It combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each LSOA in England. This allows areas to be ranked relative to one another according to their level of deprivation. The latest IMD is from 2007.

**Joint Strategic Needs Assessment (JSNA):** JSNA is a process that identifies the current and future health and wellbeing needs of a local population. The requirement for local authorities and PCTs to undertake JSNA was created by the Local Government and Public Involvement in Health Act (2007). The process should lead to stronger partnerships between communities, local government and the NHS. It should inform the priorities and targets set by Local Area Agreements, and provide a firm foundation for commissioning, including Practice Based Commissioning.
Life Expectancy: the number of years a person could expect to live if they experienced the age-specific mortality rates of the given area and time period for the rest of their life. Life expectancy is calculated separately for males and females.

Limiting Long-Term Illness (LLTI): self-assessment question from the 2001 Census, which asked respondents whether or not they considered themselves to have a limiting long-term illness, health problem or disability, including old age, which limited their daily activities and work they could do.

Local Area Agreement (LAA): a Local Area Agreement sets out the priorities for a local area agreed between central government and the local area (the local authority and Local Strategic Partnership). It aims to join up public services more effectively and allow greater flexibility for local solutions to local circumstances. From April 2008, a single set of 198 indicators replaces existing performance indicators.

Local Strategic Partnership (LSP): a single, non-statutory, multi-agency body, which matches local authority boundaries, and aims to bring together at a local level the different parts of the public, private, community and voluntary sectors. LSPs are key to tackling deep seated, multi-faceted problems, requiring a range of responses from different bodies. Local partners working through an LSP will be expected to take many of the major decisions about priorities and funding for their local area.

Lower Super Output Area (LSOA): a geographic hierarchy designed to improve the collection, analysis and reporting of small area statistics in England and Wales. LSOAs have an average population of 1,500 people. Central and Eastern Cheshire PCT contains 290 LSOAs. Also see MSOA.

Morbidity: term used to describe the burden of illness caused by disease or lifestyle factors (for example, smoking).

Morbidity Rate: The number of people affected by disease expressed as a rate (for example, the number of cases per 100,000 population).

Mortality: synonym for death. Generally used in connection with rates of death caused by disease or lifestyle factors (for example, smoking).

Mortality rate: number of deaths expressed as a rate (for example, the number of cases per 100,000 population).

Middle Super Output Area (MSOA): a geographic hierarchy designed to improve the collection, analysis and reporting of small area statistics in England and Wales. MSOAs contain around three to five LSOAs and have an average population of 7,200. Central and Eastern Cheshire PCT contains 65 MSOAs. Also see LSOAs

Obesity: when a person is carrying too much body fat for their height and sex, increasing the risk of developing a variety of diseases. A person is considered obese if they have a BMI of 30 or greater. Also see BMI and overweight.

Old Age Dependency Ratio: see Dependency Ratios
Office for National Statistics (ONS): the Executive Office of the UK Statistics Authority, a non-ministerial department, which reports directly to parliament. ONS is the UK government's single largest statistics producer and collects and disseminates data on all aspects of economy and society.

Overweight: when a person is carrying additional body fat for their height and sex above what is considered normal for a healthy weight. A person is considered overweight if they have a BMI between 25 and 29.9. Also see BMI and Obesity.

Prevalence: measure of how common a condition is within a specified population over a certain period of time. Crude prevalence of a disease in a population is defined as the total number of cases of the disease in the population at a given time divided by the number of individuals in the population.

Practice Based Commissioning (PBC): a government policy which devolves responsibility for commissioning services from PCTs to local GP practices. Under PBC, practices will be given a commissioning budget to commission services.

Primary Care Trust (PCT): Primary Care Trusts cover all parts of England and receive budgets directly from the Department of Health in order to commission health services from providers for example, hospital services. Strategic Health Authorities monitor performance and standards. Collectively PCTs are responsible for spending around 80% of the total NHS budget. Also see CECPCT and Commissioning.

Quality and Outcomes Framework (QOF): a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice.

Quintile: a quintile is a proportion of a set of data that has been ranked and divided into fifths, where each group contains an equal number of data items.

Safe limits of alcohol drinking:
- **men** should drink no more than 21 units of alcohol per week (and no more than four units in any one day)
- **women** should drink no more than 14 units of alcohol per week (and no more than three units in any one day)
- **pregnant women**. The exact amount that is safe is not known. Therefore, advice from the Department of Health is that pregnant women and women trying to become pregnant should not drink at all. If you do choose to drink when you are pregnant then limit it to one or two units, once or twice a week and never get drunk

Spearhead MSOA: 18 spearheads have been identified in CECPCT. These are MSOAs where the life expectancy for males and/or females, falls into the lowest quintile within the PCT. The poor health experience of people living within these MSOAs will be the focus of further attention.
**Synthetic Estimates**: synthetic estimates estimate the prevalence of lifestyle risk factors within local populations by extrapolation of prevalence data for England or the UK or comparable local populations. Synthetic estimates are modelled and represent the expected prevalence of a lifestyle behaviour given the demographic and social characteristics of that area. However, the estimates do not take account of any additional local factors and cannot be used to measure performance over time.


**Wider Determinants of Health**: these are factors which may not directly cause illness, disability or death, but contribute to the risk of future disease. These include individual risks (for example, genetic inheritance and lifestyle behaviour such as smoking) social determinants (for example, income, education, employment, housing, healthy environments), and service related factors (for example, access to effective health services).

**World Class Commissioning (WCC)**: the World Class Commissioning programme aims to transform the way health and care services are commissioned. It aims to deliver a more strategic and long-term approach. It comprises four elements: Competencies, Assurance, Vision, and Support and Development.

**WCC Competencies**: commissioning competencies are described by a series of 11 headlines. They set out the knowledge, skills, behaviours and characteristics expected of world class commissioners. The 11 headlines are:

1. Are recognised as the local leader of the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the NHS
7. Effectively stimulate the market to meet demand and secure required clinical, and health and wellbeing outcomes
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. Secure procurement skills that ensure robust and viable contracts
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11. Make sound financial investments to ensure sustainable development and value for money
Delivering the Vision
Taken from a discussion Paper on Practice Based Commissioning. NHS Confederation 2009. www.nhsconfed.org

Delivering the Vision depends on:
• PBC being core business
• robust governance arrangements being in place
• participation in PBC operating on a continuum
• having the right tools and incentives available
• practices and consortia having access to public health expertise
• PBC decisions being linked to patient outcomes
• PBC that covers all services
• support for PBC within the wider health system
• collaboration with providers
• PCTs having strong clinical leadership systems
• evolution not revolution
• recognition that PBC is not just about budget holding
Our Life in the North West


**PBC groups should seek to ensure that:**
The quality and quantity of primary care in areas of poor health meet local needs and is well organised with activity in place to seek out people who already have a disease or are at high risk but are accessing services sub-optimally or not at all. In particular:

**Practices and clusters:**
- have access to a variety of local data - including the Quality and Outcomes Framework (QOF), prevalence models and risk-scoring for example, actual versus expected numbers of patients on GP long-term condition registers is known and addressed
- work with other services (for example, social services and voluntary organisations) is in place to reach vulnerable groups
- have innovative ways of reaching target groups are used (for example, the local pharmacist, local meeting places)

**The PCT:**
- identifies struggling general practices and has an overall picture of performance with action to address underperformance
- provide development support for struggling general practices generically (for example, strengthening practice management) and for specific priorities (for example, effective management of diseases contributing to premature mortality - CVD, cancer, hypertension, raised cholesterol levels, diabetes and chronic obstructive pulmonary disease (COPD))
- has systems in place to assess the use of ‘exception’ reporting and to challenge the numbers of exceptions to ensure that patients who are hard to reach, have complex or multiple needs (i.e. the most vulnerable with the greatest health inequalities) are not being ‘exception’ reported for the QOF
- has a policy in place to ensure that patients are identified and registered as either ‘high risk’, or ‘with established target disease’
- analyses of why patients do not present for treatment is regularly carried out (for example, may be due to distance from practice, appropriateness of services offered - cultural, opening hours, poor literacy) and corrective strategies are put in place to deal with it
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