Public Document Pack

Cheshire East Council

NHS
Eastern Cheshire
Clinical Commissioning Group

NHS
South Cheshire
Clinical Commissioning Group

Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 28th March, 2017**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

3. **Minutes of Previous meeting** (Pages 3 - 10)

   To approve the minutes of the meeting held on 31 January 2017

For requests for further information
Contact: Julie North
Tel: 01270 686460
E-Mail: julie.north@cheshireeast.gov.uk with any apologies

4. **Public Speaking Time/Open Session**

In accordance with Procedure Rules Nos.11 and 35 a period of 10 minutes is allocated for members of the public to address the meeting on any matter relevant to the work of the body in question. Individual members of the public may speak for up to 5 minutes but the Chairman or person presiding will decide how the period of time allocated for public speaking will be apportioned where there are a number of speakers. Members of the public are not required to give notice to use this facility. However, as a matter of courtesy, a period of 24 hours' notice is encouraged.

Members of the public wishing to ask a question at the meeting should provide at least three clear working days' notice in writing and should include the question with that notice. This will enable an informed answer to be given.

5. **Updated Children and Young People's Mental Health Local Transformation Plan, 2017/18** (Pages 11 - 40)

To consider a report presenting the Children and Young People's Mental Health Local Transformation Plan for Cheshire East.

6. **Mental Health in Cheshire East - Annual Report of the Director of Public Health 2016** (Pages 41 - 132)

To receive the Annual Report of the Director of Public Health and to ensure the recommendations are considered and where appropriate, actioned.

7. **Alcohol-Related Harm Position Statement and Forward Plan** (Pages 133 - 182)

To consider a report relating to the Alcohol-Related Harm Position Statement and Forward Plan.

8. **Cancer Strategy for South Cheshire and Vale Royal** (Pages 183 - 216)

To note the Cancer Strategy for South Cheshire and Vale Royal.

9. **Summary of Health Protection Forum Discussions and Actions 2016** (Pages 217 - 218)

The notes of the Health Protection Forum Meetings are attached for information.

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 31st January, 2017 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Voting Members:
Councillor Rachel Bailey (Chairman)
Councillor L Durham, Cheshire East Council
Kath O'Dwyer, Executive Director of People, Cheshire East Council
Mark Palethorpe, Strategic Director of Adult Social Care and Health, Cheshire East Council
Jerry Hawker, Eastern Cheshire Clinical Commissioning Group
Paul Bowen, Eastern Cheshire Clinical Commissioning Group
Dr Andrew Wilson, South Cheshire Clinical Commissioning Group
Simon Whitehouse, South Cheshire Clinical Commissioning Group
Tracy Bullock, Independent NHS representative

Non-Voting:
Mike Suarez, Chief Executive, Cheshire East Council
Charlotte Simpson, Acting Director of Public Health, Cheshire East Council
Tom Knight, NHS England

Observers:
Councillor P Bates, Cheshire East Council
Councillor S Gardiner, Cheshire East Council
Councillor L Jeuda, Cheshire East Council

Cheshire East Officers/other in attendance:
Guy Kilminster, Corporate Manager Health Improvement, Cheshire East Council
Anne Riley, Commissioning Manager, Cheshire East Council
Sheila Williams, Designated Nurse Cared for Children
Rachel Graves, Democratic Services Officer, Cheshire East Council

Councillors in Attendance:
Councillor S Corcoran, Cheshire East Council
Councillor J Saunders, Cheshire East Council
Councillor L Wardlaw, Cheshire East Council

43 APOLOGIES FOR ABSENCE

Apologies were received from Caroline O'Brien and Councillor Janet Clowes.

44 DECLARATIONS OF INTEREST

No declarations were made.

45 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 29 November 2016 be approved as a correct record, subject to the inclusion of P Bowen as being present.

46 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no members of the public present wishing to use the public speaking facility.

47 **THE HEALTH OF CARED FOR CHILDREN AND YOUNG PEOPLE ANNUAL REPORT FOR THE PERIOD SEPTEMBER 2015-2016**

Sheila Williams, designated Nurse Care for Children, presented the Health of Cared for Children and Young People Annual Report for period September 2015-2016.

The purpose of the report was to provide assurance to the Board and to highlight any potential areas for service improvement in 2016/17. It recognised both the statutory responsibilities and the role of agencies working together as corporate parents.

The report provided details on the numbers of children in care in Cheshire East, health indicators, staffing and funding. The report listed 11 priorities and actions and the Board was advised that a detailed action plan had been produced taking these into account and following the Care Quality Commission Inspection report published at the end of last year.

It was noted that multi agency partnerships were being strengthened through working with the Corporate Parenting Operational Group, which reported to the Corporate Parenting Committee, so enabling greater scrutiny of how local authority and health services worked together in relation to the health of cared for children.

The Board commented on the impact of the resource shortages on statutory health assessments; the importance of emotional and mental health of care for children; the shortage of foster carers and adopters, and asked for an update on performance at a future meeting.

RESOLVED: That

1 the Annual Report on the Health of Cared for Children and Young People be noted; and

2 a follow up report be brought to the Board in May with an update based on end of year data.

48 **MENTAL HEALTH NEEDS ASSESSMENT OF ADOPTED CHILDREN AND YOUNG PEOPLE**

Michael Lloyd was unable to attend the meeting to present the findings of the mental health needs assessment of adopted children and young people.

It was therefore agreed that this item should go to the Corporate Parenting Board.

49 **ALLOCATION OF HISTORICAL SECTION 256 RESERVE FUNDS**

Consideration was given to a report on the allocation of the total historical Section 256 reserve fund (underspends) held by Cheshire East Council. The creation of the reserve fund was approved by the Health and Wellbeing Board on 24 March 2015.

The Value of the S256 was £3.391m, which was made up of underspends in financial years 2013-14 and 2014-15. These underspends had been set aside in an Earmarked Reserve by the Council to ensure that they were allocated in line with the conditions of the NHS England transfer.

Since the Board's decision in March 2015, a number of proposals for spending the reserve fund had been set out by the Council but were not agreed by the Clinical Commissioning Groups, as it was felt the initiatives did not meet the whole care system pressures and did not represent evidenced value for money.

In May 2016 the Clinical Commissioning Groups had requested the reserve fund be returned and in November 2016 agreement was reached on the allocation of the reserve funds – details of which were set out in paragraph 1.6 of the report.

RESOLVED:

That the agreed allocation of the historic Section 256 reserve funds, in line with the details contained in the table in paragraph 1.6 of the report, be noted.

50 **BETTER CARE FUND 2016/17 - QUARTER 2 REPORT**

Cheshire East Council had submitted the Quarter 2 Better Care Fund return on 17 November 2016. The return had been signed off by Councillor Rachel Bailey, as Chairman of Cheshire East Health and Wellbeing Board.

Consideration was given to a report which provided a summary of the key points arising from the return and to recommend next steps to improve performance within the Cheshire East health and social care system. The report looked at national conditions; income and expenditure; metrics; additional measures and next steps.

The Board noted the progress being made across the system to meet the national conditions. In relation to the performance metrics, the non-elective admissions the gap between the target and actual was narrowing, whilst delayed transfer of care continued to be a challenging area. The reasons for this were being examined via the respective A&E Delivery Boards.

The Better Care Fund Governance Group was currently evaluating all Better Care Funded schemes with a focus on all the schemes' effectiveness, overall benefits and costs. The findings would inform the Better Care Funding Plan for 2017/19 in Cheshire East.

RESOLVED: That

1 the contents for the Quarter 2 Better Care Fund report be noted;

2 the areas of improvement be noted;

3 the areas where performance had not improved and commitments from all partners to collectively address this in the coming months be noted;

4 the recommended next steps to improve performance where needed be supported; and

5 the two year planning of the Better Care Fund for Cheshire East for 2017-19 be supported.

51 **SOUTH CHESHIRE CLINICAL COMMISSIONING GROUP OPERATIONAL PLAN 2017-2019**

Simon Whitehouse, Chief Executive of South Cheshire Clinical Commissioning Group, gave a presentation on the Operational Plan 2017-19. A copy of the Plan was included in the agenda pack.

The South Cheshire Clinical Commissioning Group was facing significant financial challenge, with the current level of funding available not allowing

them to meet increasing patient demand if they continued to deliver services in the way they did now.

The Clinical Commissioning Group was looking at possible solutions to manage the financial position and this included the decommissioning and redesign of services; transferring care closer to home; transferring of outpatients to care communities for follow up; community services redesign; and reducing the number of community beds.

RESOLVED:

That the South Cheshire Clinical Commissioning Group Operational Plan 2017-19 be received.

52 **EASTERN CHESHIRE CLINICAL COMMISSIONING GROUP OPERATIONAL PLAN 2017-2019**

Jerry Hawker, Chief Executive of Eastern Cheshire Clinical Commissioning Group, gave a presentation on the Operational Plan 2017-19.

It was stated that, at present moment in time, Eastern Cheshire Clinical Commissioning Group would not be producing an Operational Plan for 2017-19. The Clinical Commissioning Group was trying to balance their funding allocation against the growing demand and expectations for services. A financial plan had been put in place to deal with the projected deficit of £17.8m.

The key areas of focus for 2017-18 included a system transformation through the Care Together Programme and the development of Accountable Care; the effective use of resources to deliver value for money services, and continuous improvement to the way services were delivered.

RESOLVED:

That the presentation on the Eastern Cheshire Clinical Commissioning Group Operational Plan 2017-19 be received.

53 **ANNUAL REVIEW OF THE HEALTH AND WELLBEING BOARD'S TERMS OF REFERENCE**

The Health and Wellbeing Board's Terms of Reference included the requirement for them to be reviewed on an annual basis. This provided an opportunity to ensure that they remained fit for purpose and were appropriate for the smooth functioning of the Board.

The current version of the Board's Terms of Reference had been approved by Council in October 2015. Following consultation with the Eastern and South Cheshire Clinical Commissioning Groups, there was a proposed

alteration within Section 2 – Purpose, which had two wording options for consideration:

> "To be a forum that enables member organisations of the Board to hold each other to account for implementation of strategic and operational plans"
>
> or
>
> "To be a forum that enables member organisations of the Board to hold each other to account for their responsibilities for improving the health of the population."

It was also proposed that an additional paragraph be added with Section 7 - Agenda and Notice of Meetings as follows:

> "7.2 Any voting member of the Board may approach the Chairman of the Board to deal with an item of business which the voting member believes is urgent and under the circumstances requires a decision of the Board. The Chairman's ruling of whether the requested item is considered/tabled or not at the meeting will be recorded in the minutes of the meeting."

RESOLVED: That

1 the Terms of Reference be amended to include:

a) in Section 2 – Purpose, the second wording option:

"To be a forum that enables member organisations of the Board to hold each other to account for their responsibilities for improving the health of the population.";

b) in Section 7 – Agenda and Notice of meeting, the additional paragraph:

"7.2 Any voting member of the Board may approach the Chairman of the Board to deal with an item of business which the voting member believes is urgent and under the circumstances requires a decision of the Board. The Chairman's ruling of whether the requested item is considered/tabled or not at the meeting will be recorded in the minutes of the meeting."

2 the Terms of Reference be reviewed every two years.

The meeting commenced at 2.00 pm and concluded at 3.50 pm

Councillor Rachel Bailey (Chairman)

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Agenda Item 5

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Updated Children and Young People's Mental Health Local Transformation Plan 2017/18
Date of meeting:	28th of March 2017
Written by:	Emma Leigh, Clinical Projects Manager, NHS Eastern Cheshire CCG
Contact details:	emmaleigh@nhs.net
Health & Wellbeing Board Lead:	Cllr. Paul Bates is the nominated signatory for the Local Transformation Plan

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision ☒
Why is the report being brought to the board?	To receive the updated Children and Young People's Mental Health Local Transformation Plan 2017/18For approval and sign-off , prior to formal submission to NHS England and publication of the plan.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well ☒ Living and Working Well ☐ Ageing Well ☐ All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☒ Quality ☒ Sustainability ☒ Safeguarding ☒ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To review the baseline created and the progress made during 2016 despite challenging financial circumstances within the Cheshire East health economy To acknowledge the progress made in increased partnership working to increase the efficiency of mental health provision and to support the governance structure. To support at senior executive level the recommendations made for 2017/18.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The report has been tabled at the NHS Eastern Cheshire CCG Executive Committee on the 23rd of February 2017. The report was tabled at the NHS South Cheshire Clinical Commissioning Executive.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	The recommendations from this report are generated by a means of co-production with young people, parents, carers and stakeholders. These are continually sense-checked as the plan is developed.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	**Outcome one - Starting and developing well…** Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive.

REPORT TO: Health and Wellbeing Board

Date of Meeting: 28th March 2017
Report of: Emma Leigh (Clinical Projects Manager)
Subject/Title: Updated Children and Young People's Mental Health Local Transformation Plan, 2017/18

1 Report Summary

1.1 This report presents the "Children and Young People's Mental Health Local Transformation Plan" for Cheshire East.

1.2 NHS England requires that each Clinical Commissioning Group refresh the Children and Young People's Mental Health and Wellbeing Local Transformation Plan (LTP) that were submitted in October 2015. The original LTP was signed off by the Health and Wellbeing Board at the meeting in December 2015, and then published on both NHS Eastern Cheshire and NHS South Cheshire CCG websites. The document has been prepared in partnership with Cheshire East Council and Public Health in order to be scrutinised by NHS England prior to final submission and publication.

1.3 The Transformation Plan builds on the existing local service development work which is being undertaken in partnership with the CCG, LA, Schools and third sector providers.

1.4 Since the publication of our first plans in October 2015, collaborative activity has been undertaken to commence the transformation of mental health services for children and young people across Cheshire East. Our revised plans have been written following detailed consultation with young people and their families and in partnership with Cheshire East Council, NHS South Cheshire and NHS Eastern Cheshire CCGs and NHS Cheshire and Wirral NHS Partnership Trust and voluntary and community organisations active in the area of mental health.

1.5 The Cheshire East Health and Wellbeing Board, oversees the delivery and implementation of this Transformation Plan, alongside the Local Children's Safeguarding Board and the Children's Trust. Strategic management is provided by the Children and Young people Mental Health Partnership Strategy Group. Wide and broad engagement with children, young people, families and carers has taken place to inform the priorities and we aim to continue to develop and use mechanisms to involve children, young people, families and carers throughout the scope of this plan.

2 Recommendations

2.1 To review the baseline created and the progress made during 2016 despite challenging financial circumstances within the Cheshire East health economy

2.2 To acknowledge the progress made in increased partnership working to increase the efficiency of mental health provision and to support the governance structure.

2.3 To support at senior executive level the recommendations made for 2017/18.

2.4 The following is an overview of the identified activities that will form the 2017/18 transformation activity within Cheshire East. NB: these should be considered in the way that they interlink into wider service delivery across our multiple organisations.

- Roll out “Tools for Schools” project (previously Emotionally Healthy Schools)
- Roll out “MH Links” project
- THRIVE “Getting Help” pilot
- Development of CYPIAPT Workforce
- Redesign of service specification for CAMHS
- Workforce redesign – including staffing resilience/workforce development
- Development of perinatal mental health pathways from universal services inc. acute services
- Development of a single point of contact for information and advice
- Develop access to (online) counselling services
- Implementation of Self Harm pathway
- Review local CYP MH commissioning arrangements – exploring lead commissioner models and mapping against local need
- Comprehensive workforce review as part of Strategic Clinical Network business planning

3 Reasons for Recommendations

3.1 The recommendations made have been developed in partnership with the Children and Young people Mental Health Partnership Strategy Group, and following extensive consultation and engagement with children and young people and their families.

3.2 Mental health services for young people in Cheshire are characterised by a complex system of provision, and care is being provided by NHS consultants

from three specialities – CAMHS, Community Paediatrics, and Adult Psychiatry. True transformation will address the connectivity between these specialities and the other services that exist for children and young people who are experiencing mental health difficulties.

3.3 In this second year of transformation, the areas of work which have been identified as being priorities, will both address the key areas from the Children and Young People's JSNA and will begin the journey towards redesigned services, supported by integrated commissioning, which will ultimately deliver improved mental health outcomes via improved access to services, timely intervention and children and young people accessing the most appropriate intervention for the need.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The Children and Young People's Mental Health Local Transformation Plan" for Cheshire East has a direct impact and connection to Outcome one - Starting and developing well (Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive.)

5 Background and Options

5.1 In February 2015, the Department of Health and NHS England published the policy document, Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. This set out an ambitious programme of change, and introduced the intention to require every area in England to develop a local Transformation Plan, led by CCGs but involving all partners. The scope included the full spectrum of service provision including education, and the needs of children and young people (up to age 18) who have particular vulnerability to mental health problems. The document stated that 'A whole system approach is needed focusing on prevention of mental ill health, early intervention and recovery'.

5.2 Each area was tasked with producing its own plan to:

- Set out a comprehensive and transparent local offer, including a declaration of resources, to be updated annually.

- Demonstrate a multi-agency commitment to service transformation over the coming years.

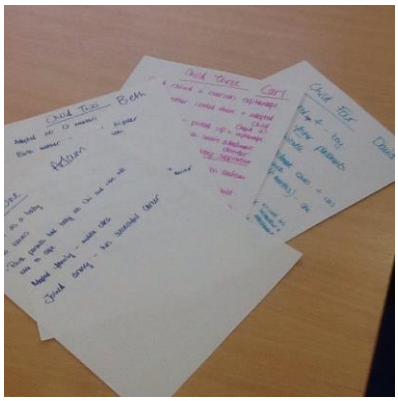
5.3 Over the next 4 years, 2016-2020, work will focus on realigning resources to the areas of need, to improve and enhance early intervention, prevention and specialist mental health services. Work will also ensure that services deliver across changing demographics and local needs. As part of embedding the new model, significant workforce development will be required to ensure shared decision making across service boundaries. This will require a variety of training, skill development and transference to ensure the workforce has both the capacity and capability to meet the needs of our current and future population.

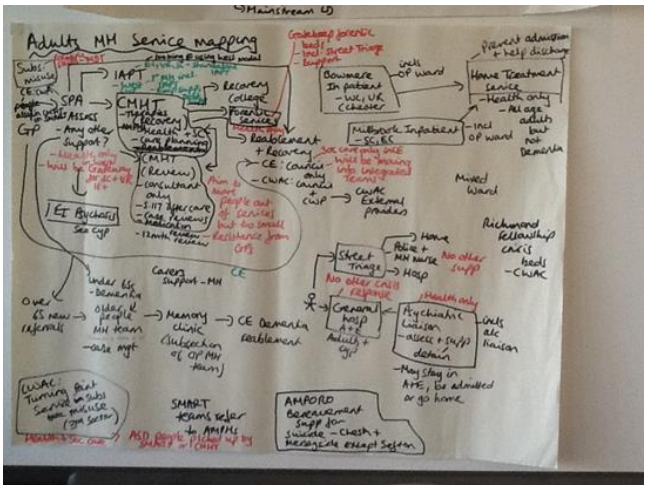
6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer: Online information relating to engagement and involvement activities can be located at: https://www.easterncheshireccg.nhs.uk/Your-Views/past-engagement.htm

The background papers relating to this report can be inspected by contacting the report writer:

Name: Emma Leigh
Designation: Clinical Projects Manager
Tel No:
Email: emmaleigh@nhs.net





Transforming Children and Young People's Mental Health in Cheshire East 2016-2020

NHS Eastern Cheshire CCG
NHS South Cheshire CCG
Cheshire East Council

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1. Introduction: Shared ambition and commitment to transformation

The Government's wide-ranging report on children and adolescent mental health, Future in Mind, March 2015, stipulates that each Clinical Commissioning Group (CCG) area is required to produce a local Transformation Plan. These Plans should cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

This plan is a living document intended to deliver whole care pathways at scale and with pace to reduce inequity in access, build workforce capacity and capability, seek to close the mental health and wellbeing gap, and deliver sustainable improvements in mental health and wellbeing for all children, and young people. The plan incorporates the full spectrum of service provision across the full spectrum of need; from universal mental health, to Learning Disability and difficulty, Children Looked After, Care Leavers, those in the youth justice, abused or sexually exploited and draws upon extensive local needs assessment as evidenced in the Public Health Annual Report 2015 and Joint Strategic Needs Assessments (JSNA) and integrates with a wide range of plans from across the partnership. (Please see Appendix 1 & 2)

The Cheshire East Health and Wellbeing Board, oversees the delivery and implementation of this Transformation Plan, alongside the Local Children's Safeguarding Board and the Children's Trust. Strategic management is provided by the Children and Young people Mental Health Partnership Strategy Group (see the governance structure in section 6). Wide and broad engagement with children, young people, families and carers has taken place to inform the priorities and we aim to continue to develop and use mechanisms to involve children, young people, families and carers throughout the scope of this plan.

Note: This document will refer throughout to Cheshire East, this being the Local Authority boundary common to both NHS Eastern Cheshire CCG and NHS South Cheshire CCG

Future in Mind[1] describes an integrated whole system approach to driving further improvements in children and young people's mental health outcomes with the NHS, public health, voluntary and community, local authority children's services, education and youth justice sectors working together to:

- place the emphasis on building resilience, promoting good mental health and wellbeing, prevention and early intervention;
- deliver a step change in how care is provided – moving away from a system defined in terms of the services organisations provide towards one built around the needs of children, young people and their families;
- improve access so that children and young people have easy access to the right support from the right service at the right time and as close to home as possible. This includes implementing clear evidence based pathways for community based care to avoid unnecessary admissions to inpatient care;

[1] Future in Mind (2015) Department of Health, NHS England, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

- deliver a clear joined up approach: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable;
- sustain a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience;
- improve transparency and accountability across the whole system - being clear about how resources are being used in each area and providing evidence to support collaborative decision making.

Over the next 4 years, 2016-2020, work will focus on realigning resources to the areas of need, to improve and enhance early intervention, prevention and specialist mental health services. Work will also ensure that services deliver across changing demographics and local needs. As part of embedding the new model, significant workforce development will be required to ensure shared decision making across service boundaries. This will require a variety of training, skill development and transference to ensure the workforce has both the capacity and capability to meet the needs of our current and future population.

Since the publication of our first plans in October 2015, collaborative activity has been undertaken to commence the transformation of mental health services for children and young people across Cheshire East. Our revised plans have been written following detailed consultation with young people and their families and in partnership with Cheshire East Council, NHS South Cheshire and NHS Eastern Cheshire CCGs and NHS Cheshire and Wirral NHS Partnership Trust and voluntary and community organisations active in the area of mental health.

In December 2015 the annual report of the Director of Public Health[2] focused on Children and Young Peoples Mental Health, and during 2016 the JSNA[3] was extensively updated. Both of these have been used to inform this updated Transformation Plan.

During 2015/16, CCG Commissioners, CWP Service Managers and data analysts have attended a series of IAPT Leadership and Demand and Capacity workshops held by the *North West Clinical Senate Network* and *NHS England North West Mental Health*. The workshops provided valuable insights into evidence based theories of system leadership and system management.

[2] Cheshire East Annual Public Health Report (2015)
http://www.cheshireeast.gov.uk/council_and_democracy/your_council/health_and_wellbeing_board/health_and_wellbeing_board.aspx

[3] Joint Children & Young People's Mental Health JSNA (2016) : Cheshire East and Cheshire West
http://www.cheshireeast.gov.uk/social_care_and_health/jsna/starting_and_developing_well.aspx#mentalhealthandwellbeing

2. Our Vision: LTP ambitions 2016-2020

By 2020 we will have built on existing practice to ensure:-

- Every young person in Cheshire East has access to a graduated and timely response to emotional health issues, ranging from maintaining a healthy mind to acute crisis
- That Cheshire East has a joined up system that operates across the THRIVE Model and harnesses the capacity of the third sector.
- All Cheshire East educational settings are better equipped to support the Emotional Health of their populations working within the getting advice and getting help quadrants of the THRIVE model
- Coordinated robust risk support is available for the most vulnerable between partners including youth justice.
- Everyone in contact with children and young people feels equipped to actively support their mental health and wellbeing
- That access to getting more help and risk support is available through local settings including primary, acute and specialist care, is timely, and based on clear pathways of care linked to different types of need.
- Well informed commissioners with comprehensive intelligence about needs and provision who strive to co-produce with children, young people and their families leading to innovative, creative and responsive support across a range of services from primary to inpatient and secure settings.

3. What is the local need?

The Cheshire East JSNA (2016)[3] currently includes five relevant sections:

- Perinatal mental health – May 2016
- Self-injury in young people under 25 years – May 2016
- Children and young people's mental health – September 2016
- Autism spectrum – November 2016
- Alcohol and drugs – currently in draft – will be published in January 2017

The JSNA highlights that around 3,800 women go through pregnancy each year. Promoting positive mental wellbeing among all pregnant women can help to reduce levels of anxiety and stress, and this will protect the mental health of 10-15% of unborn children during a critical period of brain development.

Up to 30% (1,100) of women will experience minor or moderate mental health problems during pregnancy, and around half of them can be safely managed by their midwife and/or health visitor. The others can be managed by their GP or by an IAPT service. Serious perinatal mental health problems requiring referral to psychiatric services are much less common, and affect around 3% (110) of pregnant women annually.

The high risk of recurrence of mental health problems during pregnancy and the postnatal period justifies general practitioners sharing information about historic mental health problems with midwives and health visitors either at a pre-conception stage or early in pregnancy.

There is a strong evidence base that shows that infants and toddlers who are born with or who have emerging mental health problems can be systematically identified and managed during their first two to three years of life. The JSNA[3] suggests that up to 350 infants and toddlers could benefit annually from a pathway for the early assessment and management of emerging mental health problems, including autism spectrum disorder and the earliest manifestations of conduct disorder and attention deficit hyperactivity disorder (ADHD).

Mental wellbeing can be defined as "feeling good and functioning well". It is often described as a combination of a child or young person's experiences (such as happiness and satisfaction) and their ability to function as an individual and as a member of society. Mental wellbeing is of particular importance in very young age groups, as experiences in infancy and the first five years of life have a lasting impact upon a child's mental wellbeing. Taking actions to improve mental wellbeing in this age group will deliver gains across their whole life course.

The Early Years Foundation Stage (EYFS) Profile shows that in Cheshire East there have been steady improvements in young children's personal, social and emotional development since 2013. This suggests that Early Years initiatives are having a positive impact on mental wellbeing. If these improvements can be sustained, it is likely that there will be corresponding reductions in the number of primary school age children who develop mental health problems, followed by a decline in their need for mental health services over the longer-term.

In early adolescence, there is a second opportunity to improve mental wellbeing. The proportion of young people with low levels of subjective wellbeing nearly doubles between the ages of 11 and 15, with the lowest levels being at around 14 to 15 years. The self-injury JSNA section highlights the many opportunities to improve mental wellbeing in this age

group, to provide a rapid and supportive response to young people during a time of emotional crisis, and to ensure that there are clear pathways to emergency care if needed.

Young people in all areas of Cheshire East experience mental health problems. There are no areas where the occurrence of mental health disorders in children and young people under 18 is thought to be below 9%. However, the occurrence of mental illness in children in some parts of Crewe and Macclesfield may be up to 50% higher than in other parts of the locality – affecting up to 14% of children and young people.

The most common mental health problems among children and young people are conduct disorders, emotional disorders (anxiety and depression) and ADHD/hyperkinetic disorders. Self-injury is common among teenagers.

Certain groups of children and young people are at much higher risk of developing poor mental health. The table illustrates the degree of increased risk faced by children and young people from some of these groups:

Risk group	Degree of risk	Prevalence of risk (Cheshire East)
Children with learning disability	6.5 fold increased risk of mental health problem	Just over 3% of those aged 0-25 have learning disabilities. 2,800 with moderate difficulties and 500 severe
Children with long term conditions	2 fold increased risk of emotional/ conduct disorders over a three-year period	Nearly 5,000 under 16 year olds are on chronic disease registers of general practices in Cheshire East
Cared for children	5 fold increased risk of any childhood mental disorder 6 to 7 fold increased risk of conduct disorder 4 to 5 fold increased risk of suicide attempt as an adult	In March 2015 there were 357 cared-for or "looked after" children aged under 18 years in Cheshire East
Homeless young people	8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation	There were 331 homeless young people aged 16-24 in Cheshire East in 2013/14.
Young people who are lesbian, gay, bisexual or transgender	7 fold increased risk of suicide attempts in young lesbians 18 fold increased risk of suicide attempts in young gay men	Nationally 2.1% of those aged 16-24 identified themselves as LGBT (2011), which equates to approximately 750 in Cheshire East
Young offenders	18 fold increased risk of suicide for men in custody aged 15 to 17 4 fold increased risk of anxiety/ depression 3 fold increased risk of mental disorders	174 young offenders aged 10-17 years in Cheshire East in 2013/14
Children of prisoners	3 fold increased risk of antisocial-delinquent outcomes	Approximately 635 children in Cheshire East per year are estimated to have a parent in prison, based on a national figure of 0.8%

Table originally taken from "Confident Communities Brighter Futures. A framework for developing wellbeing" Department of Health 2010 [6] prior to adding local data.

Mental health services for young people in Cheshire are characterised by a complex system of provision, and care is being provided by NHS consultants from three specialities – CAMHS, Community Paediatrics, and Adult Psychiatry. True transformation will address the

connectivity between these specialities and the other services that exist for children and young people who are experiencing mental health difficulties.

The JSNA suggests that the key requirements are to reduce teenage referrals to specialist services, and then to restructure existing capacity to improve access for younger children.

In order to ensure our work is informed by an understanding of the impact of wider inequalities on access and take up of services the C&YP MHSG and its commissioned providers will undertake **Equality Impact Analysis** of existing service provision, in line with Public Sector Equality duties and Social Value Act (2012) responsibilities to ensure plans have taken into account the need to address health inequalities and social responsibility considerations.(Please see Appendix 3)

4. What children, young people and their families are telling us?

During 2016 a significant amount of research was undertaken involving children and young people, parent and carers, and professional staff including GPs, therapists, and clinical colleagues in order to create a baseline understanding of need about current and future mental health and wellbeing services.

The intention of carrying out these areas of work simultaneously is to create a multi-faceted vision for transformation for the future that includes young people's experiences and expectations, into a workable service delivery plan.

- Engagement with young people to understand mental health service requirements
- Analysis of awareness and expectations of young people who have accessed, or are accessing, mental health services across Eastern and South Cheshire
- Exploring referrals into CAMHS, engaging with GPs & understanding Parent/Carer needs

Summary of findings:

- *No agreed approach to mental health issues in schools: teacher/pastoral staff reactions are inconsistent*
- *More early intervention (pre CAMHS referral) services available*
- *Pupils feeling undervalued and fearing indiscreet or inappropriate responses*
- *Designated 'Wellbeing areas' having negative perceptions and are age-inappropriate. Better to have wellbeing services integrated within the school*
- *Confusion amongst pupils about school and external support services*
- *Inconsistent knowledge/use of CAMHS by schools*
- *Inconsistent approaches across schools, (communication referral pathway, level and availability of resources, parent engagement) each school addressing the issue of mental health in young people differently particularly at transition points. Use of shared record keeping such as Cheshire Care Record could improve this.*
- *Family and Friends are the two key initial 'go to' groups if in need of support – important for resilience and supporting peer-to-peer networks*
- *GPs are the 'go to' service that young people are most aware of, therefore we need to make sure they are informed, educated and equipped around mental health in young people*
- *Progress is being made regarding tackling stigma of mental ill-health and this should be built upon*
- *Any future service re-design should be led by those who do or may use services*
- *Commissioners should consider use of centralised referral processes (virtual SPA) based within existing infrastructure such as CheCS*

For a detailed overview of the research carried out, please see appendices:

Appendix 3 – Engagement with young people to understand mental health service requirements
Appendix 4 – mental health needs assessment (MHNA) of adopted children and young people in Cheshire East x
Appendix 5 – Analysis of awareness and expectations of young people who have accessed, or are accessing, mental health services across East and South Cheshire x
Appendix 6 – Exploring referrals into CAMHS, engaging with GPs and understanding parent/carer needs

5. Key national drivers - one year on

Since the publication of *Future in Mind* in 2015[1], the publication of the NHS Five Year Forward View for Mental Health Task Force Strategy Report (2016)[4] has highlighted the following key recommendations as clear deliverables for Children and Young People's Mental Health by 2021:

- At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service and nationally 70,000 additional CYP will be treated over the 2014/15 baseline
- Bed use in paediatric and adult wards will be eliminated completely
- Bed use of Specialist in-patient beds for children and young people with an eating disorder should reduce substantially
- By 2020/21, in-patient stays for children and young people will only take place where clinically appropriate, and will have the minimum possible length of stay, and will be as close to home as possible and be commissioned on a 'place-basis'
- CCGs will have collaborative commissioning plans with NHS England's specialised commissioning teams by December 2016
- Creation of a *national Prevention Concordat programme*, led by Public Health England, will enable all Health and Wellbeing Boards to support local needs and produce mental health *Prevention Plans*
- Emphasis on the mental health and wellbeing of staff across the NHS and all those working with people with mental health problems
- Implement new access and waiting time standards, and plan for improvement against the standard beginning from 2017/18
- Perinatal mental health support; 30,000 more women per year to receive support
- Prioritisation of mental health support for anyone with long term physical health conditions
- Reduce suicides by 10%
- The championing of digital innovations to improve access and choice to mental health support.

In line with findings from *Future in Mind*, The *Mental Health Taskforce Report* made clear, that 75% of people experiencing mental health problems are not using health services, possibly due to stigma, inadequate provision and people using their own resources to manage their mental health. The action for a *Prevention Concordat Programme for Better Mental Health* will aim to galvanise local and national action around the prevention of mental illness and facilitate every local area to put in place effective planning arrangements led by Health and Wellbeing Boards, CCGs and Local Authorities. The programme will cover

[4] NHS Five Year Forward View for Mental Health Task Force Strategy Report (2016)
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

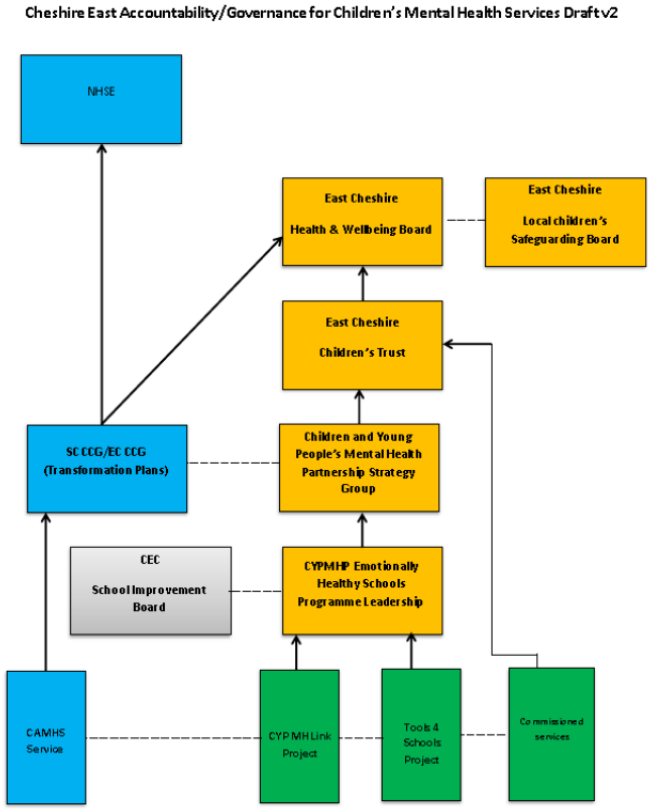
prevention in the widest sense from promotion of good mental health through to living well with mental health problems and everything in between.

6. What we did in 2015/16

A timeline of key achievements in 2015/16 includes:

Children & Young People's Mental Health JSNA	The development of the **Joint Children & Young People's Mental Health JSNA (2016): Cheshire East and Cheshire West**[3]**.** This section of the local JSNA was developed in partnership across Cheshire East Council, NHS Eastern Cheshire CCG and NHS South Cheshire CCG: http://www.cheshireeast.gov.uk/social_care_and_health/jsna/jsna.aspx Key Points from the Children & Young People Mental Health JSNA include: • Inadequate support for mothers mental health during and after pregnancy • Little use of CAMHS by the under-fours • Inconsistency in what the upper age for CAMHS should be – *reinforced by our CYP research* • Many services are not being "joined-up" for young adults – *reinforced by our CYP research* • Poor support for teenagers who self-injure – *reinforced by A&E data* • Many young people with autism spectrum disorder or a learning disability not receiving effective support (See section 3 for further detail of need)
Phase 1 of Emotionally Health Schools (EHS)	The delivery, review and evaluation of **Phase 1 of EHS**. Work was initially funded by a DoE bid secured by NHS South Cheshire CCG and NHS Eastern Cheshire CCG. A Pilot programme working with 6 Secondary Schools across Cheshire East. The pilot was delivered in partnership by a number of CAMHS providers which include Visyon, Just Drop In, Children's Society and Cheshire and Wirral Partnership NHS Trust. This included a CAMHS link role and the development of systems, promising approaches and tools to enable schools to improve their support to children with emotional health needs. The pilot programme has been independently evaluated by Salford University. The evidence from the evaluation has been used in conjunction with performance data and learning from schools, CAMHS providers and commissioners, to develop an enhanced programme for wider delivery across Cheshire East (Phase 2 of EHS) from January 17
Supporting the Mental Health of Children & Young People Strategy (2016-2018)	The Children and Young people's Trust **'Supporting the Mental Health of Children & Young People Strategy (2016-2018)'** has been developed based on local need and national guidance. Strategic priorities from the strategy include: • Putting front-line mental health care and support into every community: New Approaches to Care and Support; • Support all women who experience anxiety and depression during pregnancy; • Diagnose and treat young children with mental health problems during their second year of life

	• Improve awareness and support for young people with autism spectrum disorder and learning disability • Help teenagers to deal with the dark feelings that can lead to self-injury • Bring together all emotional health and wellbeing services for young people, possibly up to the age of 25
Sustaining Emotionally Healthy Schools Post Pilot Phase	The development of **Phase 2 Emotionally Healthy Schools**, based on learning from phase 1. There are 5 key components to phase 2 of EHS, as follows: 1. Access to specialist mental health advice (single point of access) and a brokerage model to support professionals working with Children and Young people (**CYPMH Link Programme**) 2. **Access to tools 'Tools for Schools'** piloted through phase 1 and support to professionals to implement 3. Education specialist **Leadership** 4. Systems and processes to identify and support children and young people in the different THRIVE groups (**Vulnerable Children's Project**) 5. Development of **'Getting Advice'** quadrant including on-line platform Components 1 (**CYPMH Link**) and 2 (**Tools for Schools**) have been commissioned by Cheshire East Council, as part of the MoU with NHS Eastern Cheshire CCG and NHS South Cheshire CCG and commenced from January 2017. Component 3 Education specialist **Leadership** and component 5 Development of **'Getting Advice'** quadrant of the THRIVE model are in co-production phase. Component 4 (**Vulnerable Children's Project**) has been extended to July 2017. The key aims of the commissioned programmes are: **CYP MH Link** – • Pathways, Assessment & Threshold Development, • Mental Health Service Consultation sessions, • Group Facilitated Reflection, • Training, • Liaison between schools, primary care and other providers. **Tools for Schools** - Interventions within the Tools for Schools Programme will aim to: • Develop leadership and management that support and champions efforts to promote emotional health and wellbeing, • Support curriculum, teaching and learning to promote resilience and support social and emotional learning, • Enable the student voice to influence decisions, • Interventions to support staff development to support their own wellbeing and that of students, • Support identifying need and monitoring impact (e.g. tools to support whole school surveys of wellbeing – either anonymously or identifiable with consent), • Support working with parents/carers, • Support interventions linked to appropriate referral,

	• Support an ethos and environment that promotes respect and values diversity.
Review of Governance - Children and Young Peoples Mental Health Strategy Group	Following a review of local governance arrangements the **Children and Young Peoples Mental Health Strategy Group** has been developed. Membership of this group includes Cheshire East Council (Public Health and Children's Prevention leads), NHS Eastern Cheshire CCG, NHS South Cheshire CCG, CAMHS providers (Voluntary and Community Sector and Health) and School leadership representatives. This is the accountable group for the delivery of the Local Transformation Plan, which includes phase 2 of EHS. 
Early Help - (Parenting/ Perinatal)	A **Parenting/Perinatal Programme** is in the early stages of development by Cheshire East Council with partners. The aim is that the programme will be delivered early 2017.
CYP Eating Disorders Service	A Hub & Spoke Eating Disorders Service across Cheshire is in full operation (one spoke is in Eastern Cheshire and one spoke is in central Cheshire), and is meeting mandated targets for service delivery. Development of the community provision is taking place alongside young people and their families.
Early Intervention in Psychosis (EIP)	NHS Eastern Cheshire CCG Commissioning and NHS South Cheshire CCG an EIP service delivering a 16+ service for those experiencing first episode in psychosis and that all referrals are offered NICE-recommended treatment (from both internal and external sources)
Getting Help – Developing the	NHS Eastern Cheshire have commenced a 'Getting Help' service which operates in connection with CAMHS in Eastern Cheshire and is

THRIVE Model in Cheshire East	the first step in implementing the THRIVE methodology locally. The introduction of this provision has allowed the primary mental health care waiting lists to be re-opened.

7. Monitoring and publishing progress of our ambitions

The co-design and co-production with children, young people, their families and wider stakeholders as critical friends will continue to shape a new set of outcome measures to be agreed. As part of this process a system wide outcomes framework which is based on the THRIVE model and incorporates health, care and education outcomes for both children and young people will be used to support contractual arrangements, commissioning models and monitoring delivery of services going forward.

The Mental Health Five Year Forward View dashboard Toolkit (2016)[5] will be utilised in relation to the core elements of the mental health programme transformation and some of the metrics to date that will be measure local commissioning on a national scale. We will adopt and embed this dashboard tool as part of our performance management processes to improve commissioning quality, intelligence reporting and monitoring our local direction of travel progress, in line with national expectations.

Learning from national pilot outcomes will further help to shape our future commissioning decisions and set ambitious performance metrics. Along with the shared learning, new national prevalence data to help with demand and capacity planning in 2018, along with Public Health England fingertips profiles, CHIMAT and local improved data collection for *Prevention Concordat* will support financial modelling for sustainable transformation based on evidenced need. All new care models will measure impacts across prevention, quality, efficiency and be adapted if not working to invest in results that show impact across the THRIVE quadrants:

- Getting Advice: Resilience measures
- Get Help: Change measures
- Getting More help: Impact on life
- Risk Support: Risk management measures.

In addition to our local roadmap (Please see Appendix 7) the work in Cheshire East will also mirror and be aligned to the National Roadmap, which brings together the proposed mental health pathway and infrastructure development programme to deliver the Five Year Forward View. By using the national roadmap as a guide locally we shall ensure that our referral to treatment pathways meet mandated standards.

Pathway		2015/16	2016/17	2017/18	2018/19	2019/20
Referral to treatment pathways						
	Early intervention in psychosis					
	CAMHS: community eating disorder services					
	Perinatal mental health					
	Crisis Care					
	CAMHS: emergency, urgent, routine					

[5] Mental Health Five Year Forward View dashboard Toolkit (2016)
https://www.england.nhs.uk/mentalhealth/taskforce/imp/mh-dashboard/

	Acute mental health care					
	Self harm					
	CAMHS: school refusal					
	Attention deficit hyperactivity disorder					
	Autistic spectrum disorder (jointly with learning disability)					
	Secondary care recovery (will include a range of condition specific pathways)					

National Roadmap - Proposed mental health pathway and infrastructure development programme
Source: NHS Five Year Forward View for Mental Health Taskforce Strategy Report (2016:36)

8. What are our plans for 2016-2020

Priority themes:

Life course approach
As we continue with our whole system, life course approach, increased involvement from the third sector and community groups will be essential to improve the mental health and wellbeing of children, young people and families. Simplifying the provider system, agreeing outcomes and standards to deliver across the THRIVE quadrants will require holistic, integrated and evidence based care for biological, psychological and social needs of our children and young people to be met.

Parity of Esteem
The number of children and young people living with long term mental health conditions, which includes medically unexplained symptoms, needs to be met to help contribute to reduced demand on other services, such as A&E, but most importantly equally deliver *Parity of Esteem, Health and Social Care Act (2012).* A community based 'Get Help' drop in model of delivery with psychiatrist provision will be a move away from clinical environments to community settings, with sustainable recovery pathways integrated with condition specific pathways and vulnerability pathways.

Self-care and awareness
More emphasis on developing social media related campaigns and mental health apps will provide low cost, easily scalable interventions through accredited online provision, live chat, text or telephone help as part of the THRIVE 'Get Help' offer. Ongoing co-production and co-design approaches with children and young people will help to shape future media provision/campaigns and self-care management. A centrally held directory of services that is accessible, current, along with branding of one service with access to shared care records, with consent, will support the single front door approach and overall THRIVE delivery.

We will encourage local organisations and employers to sign up to the national Time to Change Employer Pledge[6] , to improve workplace practice and employer understanding of mental health conditions, and greater inform preventative stress management approaches.

Crisis Care
A mental health crisis for children and young people may require compliance with child protection and safeguarding legislation. Crisis Care Concordat plans will need to cover mental health and link to locally approved robust safeguarding arrangements. Children and young people and their families will need the best help and clinical interventions, as close to home, as possible, when dealing with mental health crisis. This includes the need to ensure that there is enough capacity to stop children and young people (or vulnerable adults), undergoing mental health assessments in police cells. Section 136 and Street Triage Care arrangements will need to be reflective of children and young people no longer being detained in police cells from April 2017, following detention under Section 135 or 136 of the Mental Health Act.

We will seek to embed The *Future in Mind* recommendations for crisis care:

- Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat is implemented.

[6] Time to Change, Employer Pledge, https://www.time-to-change.org.uk/get-involved/get-your-workplace-involved/employer-pledge

- Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care
- Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour
- Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.

Liaison Psychiatry Services in Accident and Emergency

The national development of all age liaison mental health services in Accident and Emergency (A & E) Departments, should improve access to appropriate mental health support in A&E for children and young people experiencing mental health crisis. It is mandatory that that the views and experience of children and young people are taken fully into account as urgent and crisis care services are transformed and improved. In particular they should be involved on the co-production of further access and waiting time standards. We will adopt many of the recommendations in the Healthy London Partnership[7]. This document also contains a directory of best practice examples from across the UK. From 2017/18 commissioners will be developing an all age liaison psychiatry service that meets the requirements of Core 24 in collaboration with Local authority partners. This will include a review of the Children and Young People's Self Harm pathway

Integrated Commissioning

Integrating collaborative commissioning arrangements with NHS England will need to move at pace in relation to specialist health and justice pathways, and transition planning in 2017/18. Working with our partners across Cheshire Constabulary and Cheshire Fire and Rescue Service and the use of Safe Havens will all play a part of Crisis Care, youth justice, transition pathways and the THRIVE offer across Cheshire East.

Transition and integrated mental health and wellbeing

Our local CCG plans to deliver the primary care General Practice Forward View (2016) will be integrated in design to support transitional services for vulnerable ages and be a part of the THRIVE framework across Cheshire East. Continuity of service for those transitioning from improved children and young people pathways to adult, or from inpatient or secure care pathways will be scoped as part of local Multispecialty Community Providers plans. The specific condition needs of children and young people with long term conditions will need to be included in workforce plans. The Adult IAPT access rate set to increase to 25% by 2020 will need to include vulnerable transitional needs and accessible, cost effectiveness short term group work across educational locations. Whole population based budgets based on GP registered lists to improve the underlying health and life chances of children and young people will be part of the plan to tackle inequalities, and system variance across Cheshire East.

The *NEF 5 Ways to Wellbeing*[8], social prescribing concepts and Asset Based Community Development models of delivery incorporating outcome frameworks of the NHS, Public Health and Social Care sectors will be aligned with THRIVE approach to grow community resilience – "community manages itself." The future development of the *Cheshire East Prevention Concordat* will enable use of the best data available to plan and commission the right mix of provision to meet local mental health and wellbeing need. The JSNA will require

[7] Healthy London Partnership, Children and Young People Programme:
Improving care for children and young people in mental health crisis in London: Recommendations for transformation of services
https://www.myhealth.london.nhs.uk/system/files/Improving%20the%20care%20of%20CYP%20with%20mental%20health%20crisis%20in%20London%20-%20Emerging%20findings%20November%202015.pdf

[8] NEF 5 Ways to Wellbeing http://neweconomics.org/2008/10/five-ways-to-wellbeing-the-evidence/

a focus on mental health with co-morbid drug and alcohol, parenting programmes, housing, worklessness and suicide prevention plans with a strong multi-agency approach. Opportunities to access the *Public Health England, Life Chances Fund,* to improve assessment, care, support for co-morbid substance misuse and mental health will need real time data to evidence need.

Providing accessible locations, with the right resources at the right time by a children and young people focussed workforce with the right skills, competencies and experience will mobilise a shared vision, created, and agreed by all, with sound governance, and commitment to meet future lower and higher intensity needs and demands.

Data and intelligence

NHS services in Cheshire are largely unable to provide robust information about their diagnostic workload and clinical outcomes. Voluntary, community and faith sector services are generally able to provide better information about case-mix and outcomes.

Information systems should support regular reporting with high data quality, to address need and to support quality improvement. Any hidden waits for treatment following assessment will need to be transparently reported by providers. System service resilience planned around holiday periods will need to be forward planned by providers to ensure waiting time standards and recovery outcomes metrics are continuously met as part of business continuity.

Data collection and quality measures to improve recording of case-mix and clinical outcomes, dual diagnosis, complex needs, risk factors, risk stratification and population segmentation approaches will inform refreshed JSNA updates and thereby support evidence based commissioning decisions.

Utilising resources/workforce planning

Strong leadership, effective communication, quality measures, financial balance, stakeholder involvement, interagency cooperation, informed JSNA intelligence, robust project management and commissioning to contract or adjust new models of integrated care will be partnership actions to deliver sustainable landscape change.

Promoting and maintaining good mental health

- Improve access to high quality **acute maternal acute mental health services**
- improve **Early Years initiatives** for children who are eligible for free school meals, and maintain a comprehensive range of parenting initiatives that are accessible to young children in all geographical areas
- improve the **emotional wellbeing of looked after children,** and children and young people who are in **particular risk groups** (see table in section 3 above)
- commission selective prevention programmes for **young children at high risk of conduct disorder**
- **diagnose and treat** very young children with emerging mental health problems

Reduce self-injury in teenagers

- reduce **school bullying** and provide support for **sexual orientation** and other worries
- encourage active participation of pupils in **sports and other forms of regular exercise**
- support parents to promote **good sleep patterns** and **reduce gaming and social communication** at night time
- **raise awareness about** how to access local services, including school-based support, services provided by the voluntary sector, and reliable **online resources**

Improve access to care and support

- children and young people requiring mental health care currently use services in Crewe, Macclesfield and Congleton. Services should be available in **age-appropriate locations** closer to where they live
- all children and young people should have **ready access to a counsellor** (and overcome their dislike of special areas designated to mental health in schools/colleges or reluctance to approach pastoral staff)
- **bring together all emotional health and wellbeing services for young people**, possibly up to the age of 25. Youth information, advice and counselling services should provide social welfare legal advice alongside mental health interventions in accessible young person friendly settings. Services should not be located in buildings associated with authority or with services that carry stigma
- enable young people to **transition to adult mental health services** when it is right for them as an individual, possibly up to the age of 25

9. Our Roadmap – the 'Quick View'
For our detailed plans, please see Appendix 7

2017/18	Roll out "Tools for Schools" project Roll out "MH Links" project THRIVE "Getting Help" pilot Development of CYPIAPT Workforce Redesign of service specification for CAMHS Workforce redesign – including staffing resilience/workforce development Development of perinatal mental health pathways from universal services inc. acute services Development of a single point of contact for information and advice Develop access to (on-line) counselling services Implementation of Self Harm pathway Review local CYP MH commissioning arrangements – exploring lead commissioner models and mapping against local need Comprehensive workforce review as part of Strategic Clinical Network business planning
2018/19	Implementing new models of care for THRIVE Recommissioning of YP Substance Misuse Services Develop all age dedicated MH Crisis and liaison Response appropriate to CYP Recommissioning of 0-19 services Brokerage of Counselling Services for educational settings
2019/20	Full parity of esteem in all settings 0-25 delivery of an integrated MH service with a single point of access and locally accessible points of access Stronger linkage between needs analysis and resources for MH

Appendices

Appendix Number	Can be located	Embedded
Appendix 1 - JSNA	http://www.cheshireeast.gov.uk/social_care_and_health/jsna/starting_and_developing_well.aspx	
Appendix 2 – Annual Report of the Director of Public Health		Annual-Public-Health -Report-2014-FINAL.
Appendix 2 – Equality Impact Assessment CYPMH		Equality Impact Assessment CYPMHTI
Appendix 3 – Engagement with young people to understand mental health service requirements	http://www.easterncheshireccg.nhs.uk/Downloads/STITCH%20-%20MENTAL%20HEALTH%20YOUNG%20PERSON%20ENGAGEMENT.pdf	
Appendix 4 – mental health needs assessment (MHNA) of adopted children and young people in Cheshire East	http://www.easterncheshireccg.nhs.uk/Downloads/DRAFT_Report1_EvidenceReview_MentalHealthNeedsAssessment-AdoptedCYP_2016v1.pdf	
Appendix 5 – Analysis of awareness and expectations of young people who have accessed, or are accessing, mental health services across East and South Cheshire	http://www.easterncheshireccg.nhs.uk/Downloads/April%2016%20CWP%20Young%20Advisors%20%20East%20Cheshire%20CAMHS%20%20Service%20user%20report%20-%20FINAL.pdf	
Appendix 6 – Exploring referrals into CAMHS, engaging with GPs and understanding parent/carer needs		MENTAL HEALTH ENGAGEMENT REPOR
Appendix 7 – Detailed Cheshire East Roadmap of activity 2017-2020		Detailed Roadmap.docx

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Agenda Item 6

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Annual Report of the Director of Public Health:
Date of meeting:	28th March 2017
Written by:	Guy Hayhurst/Charlotte Simpson
Contact details:	charlotte.simpson@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Fiona Reynolds

Executive Summary

Is this report for:	Information ☐	Discussion ☒	Decision ☐
Why is the report being brought to the board?	The Director of Public Health has a duty to write an independent Annual Report on the health of the local population, and the Local Authority has a duty to publish it (section 73B(5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act). Mental health is an important public health issue which requires cross-organisational system working in order to improve outcomes. A number of recommendations are outlined.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well ☐ Living and Working Well ☐ Ageing Well ☐ All of the above ☒		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above ☒		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	Health and Wellbeing Board are required to consider and discuss the recommendations as outlined in the List of Recommendations on page 8 of the report.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	N/A		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	Not directly but some of the source information has been informed through surveys.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Improved mental health outcomes as specified in the report.

Cheshire East Council

Health and Wellbeing Board

Date of Meeting:	28th March 2017
Report of:	Director of Public Health
Subject/Title:	Mental Health in Cheshire East Annual Report of the Director of Public Health 2016
Portfolio Holder:	Councillor Paul Bates

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1. Report Summary

1.1. This Annual Report for 2016 continues the theme of mental health that we started last year. Although it has adult mental health as its primary focus, we are also reporting on what has happened since the publication of last year's Public Health report "Supporting the Mental Health of Children and Young People".

2. Recommendation

2.1. **The Health and Wellbeing Board is asked to receive the Annual Report of the Director of Public Health and to ensure the recommendations are considered and where appropriate, actioned.**

3. Other Options Considered

3.1. No other options have been considered. The Director of Public Health has a duty to write an independent Annual Report on the health of the local population, and the Local Authority has a duty to publish it (section 73B(5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act).

4. Reasons for Recommendation

4.1. To ensure that the Director of Public Health's Annual Report is considered as services are reviewed and / or recommissioned, and recommendations from the Report implenmted as appropriate.

5. Background/Chronology

5.1. This is the fourth Annual Report of the Director of Public Health for Cheshire East. In 2013, the report focussed on premature mortality; in

2014 on the health of children and young people; and in 2015 on the mental health of children and young people. This report focusses on adult mental health but refers back to last year's report and reports on local progress. The previous Annual Reports are available for download from the webpage of the Cheshire East Health and Wellbeing Board.

5.2. The topic of the report reflects the commitment of the Public Health team and Cheshire East Council as a whole to promoting good mental heath amongst it residents, and that improving mental health is a priority within the Health and Wellbeing Strategy.

6. Wards Affected and Local Ward Members

6.1. No wards have been specifically named in this report.

7. Implications of Recommendation

7.1. Policy Implications

7.2. Policy proposals are made in the Annual Report that will improve the Cheshire East Parenting Journey and achieve better outcomes for pregnant women and their babies.

7.3. Legal Implications

7.4. The Director of Public Health has a duty to write an Annual Report on the health of the local population, and the local authority has a duty to publish it (section 73B(5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act).

7.5. Financial Implications

7.5.1. None specifically. Good practice need not cost extra money.

7.6. Equality Implications

7.6.1. The report highlights the ongoing inequalities that are being experienced in Cheshire East by young people with learning disability.

7.7. Rural Community Implications

7.7.1. None specifically.

7.8. Human Resources Implications

7.8.1. None.

7.9. Public Health Implications

7.9.1. The report contains several recommendations that would impact on Public Health commissioned services.

7.10. **Implications for Children and Young People**

7.10.1. The report contains several recommendations that would impact on Cheshire East Children's Services.

7.11. **Other Implications (Please Specify)**

7.11.1. The report contains several recommendations that would impact on CCG and NHS England commissioned services.

8. Risk Management

8.1. None specifically.

9. Access to Information/Bibliography

9.1. Comprehensive references are provided within the Annual Report.

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Mental Health
in Cheshire East

The Annual Report
of the
Director of Public Health

2016

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Foreword

This Annual Report continues the theme of mental health that we started last year. Although it has adult mental health as its primary focus, we are also reporting on what has happened since the publication of last year's Public Health report "Supporting the Mental Health of Children and Young People".[1] We have included chapters on perinatal mental health and on children and young people's mental health, as well as describing some of the many national initiatives and reports in relation to this younger age group. One of these was the publication in November 2016 of the third and final report of the Education Policy Institute's Mental Health Commission – "Time to Deliver".[2] The Commission made several important policy recommendations, but we particularly want to highlight one of these:

> *"The practice of making a young person leave their support service on their 18th birthday must end. Young people should be able to choose when to transition up to the age of 25 with support from their therapists and parents or carers."*

This echoes a recommendation that we made in last year's Public Health report. It is timely to re-emphasise the importance of this as there is still much to be done to ensure that this is the case locally.

Over the last few years, close working arrangements have developed between the two Public Health teams at Cheshire East Council and Cheshire West and Chester Council. The teams have jointly carried out Cheshire-wide needs assessments on children and young people's mental health, and more recently on adult mental health. One of our colleagues in Cheshire West and Chester Council has completed a rapid literature review on adult mental health[3], and he has kindly given permission for us to use extracts from his work in this Annual Report. These extracts appear in Chapters Four and Five.

For perinatal mental health, we note that considerable investment is being put into some large-scale initiatives across Cheshire and Merseyside and the North West, but addressing the mental health needs of the majority of pregnant women remains a significant local need. We know that maintaining good mental health is as important as maintaining good physical health in pregnancy, yet there remains significant room for improvement in achieving "parity of esteem" in practice. Systems on the whole need to be more responsive to the needs of women.

It is important that we don't just follow historic models of thinking. Services can make the most of modern connectivity that can link women quickly to peer or professional support. Services can create further and new opportunities for sharing antenatal care more widely with midwives and empowering women to take greater control over determining the support that they may need during pregnancy.

Cheshire East Council has taken some important first steps towards creating a unified Parenting Journey, with clearly stated time points. However, much more work remains to be done to ensure that the Parenting Journey properly addresses the needs of women during pregnancy and capitalises upon key opportunities to improve their physical and mental health at this time. There is also clear evidence that not enough women are accessing the Journey during pregnancy, particularly at the

statutory contact at 28 weeks when the majority of women should have a face-to-face contact with their health visitor.

In Cheshire East, 19 out of every 20 women are seen by their health visitor following birth, but only 7 of those same women see the health visitor 12 weeks prior to birth. The Parenting Journey includes a contact at the Children's Centre on a fixed date just four weeks before birth. However, there are other opportunities earlier on in pregnancy to organise necessary support.

Most women will not require additional support to be organised through the Parenting Journey, but for those that do, the Journey could start earlier in their pregnancy. We are recommending that the addition of a new "Booking Stop" at between 10 to 16 weeks gestation, and the movement of the current "Stop 2" on the Cheshire East Parenting Journey to 32 weeks instead of the current 36 weeks gestation should be explored.

Later in the report, we again draw attention to the marked under-recording of moderate learning disability by schools in Cheshire East. Currently only 1.23% of pupils are recorded by local schools as having a moderate learning disability compared to 3.46% of all pupils in England. This under-recording has important consequences for the health of young people as they grow to adulthood.

We turn now to the second major set of findings in this Annual Report. In Chapter Seven we report on new evidence that suggests that the quality of care for people with serious mental illness is falling below what is being achieved in other areas of the country. Outcomes of care cannot be assessed for large numbers of people in Cheshire East who have a serious mental illness, either because they are excluded from quality monitoring processes in primary care, or because their specialist mental health services are not using the correct clinical codes to allow their outcomes to be monitored.

The use of clinical codes provides a bridge between the clinician who is caring for the patient and the commissioners who are monitoring the outcomes of that care. Where clinical codes are incomplete or inconsistently reported, it becomes more difficult for commissioners to understand needs at a population level, and patient groups cannot understand and challenge poor outcomes of care.

Several indicators can be used to assess outcomes of care in Cheshire East, and collectively these are suggesting that outcomes are on the whole worse than in other areas of the country. Another key piece of evidence that draws attention to the quality of care locally is that people in Cheshire East who have a serious mental illness have higher death rates than England, and that the gap in death rates between Cheshire East and England has remained wide for the last two years.

Overall, there is still much to be done to truly achieve "parity of esteem" for mental health in Cheshire East. As stated in The Five Year Forward View for Mental Health[4]:

> *"Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond."*

List of Recommendations

The following are a list of recommendations from within this report:

Chapter 3 (Progress on Perinatal Mental Health)

3.1 The North West Coast Strategic Clinical Network Perinatal Mental Health Working Group for Cheshire and Merseyside should consider how clinical pathways for specialist perinatal mental health community services in Cheshire East might support a mother's inpatient care to be provided in the Manchester Mother and Baby Unit (located at Wythenshawe Hospital) or the South Staffordshire and Shropshire Mother and Baby Unit (located in Stafford), depending on where she lives;

3.2 Improve cross-sector partnership working to identify and respond to gaps in peer support provision and capacity issues in meeting needs, share best practice and identify where consistent approaches across organisations would be beneficial;

3.3 Develop cross-sector pathways between providers of perinatal mental health support which facilitate women to access the right support at the right time for them;

3.4 Consideration should be given to adding a new "Booking Stop" to the Cheshire East Parenting Journey at between 10 to 16 weeks gestation;

3.5 Consideration should be given to moving the current "Stop 2" on the Cheshire East Parenting Journey to 32 weeks instead of the current 36 weeks gestation;

3.6 Local materials should be developed for women and their families to outline what they can expect to receive as part of the Healthy Child Programme, and the pathways they can choose to follow. These materials need to be developed quickly, and promoted very widely including to all women who are either pregnant or a planning a pregnancy;

3.7 Local Authority and CCG commissioners in Cheshire East should work closely together within the Local Maternity System to plan how and where the new maternity community hubs should be developed inside the borough.

Chapter 6 (Mental Health in People with Learning Disabilities)

6.1 Steps should be taken to improve the ongoing significant shortfall in recording pupils with moderate learning disability in secondary schools in Macclesfield, Congleton, Crewe and Wilmslow. Head Teachers should be asked to inform the general practitioner about any child or young person that the school identifies as having a learning disability.

Chapter 7 (Serious Mental Illness and Psychosis)

7.1 Commissioners of mental health services (CCGs, NHS England and local authority commissioners) should consider within their quality and performance function or equivalent, whether there is a systematic data coding issue with their local mental health providers for severe mental illness and take appropriate action;

7.2 Local commissioners and providers should consider the variations in the local CCG performance on serious mental illness compared with peer CCGs, using comparative approaches

such as RightCare to guide further enquiry.

Chapter 8 (Smoking and Mental Illness)

8.1 As the main commissioners of stop smoking services for Cheshire East, Public Health should work with the specialist stop smoking service to develop their approaches to meet the specific needs of individuals with different forms of mental illness. Performance measures should include the number and proportion of smokers with serious mental illness who are engaged with the service, and outcomes for this group;

8.2 Cheshire East should consider enhancing this service with further investment in order to increase the number of people with a mental illness receiving support and hence achieving an increase in the number of quits for this group of people;

8.3 Mental health services should ensure that a holistic approach is taken when assessing patients and reviewing their care plans. Lifestyle related behaviours such as physical activity, diet, alcohol use and tobacco are all crucial to ensuring that patients do not continue to be at increased risk of premature mortality due to risk factors that are preventable. The integrated approach to lifestyle services provided through One You Cheshire East must be made available to all those receiving mental health services;

8.4 All mental health service staff should continue to receive training in very brief advice as well as providing stop smoking support. Where possible, but especially within inpatient facilities, stop smoking support to patients should be integrated within mental health services. This stop smoking support should range from harm reduction measures such as provision of nicotine replacement therapy on admission, to structured behavioural support and pharmacotherapy for those who want to achieve abstinence;

8.5 All primary care professionals should assess all patients smoking status and offer very brief advice, using the free online training in Very Brief Advice. Smokers should be signposted to the appropriate service – community services (this includes those with low level mental illness) and specialist services for those with a severe mental illness.

Chapter 9 (Suicide and Self-harm)

9.1 As part of the new approaches to real-time suicide surveillance, the Cheshire East Public Health Intelligence Team should create a new Suicide Prevention Database that is directly accessible to the Cheshire East suicide lead and the Director of Public Health. The database should have defined processes to capture and collate the following information about suspected suicides:

- coroner-related information such as substances specified in self-poisoning deaths;
- contact with primary care services including reasons for the contact and frequency;
- demographic and family details such as age, gender, ethnicity and family structure;
- social, educational, occupational, residential and workplace characteristics;
- contacts with acute hospital services such as A&E attendance and inpatient admission;
- psychiatric history and psychological assessments.

Chapter One

New Guidance, Research, and Expert Resources for Mental Health

This chapter draws attention to relevant information and resources for local commissioners that have either recently been published or are due to be published in the near future.

Survey of the Mental Health of Children and Young People

The last national survey of the mental health of children and young people was carried out in 2004. A new survey is being carried out in 2017 and NHS Digital will report on the findings in 2018. This survey will update and extend our understanding of the prevalence of mental health conditions in children and young people in the general population. It is also finding out about issues that have become more common since the previous survey, including eating disorders, the impact of social media and cyberbullying.

The Department of Health is also looking at how to improve our understanding of the mental health of some vulnerable groups of children and young people, such as those who are cared for or voluntarily in care. It is likely that separate studies will be carried out for those groups.

Mental Health in Schools

In May 2016, the Institute for Public Policy Research published an independent report that highlighted a substantial level of variation in the availability and quality of school-based early intervention provision.[5] They suggested that this is due to four major barriers:

1. Schools' inability to access sufficient funding and resources;
2. A lack of established mechanisms by which schools can influence commissioning decisions taken by clinical commissioning groups. In the current school system, schools often lack the internal expertise they need to commission mental health support effectively;
3. The inconsistent quality of mental health support (particularly school counselling) available to schools to buy in directly. Schools often do not receive sufficient guarantees that the specialists they commission or purchase have suitable levels of training and experience;
4. An insufficient level of external checks on the appropriateness and quality of the professional support available in individual schools, with just one third of Ofsted reports making explicit reference to pupils' mental health and/or emotional wellbeing.

The independent social research agency NatCen has been commissioned by the Department for Education to carry out a study of mental health provision in schools across England. Their sample survey has already commenced and is covering a range of topics including:

- How each school identifies and provides for mental health needs;
- What support the school offers individual pupils with specific mental health needs;
- Activities in the school that promote good mental health;
- What it has been like to set up mental health provision in the school;
- Training for staff.

This research, which is likely to be published later in 2017, will provide new information about the types of mental health provision available to children and young people, how schools put this into practice and what the barriers are to supporting pupil's mental health needs. The Department for Education has indicated that the research will be used to inform future Government policy surrounding mental health provision in schools.

Adverse Childhood Experiences

There is emerging evidence of the importance of adverse childhood experiences (ACEs) in longer term health behaviours and outcomes. Increasing numbers of ACEs have been shown in recent research to be associated with lower life satisfaction and mental wellbeing[6]. Adverse childhood experiences are childhood stressors that can alter brain and biological development. They include physical, sexual or emotional abuse and neglect as well as indirect experiences such as witnessing abuse within the household.

There is furthermore an interactive relationship between mental health and domestic abuse. Those with mental health disorders or problems with substance misuse may be more vulnerable and having been subject to domestic abuse can increase the risk of mental health disorders, substance misuse, self-harm and suicide. Interventions aimed at breaking the ACE cycle are thus critical.

Government Response to the Five Year Forward View for Mental Health

The Government has recently published its response to the Mental Health Taskforce report "Implementing the Five Year Forward View for Mental Health"[7] and has accepted the Taskforce's recommendations in full [8]. In relation to children and young people, the Government is planning to take the following steps:

- Publishing a Green Paper on children and young people's mental health later in 2017;
- Supporting schools, colleges and local NHS services to work closely together to provide dedicated children and young people's mental health services;
- A programme of peer support for young people, testing the provision of well-trained mentors within a comprehensive support structure in schools, colleges and community settings;
- A programme testing three different approaches to mental health promotion and the prevention of mental health illness, to help schools decide which programmes are most effective for their pupils;
- Requesting that the Care Quality Commission undertakes an in depth thematic review of children and young people's mental health services in 2017/18.

Priorities for Mental Health Economic Report

This report provided an economic analysis of possible priorities for service improvement in mental health[9]. It was commissioned by NHS England as an input to the five-year strategy recently produced by the independent Mental Health Taskforce. The Centre for Mental Health found that there was a strong evidence base for a range of interventions in mental health which produce better outcomes

at lower cost. However, these are not always widely available or their effectiveness is reduced by poor implementation.

A key ingredient of any mental health strategy should therefore be to promote the wider adoption of best practice, as represented by the delivery of specific evidence-based interventions in line with national guidelines. The report examined nine possible areas for service improvement where there is good evidence of cost-effective interventions, with specific costed proposals. The nine areas can be grouped under three main headings.

Prevention and early intervention

- Identification and treatment of maternal depression and anxiety during the perinatal period;
- Treatment of conduct disorder in children up to age 10;
- Early intervention services for first-episode psychosis.

Better mental health care for people with physical health conditions

- Expanded provision of liaison psychiatry services in acute hospitals;
- Integrated physical and mental health care in the community for people with long-term physical health conditions and co-morbid mental health problems;
- Improved management of people with medically unexplained symptoms and related complex needs.

Improved services for people with severe mental illness

- Expanded provision of evidence-based supported employment services for people with severe mental illness;
- Community-based alternatives to acute inpatient care for people with severe mental illness at times of crisis;
- Interventions to improve the physical health of people with severe mental illness.

We covered the first two of these (maternal depression and anxiety, and treatment of conduct disorder in young children) in some detail in the 2015 Public Health Report, where we highlighted the considerable gains that can be achieved locally at low cost. [10]

Prevention Concordat Programme for Better Mental Health

As part of delivering the recommendations in the Five Year Forward View for Mental Health [2], Public Health England is working with partners to develop a Prevention Concordat Programme for Better Mental Health. This programme aims to:

- Galvanise local and national action around the prevention of mental illness;
- Facilitate every local area to put in place effective prevention planning arrangements led by Health and Wellbeing Boards, clinical commissioning groups and local authorities;
- Enable every area to use the best data available to plan and commission the right mix of provision to meet local needs.

The Prevention Concordat Programme is aimed at supporting all Health and Wellbeing Boards to put in place updated Joint Strategic Needs Assessments and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017. The first resources include a rapid review of the evidence of what works [11]. Other resources will include a Mental Health Promotion and Prevention Return on Investment tool that will be published in the spring of 2017.

The Adult Psychiatric Morbidity Survey 2014

The Adult Psychiatric Morbidity Survey is carried out every seven years and provides data on the prevalence of treated and untreated psychiatric disorder in the English adult population aged 16 and over. The fourth survey was carried out in 2014 and the findings were published in September 2016 [12]. The report contains chapters on common mental disorders, mental health treatment and service use, post-traumatic stress disorder, psychotic disorder, autism, personality disorder, attention-deficit/hyperactivity disorder, bipolar disorder, alcohol, drugs, suicidal thoughts, suicide attempts and self-harm, and comorbidity.

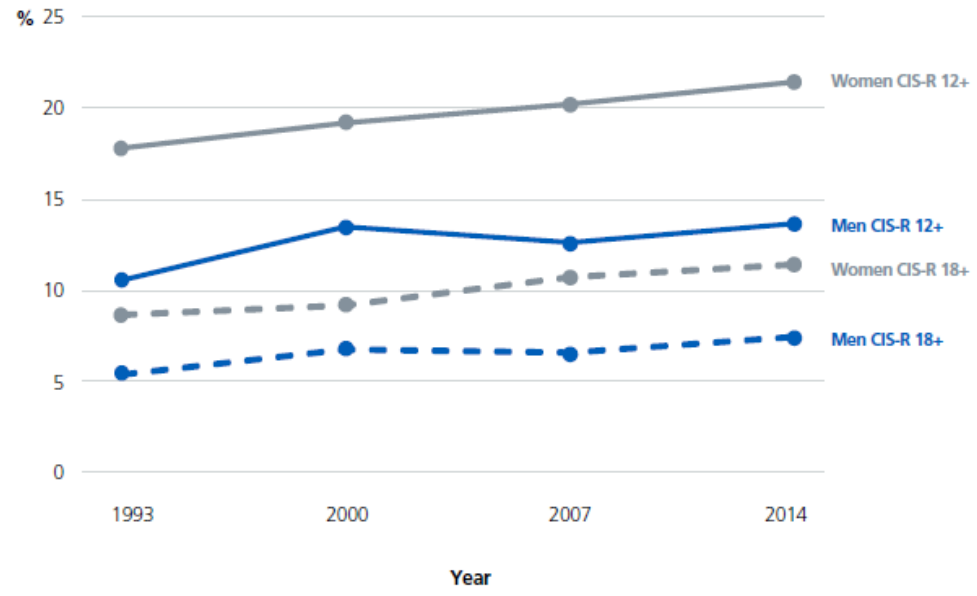
The report makes the observation that the following changes in the economy and models of mental health service delivery mean that the context of mental health has evolved since 2007. Although the survey cannot tell us whether these changes have impacted on mental health, it does provide a recent profile of mental health in England:

- Since the 2007 survey, society has experienced changes in technology and media and the onset of recession;
- Treatment services have undergone change, including the introduction of the Improving Access to Psychological Therapy (IAPT) programme;
- The cross-government strategy “No Health without Mental Health” has sought to mainstream mental health and give it parity with physical health.

Overall, one adult in six (17.0%) had a common mental disorder – about one woman in five (20.7%) and one man in eight (13.2%). Since 2000, rates of common mental disorder in England have steadily increased in women and remained largely stable in men. The presence of common mental disorder in the past week was assessed using the revised Clinical Interview Schedule (CIS-R). Disorders such as depression and generalised anxiety disorder (GAD) were identified, and a severity score produced. A score of 12 or more indicated symptoms warranting clinical recognition, a score of 18 or more is considered severe and requiring intervention. Women were also more likely than men to report severe symptoms.

CMD symptoms in past week (CIS-R score 12+ and 18+) by sex: 1993 to 2014

Base: adults aged 16–64



One in three adults aged 16-74 (37%) with a common mental disorder such as anxiety or depression reported current use of mental health treatment in 2014, an increase from the one in four (24%) who reported this in 2000 and 2007. This was driven by steep increases in reported use of psychotropic medication. Increased use of psychological therapies was also evident among people with more severe common mental disorder symptoms. Since 2007, people with common mental disorder have become more likely to use community services and more likely to discuss their mental health with a general practitioner.

Most common mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed. Although poverty and unemployment tend to increase the duration of episodes of common mental disorder, it is not clear whether or not they cause the onset of an episode. Debt and financial strain are associated with depression and anxiety, and increasingly the evidence is suggestive of a causal association.

Young women have emerged as a high-risk group, with high rates of common mental disorder, self-harm, and positive screens for post-traumatic stress disorder and bipolar disorder. The gap between young women and young men has increased. This may be linked to increases in some of the known associations, including work stress and social isolation, being a member of some ethnic groups, physical and sexual abuse, and problems with alcohol and illicit drugs. There is an increasing understanding about how these risk factors act in in combination, and risk algorithms for predicting depression and anxiety disorders are already influencing prevention efforts in primary care.

In 2014, one in five 16 to 24 year old women reported having self-harmed at some point in her life when asked face-to-face and one in four reported this in the self-completion section of the survey.

Most of the young people who reported self-harming did not seek professional help afterwards. Individuals who start to self-harm when young might adopt the behaviour as a long-term strategy for coping; there is a risk that the behaviour will spread to others; and also that greater engagement with the behaviour may lead in time to a higher suicide rate.

Other disorders were rarer, for example psychotic disorder and autism each affected about one adult in a hundred. Bipolar disorder was covered for the first time in the survey series in 2014, the Mood Disorder Questionnaire identified traits in about one adult in fifty.

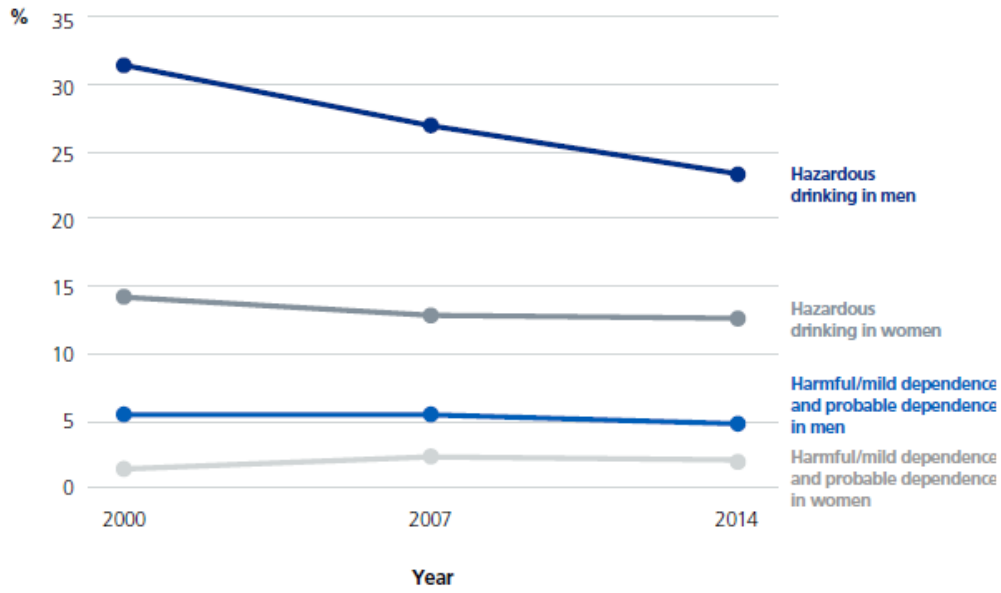
The data from the Adult Psychiatric Morbidity Survey was also used to examine comorbidity between physical and mental illnesses. The report focused on five chronic physical conditions: asthma, cancer, diabetes, epilepsy, and high blood pressure. All had some association with at least one mental disorder. Even sub-threshold levels of common mental disorder symptoms were associated with higher rates of chronic physical conditions.

Adult Psychiatric Morbidity Survey: Hazardous and Harmful Drinking

Signs of drug dependence were evident in one adult in thirty, with a similar level found for probable alcohol dependence (an AUDIT score of 16 or more). Both types of substance dependence were twice as likely in men as women. Since 2000, rates of hazardous drinking (AUDIT scores 8–15) declined in men and remained (at a lower level) stable in women. Levels of harmful or dependent drinking (AUDIT 16+) had not experienced a corresponding fall. When the survey findings were examined by age group, a decline in rates of harmful and probable dependent drinking since 2000 was clearly seen in young men, although such improvements are less evident in young women.

Hazardous and harmful/dependent drinking (AUDIT score 8+ and 16+) in past year by sex: 2000, 2007 and 2014

Base: adults aged 16–74



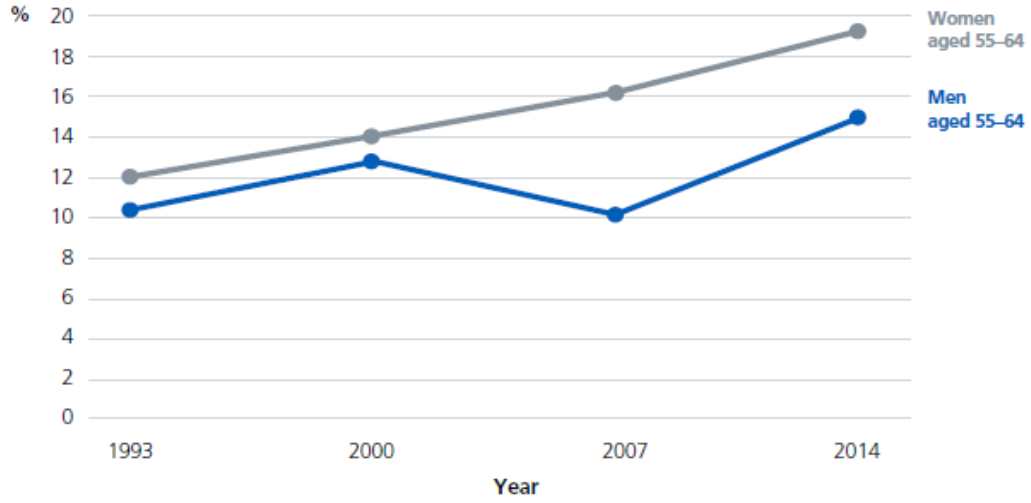
In contrast with the decline in rates of probable alcohol dependence in young men since 2000, there was no evidence of any decline in alcohol dependence rates in men and women aged 55 to 64.

Adult Psychiatric Morbidity Survey: Mental Illness in Late Midlife

Since 2007, there have been increases in common mental disorder symptoms in late midlife men and women (aged 55 to 64). This continued an upward trend in common mental disorder in midlife women since 1993 (the longer term trend in men is less clear). Like young people, those in late midlife had also seen a steep increase in rates of reported lifetime self-harm. Men in this age-group have the highest rates of registered suicide, and have been identified as a priority group in England's National Suicide Prevention Strategy.

CMD symptoms in past week (CIS-R score 12+) in 55 to 64 year olds by sex: 1993 to 2014

Base: adults aged 55–64



Implementing the Five Year Forward View for Mental Health

This report provides the responses for the Taskforce recommendations made to NHS England, and is intended as a blueprint for the changes that NHS staff, organisations and other parts of the system can make to improve mental health. [13] It describes initiatives to better integrate physical and mental health services, develop specialist perinatal mental health services, test new approaches to delivering mental health care, and develop Liaison and Diversion services for people who may have mental health needs and find themselves in the court system or police services.

A Public Health Approach to Mental Health Improvement

This report on "Better Mental Health for All"[14] was commissioned from the Mental Health Foundation by the Faculty of Public Health and supported financially by Public Health England. It included a list of key actions that all professionals working in public health and beyond can take to promote mental wellbeing and prevent mental health problems:

- Whether you work in a specialised public health role or generalist/general work force, consider what you can do within your sphere of influence to advance the public's mental health as a leader, partner and advocate;
- Move, wherever possible, from deficit to strengths-based approaches and ensure you promote good mental wellbeing, address the factors that create mental wellbeing and tackle mental health problems;
- Adopt a proportionate universalism approach, including universal interventions to promote mental wellbeing across whole populations, with more progressively targeted interventions to address specific needs among more vulnerable and at risk groups;
- As part of the universal approach, ensure that you are working towards your own mental wellbeing and that of your colleagues;
- Move towards ensuring mental health receives the same billing and priority as physical health in your work;
- Adopt a life course approach. The foundations of mental health are laid down in infancy in the context of family relationships. Place-based intervention in settings such as schools, workplaces and communities complements the life course approach and makes the most of existing opportunities;
- Reduce stigma and discrimination by increasing mental health and wellbeing literacy across the whole population. Include interventions to improve understanding of the impact stigma and discrimination have on the lives of people with mental health problems;
- Contribute to the expansion of the public mental health evidence base and focus on the interventions and activities that make the biggest impact;
- Ensure that you build evaluation into everyday practice and monitor the effects of practice on mental health.

Chapter Two

Progress on Transforming Mental Health Services for Children and Young People

Children and young people's mental health has become a priority for partners across the NHS, public health, children's social care, youth justice and education sectors. The Cheshire East Children and Young People's Trust, CVS Cheshire East and Healthwatch Cheshire East are all closely involved.

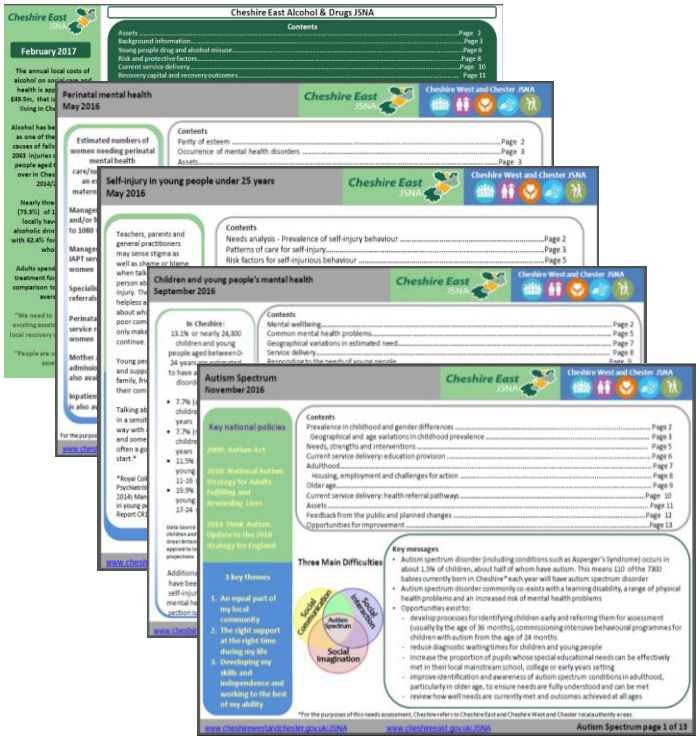
In this chapter we look at some of the work that has taken place locally during 2016, and the key features of the Local Transformation Plan, now in its second year of existence.

Joint Strategic Needs Assessment

The Children and Young People's Mental Health Joint Strategic Needs Assessment (JSNA) has been prepared as a partnership between Cheshire East Council and Cheshire West and Chester Council. Although the JSNA is a joint resource for both Health and Wellbeing Board areas, it presents information separately for the two local authorities and the four clinical commissioning groups.

The JSNA can be found at: http://www.cheshireeast.gov.uk/social_care_and_health/jsna/jsna.aspx and it currently includes five sections of particular relevance to children and young people:

- Perinatal mental health – May 2016;
- Self-injury in young people under 25 years – May 2016;
- Children and young people's mental health – September 2016;
- Autism spectrum – November 2016;
- Alcohol and drugs – February 2017.



In relation to children and young people's mental health, the main finding from the JSNA is that mental health services for young people in Cheshire are characterised by a complex system of provision, and care is being provided by NHS consultants from three very different specialities – Child and Adolescent Mental Health Services (CAMHS), Community Paediatrics, and Adult Psychiatry. True transformation will address the connectivity between these specialities and the other services that exist for children and young people who are experiencing mental health difficulties.

The JSNA also suggests that the key requirements to meet need are to reduce teenage referrals to specialist services, and then to restructure existing capacity to improve access for younger children.

Emotionally Healthy Schools

Some of the difficulties associated with improving mental health and mental wellbeing in school settings are already being tackled head-on through innovative work that is being carried out in Cheshire East. In 2015, the Director of Public Health allocated part of the ring-fenced public health budget to pump-prime an initiative to support the development of emotionally healthy schools. This drew in additional funding from NHS England and the Department for Education and led to two other linked schemes (Cheshire East's Vulnerable Children in Schools Project and the Child and Adolescent Mental Health Service and Schools Link Scheme) that together involved six secondary schools and fourteen out of thirty of their partner primary schools.

Phase 1 of the emotionally healthy schools programme was delivered in partnership by a number of CAMHS providers including Visyon, Just Drop In, the Children's Society, and Cheshire and Wirral Partnership NHS Foundation Trust. This included a CAMHS link role and the development of systems, approaches and tools to enable schools to improve their support to children with emotional health needs. The pilot was independently evaluated by Salford University and the findings have been used to develop an enhanced Phase 2 programme for wider delivery across Cheshire East. There are five main components to Phase 2 of the emotionally healthy schools programme:

1. access to specialist mental health advice (single point of access) and a brokerage model to support professionals working with children and young people (CYPMH Link Programme);
2. wider access to the tools "Tools for Schools" piloted in phase 1 and support to professionals to implement them;
3. education specialist leadership;
4. systems and processes to identify and support children and young people in the different Thrive groups (Vulnerable Children's Project);
5. development of the 'Getting Advice' quadrant of the Thrive model including an on-line platform.

Component 3 (Education specialist leadership) and Component 5 (Development of the 'Getting Advice' quadrant of the Thrive model) are currently in a co-production phase. Component 4 (Vulnerable Children's Project) has been extended to July 2017. Components 1 (the CYPMH Link Programme) and 2 (Tools for Schools) have already been commissioned by Cheshire East Council and began in January 2017. The key aims of these two programmes are:

Component 1 (CYPMH Link Programme):

- pathways, assessment and threshold development;
- mental health service consultation sessions;
- group facilitated reflection;
- training;
- liaison between schools, primary care and other providers.

Component 2 (Tools for Schools):

- develop leadership and management that supports and champions efforts to promote emotional health and wellbeing;
- support curriculum, teaching and learning to promote resilience and support social and emotional learning;
- enable the student voice to influence decisions;
- interventions to support staff development to support their own wellbeing and that of students;
- support identifying need and monitoring impact (e.g. tools to support whole school surveys of wellbeing – either anonymously or identifiable with consent);
- support working with parents and carers;
- support interventions linked to appropriate referral;
- support an ethos and environment that promotes respect and values diversity.

Cheshire East Children and Young People's Trust

In 2016, the Children and Young People's Trust updated its strategy for supporting children and young people's mental health to take account of the Local Transformation Plan, the local needs described in the JSNA, national guidance, and the emotionally healthy schools work referred to above. The updated "Supporting the Mental Health of Children & Young People Strategy (2016-2018)", which is part of the Children and Young People's Plan, can be found at:

http://www.cheshireeast.gov.uk/children_and_families/childrens_trust/childrens_trust.aspx

This new strategy contains six strategic priorities:

1. put front-line mental health care and support into every community;
2. support all women who experience anxiety and depression during pregnancy;
3. diagnose and treat young children with mental health problems during their second year of life;
4. improve awareness and support for young people with autism spectrum disorder and learning disability;
5. help teenagers to deal with the dark feelings that can lead to self-injury;
6. bring together all emotional health and wellbeing services for young people, possibly up to the age of 25.

A Children and Young Peoples Mental Health Strategy Group has been established to take forwards local work on these strategic priorities. The membership of this group includes Cheshire East Council

(Public Health and Children's Prevention leads), NHS Eastern Cheshire CCG, NHS South Cheshire CCG, CAMHS providers (Voluntary and Community Sector and Health) and School leaders.

The Children and Young Peoples Mental Health Strategy Group is also the accountable group for the delivery of the Local Transformation Plan and Phase 2 of the Emotionally Healthy Schools project.

Cheshire East Local Transformation Plan

The purpose of the Local Transformation Plan is to describe the full range of local actions for the prevention and care of mental health problems, ensuring that the most vulnerable are supported and that gaps between services and age transitions are reduced. The Plan should be:

1. **Transparent**: containing a full description of local needs assessments, the current and planned investments to meet those mental health and wellbeing needs; and declarations by local providers about the services that they already provide, including staff numbers, skills and roles, waiting times and access to information;
2. **Transformative**: clearly showing how all partners will collaborate with children and young people, and their families and schools, to improve mental health and wellbeing services so that they are locally accessible, responsive, appropriate to need, and outcome-focussed;
3. **Tracking change**: with auditable statements about achievement towards the aspirations set out in Future in Mind and the Children and Young People's Trust six strategic priorities.

The first annual update of the Local Transformation Plan was due in late 2016, but was delayed. In the refreshed Local Transformation Plan that was published in February 2017, the vision and ambitions for 2020 is described as having built on existing practice to ensure:-

- every young person in Cheshire East has access to a graduated and timely response to emotional health issues, ranging from maintaining a healthy mind to acute crisis;
- that Cheshire East has a joined up system that operates across the THRIVE Model and harnesses the capacity of the third sector;
- all Cheshire East educational settings are better equipped to support the Emotional Health of their populations working within the getting advice and getting help quadrants of the Thrive model;
- coordinated robust risk support for the most vulnerable between partners including youth justice;
- everyone in contact with children and young people feels equipped to actively support their mental health and wellbeing;
- that access to getting more help and risk support is available through local settings including primary, acute and specialist care, is timely, and based on clear pathways of care linked to different types of need;
- well informed commissioners with comprehensive intelligence about needs and provision who strive to co-produce with children, young people and their families leading to innovative, creative and responsive support across a range of services from primary to inpatient and secure settings.

Chapter Three

Progress on Perinatal Mental Health

Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. They include mental health problems that arise for the first time, as well as problems that were present before the pregnancy began.

In Cheshire East around 3,800 women go through pregnancy each year. Up to 30% (1,100) will experience some form of minor or moderate mental health problem during their pregnancy, and around half of these women can be safely managed by their midwife and/or health visitor. The remainder can usually be managed by their GP or by a psychological therapies (IAPT) service. Serious perinatal mental health problems requiring referral to specialist perinatal mental health services are much less common, and affect around 3% (110) of pregnant women annually.

In last year's report we highlighted how promoting positive mental wellbeing among all pregnant women can help to reduce levels of anxiety and stress, and how this would protect the mental health of around 10-15% of babies during a critical period of brain development in the womb.

This chapter looks at some of the progress that has been made since last year and outlines some of the transformation work that remains to be completed in Cheshire East.

The Transformation of Perinatal Mental Health Care

This process is being led by a National Transformation Board that is filling gaps in the availability of Mother and Baby Units and the provision of specialist perinatal mental health community services. Locally, transformation changes are being led by a Working Group for Perinatal Mental Health that has been set up to cover the Cheshire and Merseyside Sustainability and Transformation Plan (STP) footprint.

NHS England is commissioning four new Mother and Baby Units nationally. One of these units will be built in Lancashire and Cumbria, and this will help to address the significant access issues that exist in the North West. This new unit will provide much needed inpatient mother and baby support for women who are experiencing severe mental health crisis including post-partum psychosis.

Although the new North West unit will help to improve access to this very specialist form of care, the STP Working Group for Perinatal Mental Health should consider how clinical pathways for specialist perinatal mental health community services in Cheshire East might support a mother's inpatient care to be provided in the Manchester Mother and Baby Unit (located at Wythenshawe Hospital) or the South Staffordshire and Shropshire Mother and Baby Unit (located in Stafford), depending on where she lives. Both of these units are geographically convenient to women in Cheshire East.

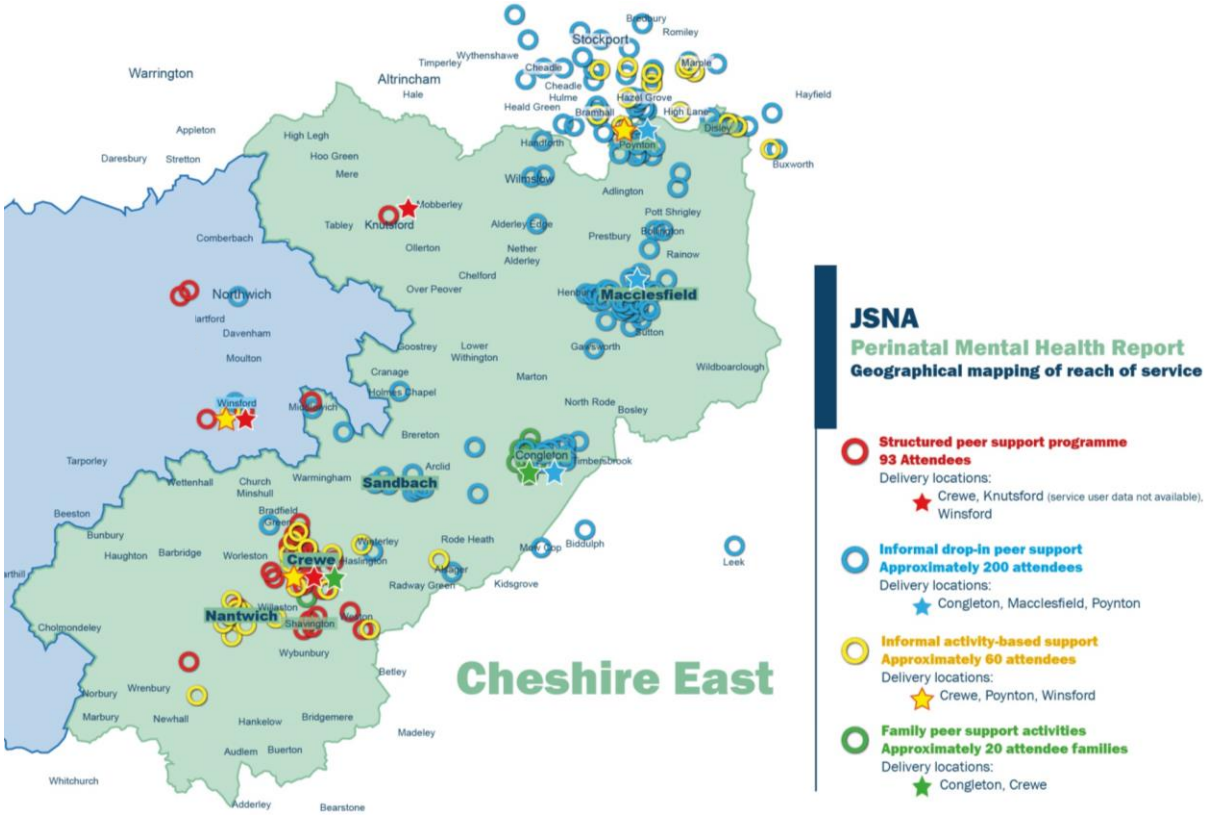
NHS England has also established a Perinatal Community Services Development Fund and has awarded £3.3m to Cheshire and Merseyside Sustainability and Transformation Plan (STP) to develop community perinatal mental health services. This money will be used to develop a Specialist Perinatal Community Mental Health Service which will be delivered through three locality teams across Cheshire and Merseyside. These teams, provided by Cheshire and Wirral Partnership, 5

Boroughs Partnership and Mersey Care NHS Foundation Trusts, will support women with serious mental health problems during pregnancy and in the first year after birth."

Supporting Maternal Mental Health

In last year's Public Health Report we identified that if we want the best outcomes for our children we need to provide the best possible emotional care for pregnant women. Although very common, anxiety and depression in pregnant women goes largely undetected and untreated. A wide range of circumstances can cause stress, anxiety and depression, including a poor relationship with the partner. Appropriate personalised help and support should be available to every woman.

In their recent Community JSNA report on Perinatal Mental Health, Cheshire East CVS looked at the needs and usage of peer support services for pregnant women in Cheshire East[15]. They identified four local service providers, three from the Voluntary, Community and Faith Sector (VCFS) – "Motherwell CIC", "SMILE" and "Poynton Pandas", and one public service provider – Wirral Community NHS Trust, whose health visitors run "Lavender Groups". The distribution of service contacts is shown in the map.



The key findings from this Community JSNA report include:

- The groups offer a range of services including: structured peer support programmes; informal drop-in peer support sessions; informal activity-based support and family support activities and events (including We Are Family Motherwell sessions for lesbian, gay, bisexual, and transgender parents);

- All of the VCFS groups can be accessed by self-referral or professional referral;
- There is a predominance of structured peer support in the south of the borough with a lack of informal drop-in peer support;
- Poynton PANDAS attracts many service users from outside the borough;
- The SMILE Group will be providing a new informal drop-in peer support group in Sandbach;
- Motherwell CIC also have experience, with their 6 week programme, of supporting mums who have had children removed.

Some of the main characteristics of the peer support services in Cheshire East are illustrated in the table. Mums tend to 'journey' through the menu of services as their need for support changes over time. A number of the mums have stayed on with groups who provide informal drop-in sessions as peer supporters themselves, and are trained by the groups (these positions are either voluntary or paid, but all are provided with training).

Some of the characteristics of peer support services in Cheshire East				
	SMILE	Poynton PANDAs	Motherwell	Lavender
Delivery location	Children's Centres	Church Hall	Lifestyle Centre	Children's Centre
Peer support groups	weekly, all year	weekly, term time	6-week programme	6-week programme
One-to-one support	yes	no	yes	no
Online support	no	yes	no	no
Can drop-in with friends/relatives	yes	yes	no	no
Method of referral	self-referral or by a professional	self-referral or by a professional	self-referral or by a professional	only referral by a Health Visitor
Quality assurance	yes	yes	yes	yes
Outcomes measurement	CORE10	no specific mechanisms	GAD	EPND/GAD
Community JSNA report on Perinatal Mental Health, Cheshire East CVS				

This Community JSNA illustrates that there are inconsistencies in the level of peer and professional support for women in Cheshire East. Peer support groups are not yet in place in all areas although some developments are underway. Programmed approaches to treatment such as the Lavender groups will not meet the immediate needs of many women as the scheduling may lead to time delays before women can start attending a group. These groups should therefore form part of a broad range of peer support rather than being the primary service offer. In developing future provision, there is a need to understand the capacity of all peer support providers to deal with current and future levels of demand. Cross-sector pathways could then be developed which facilitate women to access the right support at the right time for them. There are also opportunities, through improved partnership working, to share best practice and identify where consistent approaches across organisations would be beneficial.

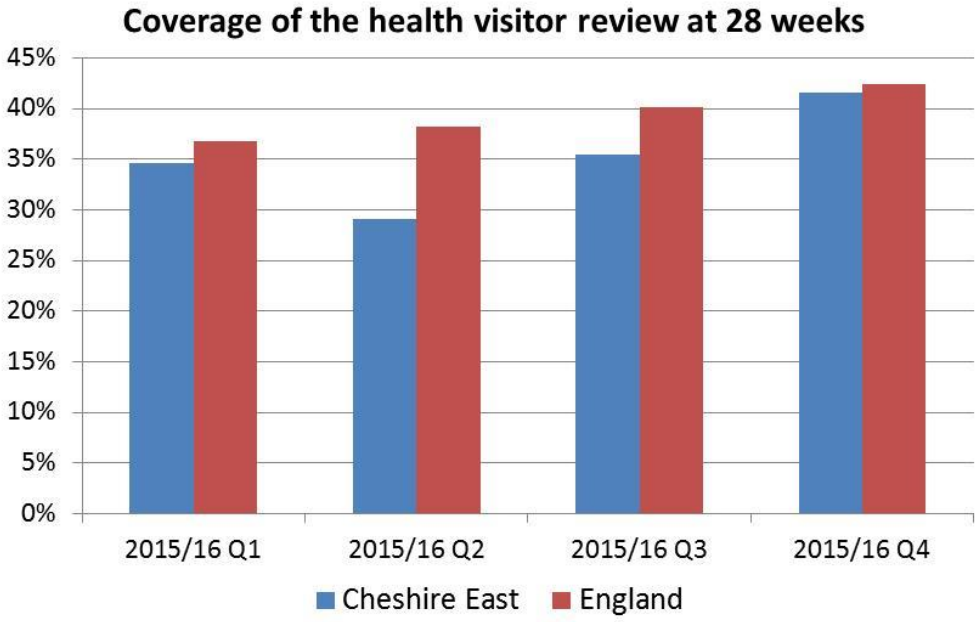
The Universal Health Visitor Review at 28 Weeks

Cheshire East Council must ensure that universal health visitor reviews are offered to pregnant women and young children at specified stages in their development.[16] The details of these health

and development reviews are set out in the Healthy Child Programme.[17] The review is generally carried out by a health visitor although it may be delegated to a suitably qualified health professional or nursery nurse, or a family nurse within the Family Nurse Partnership. The 28 week review cannot be carried out as an activity that is offered to a group of pregnant women.

One of the universal health visitor reviews is offered during pregnancy to women who are more than 28 weeks pregnant. The review should be offered to all women and not just those who are booked to deliver in the two local maternity units. In 2015, 83.2% women from Cheshire East (3,177 out of 3,818) delivered their baby in a maternity unit inside the borough, and 90 (2.3%) women delivered at home. This suggests that over 85% of pregnant women received their antenatal and intrapartum care from midwives locally. 6.5% and 2.7% of women delivered at Wythenshawe and Stepping Hill hospitals, and 1.8% each at Royal Stoke and St Mary's hospitals.

Although the number of pregnant women who receive a first face-to-face antenatal contact with a health visitor is collected every quarter, coverage rates are not normally calculated due to the difficulties in defining the denominator. As the review is usually offered at 28 weeks, which is three months before the expected birth date, coverage can be estimated using the number of births that take place in the following quarter.



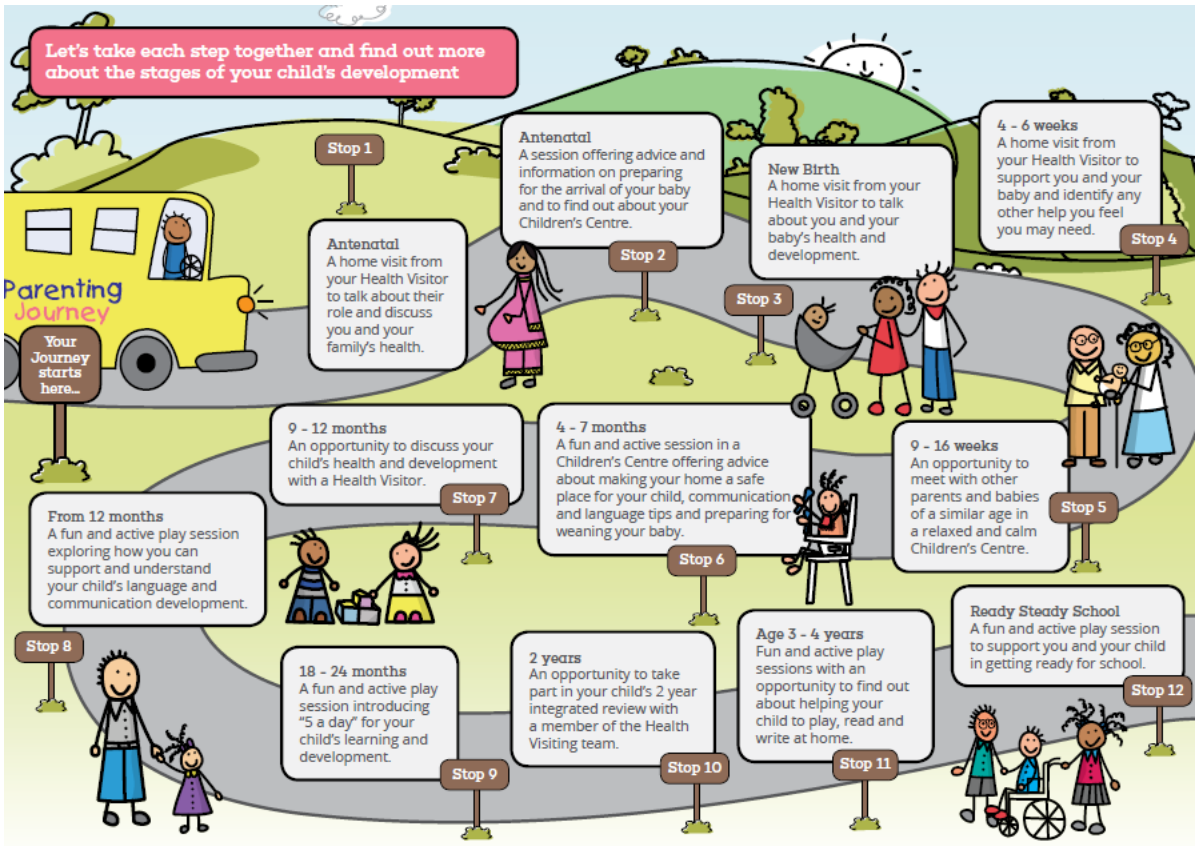
This chart and Appendix B illustrate recent trends in the number and proportion of the 28 week reviews. In Cheshire East there are variations from quarter to quarter, and coverage has fallen markedly in the first two quarters of 2016/17, although this may be a data quality issue. This is quite different to what is happening in England, where the rates for the four quarters of 2015/16 (calculated using the same approach) are 36.8%, 38.2%, 40.2% and 42.5% - i.e. increasing by a relatively steady 2% each quarter. Cheshire East's rate for the whole of 2015/16 was just 35.1%, compared to 40.3% in Cheshire West and Chester and 69.2% in Wirral.

The Cheshire East Parenting Journey

Cheshire East has created an integrated Parenting Journey that runs until the child starts school. This work has led to co-location of healthy child services (health visitors and school nursing services) in Children's Centres, and new joint working arrangements for groups of staff.

The Cheshire East Parenting Journey currently starts at 28 weeks (70% of the way through pregnancy) with the antenatal visit from the health visitor. This is termed Stop 1 and it allows the health visitor "to talk about their role and discuss you and your family's health". This particular contact with the pregnant woman is a statutory requirement under current legislation.

The second contact in the Cheshire East Parenting Journey (Stop 2) occurs at 36 weeks (90% of the way through pregnancy) when the woman is invited to come to the local Children's Centre to "prepare for the arrival of your baby and find out about your Children's Centre". Heavily pregnant women may choose not to take up this offer and it may be of limited benefit (with respect to modifying any lifestyle or environmental factors that could impact on the outcome of the pregnancy) so late in the pregnancy. For this reason, we think that the timing of this 'stop' could be reviewed.



In both of the last two Public Health Reports, we have drawn attention to the critical importance of early pregnancy to the physical and mental development of a child, and we have recommended that Children's Centres should become a resource for parents at all stages of pregnancy, including:

> *(2014) Preconception care can reduce the number of babies who are exposed to risks during the earliest stages of their development, particularly from alcohol and smoking. There should be access to preconception advice for second and subsequent pregnancies from health*

visitors. Children's centres should help and support couples to receive alcohol counselling and advice, smoking cessation services and signpost to weight reduction if needed.

(2014) As children's centres become established as part of the antenatal pathway, they need an agreed approach to enable them to respond to midwives' and health visitors' assessment of which families and children are most able to benefit from support to improve their health, including those that have newly moved to the area. Children's centres must agree methods to track the outcomes that are achieved amongst these children.

(2015) The universal health visitor review during pregnancy should also include an offer of practical help with any relationship problems that the pregnant woman may be experiencing, a discussion about any additional social support that she might need, and practical help with any housing issues or worries.

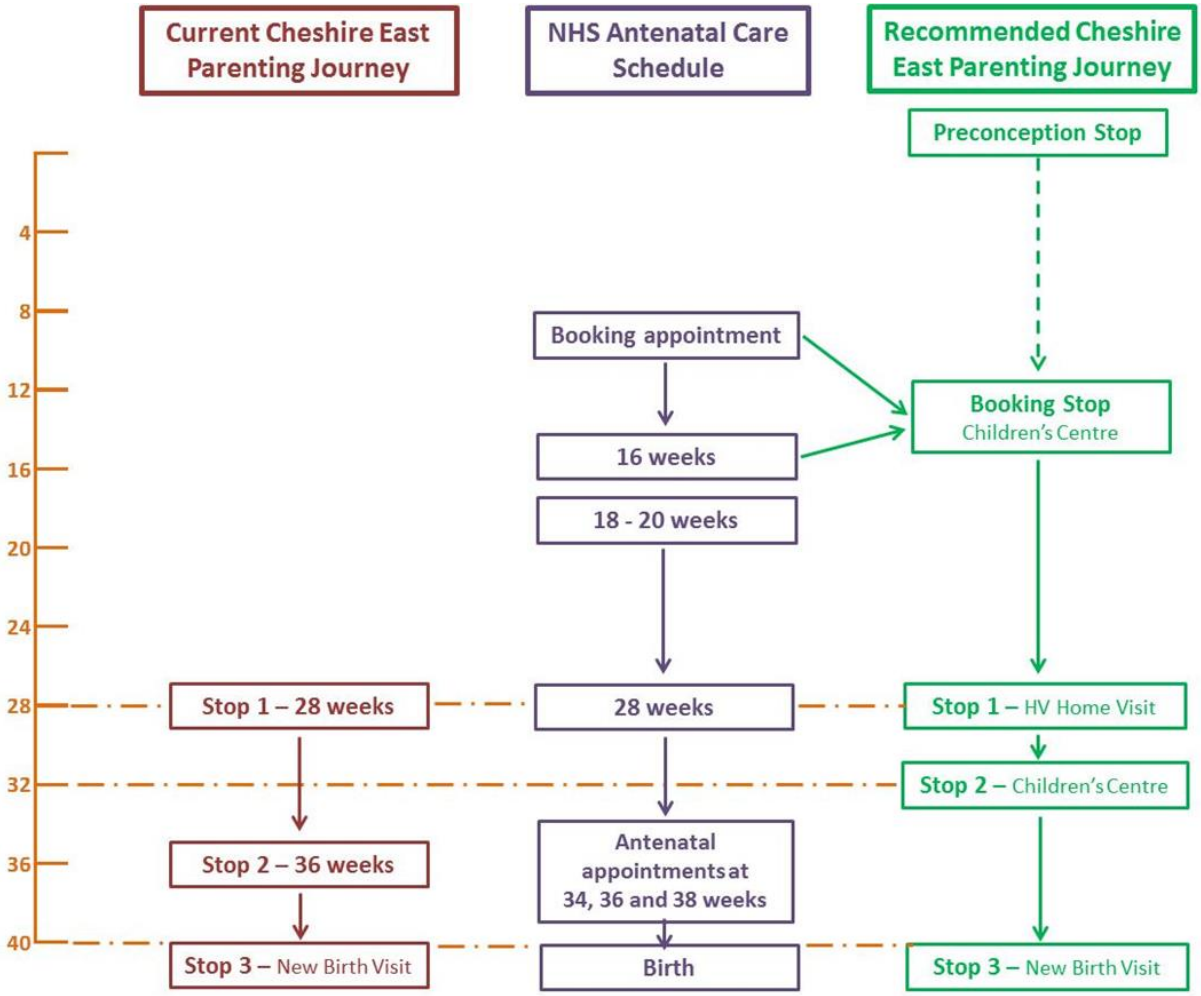
It may be that some professionals have concerns about starting the Cheshire East Parenting Journey too early because they believe that a higher proportion of pregnancies may be non-viable before 28 weeks compared to later on in gestation. They may be worried about recruiting a woman onto a journey that may not continue should she miscarry. Research indicates that rates of miscarriage (of a recognised pregnancy) are highest before about 11 weeks of pregnancy. After this time the miscarriage rate declines quickly and it stays at a low rate from about 16 weeks onwards, although the risk of stillbirth does increase in late pregnancy. When risk of miscarriage is considered from the stage of ultrasound at 7 to 10 weeks, and those pregnancies that have been considered unlikely to survive due to fetal abnormalities are excluded, the overall rate of pregnancy loss is thought to be as low as 2 to 3 per cent.

As a woman's risk of pregnancy loss declines significantly after the 11 week stage, it may be reasonable to identify the start of the Cheshire East Parenting Journey to be either after a woman has her booking appointment, which usually happens at around 10 weeks into a pregnancy, or to start her Parenting Journey following the 16 week appointment with her midwife, which is a time when women are being prepared by their midwife for their parenting role by providing more information and encouraging attendance at antenatal classes.

In either case the decision to commence on the Cheshire East Parenting Journey should be taken by the woman herself in conjunction with her midwife and health visitor. If she begins her Parenting Journey earlier in pregnancy, she may wish to be offered a choice of appointments at the Children's Centre so that she can attend on days and times that are convenient for her.

Those women who do miscarry are likely to have greater needs for advice and support in their next pregnancy, and they are probably **more** likely to want to participate in a Parenting Journey that is reframed to start from preconception onwards (i.e. the first 2014 recommendation shown above).

The current Parenting Journey could also be better connected to a woman's antenatal care pathway, particularly given that in some areas the NHS Antenatal Care pathway is already being delivered within Children's Centres.



For the many reasons outlined above, we are recommending that the addition of a new "Booking Stop" in the Cheshire East Parenting Journey at 10-16 weeks depending on when the midwife notifies the staff in the Healthy Child Programme about prospective parents requiring additional early intervention and prevention (as listed in the box at the end of this chapter) should be explored. Pregnant women should also be able to refer themselves to this "Booking Stop" if they have other needs. This new "Booking Stop", which should take place at a Children's Centre, will be a key opportunity for Health Visitors and Children's Centre staff to assess these families' needs.

We also recommend exploring the movement of the current Stop 2 on the Parenting Journey earlier to 32 weeks (or 34 weeks if it is carried out during the same visit as the 34-week antenatal care appointment) instead of the current 36 weeks. This would allow much more effective support to be put in place for those women whose needs arise later on in their pregnancy.

Healthy Child Programme: Pregnancy and the first five years of life

At this juncture, it is worth reminding ourselves about the Best Practice Guidance for the Healthy Child Programme that was originally set out in 2009 by the Department of Health and the then Department for Children, Schools and Families (predecessor to the Department for Education).[17] This

Best Practice Guidance was specifically referenced in the new Public Health Regulations that came into force on 1st October 2015.[16] Regulation 5A(5) states:

> *(5) In this regulation, "the Healthy Child Programme" means the programme of that name, described in a policy guidance paper published by the Department of Health on 27th October 2009(b), that—*
>
> *(a) is intended for the benefit of pregnant women, children aged under five years and the families of such pregnant women and children;*
>
> *(b) provides for health and development assessments and reviews, screening tests, immunisations and health promotion guidance and support tailored to the needs of the pregnant woman, child, or their family at specified stages of development of the pregnant woman or child; and*
>
> *(c) assists the identification of families in need of additional health or well-being support and children who are at risk of suffering poor health or well-being.*

The following introductory paragraph in the Foreword for the Healthy Child Programme, written in 2009 by Dr Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services, is as relevant today as it was then.[17] Her advice requires very little in the way of update or modification:

> *"This is a critical moment in the development of the Healthy Child Programme. The advances taking place in neuroscience and genetics – and our understanding of how early childhood development can be both promoted and damaged – create an imperative for the Healthy Child Programme to begin in early pregnancy. At the same time, the development of Sure Start children's centres gives us an opportunity to make more of a difference to children – across a wider set of outcomes – than we have been able to in the past."*

The following are some of the core requirements of the Healthy Child Programme **for women up to 28 weeks gestation** (fuller details in Appendix C). There are **other requirements after 28 weeks gestation**. The national Healthy Child Programme policy guidance paper provides a clear blueprint for developing the detailed content of the antenatal stage of the Cheshire East Parenting Journey:

- ***Promotion of health and wellbeing**, including a full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy by a midwife or maternity healthcare professional, with notification to the Healthy Child Programme team of prospective parents requiring additional early intervention and prevention;*
- ***Promotion of health and wellbeing**, including introduction to resources, including Sure Start children's centres, Family Information Services, primary healthcare teams, and benefits and housing advice;*
- ***Preparation for parenthood**, including information on services and choices, maternal/paternal rights and benefit, and social support using group-based antenatal classes in community or healthcare settings that respond to the priorities of parents;*

- ***Women experiencing domestic abuse.*** *Women are at increased risk of domestic abuse during pregnancy, and this should be identified as part of the Healthy Child Programme (see the box on page 32). Interventions include information, advice and support from the Cheshire East Domestic Abuse Hub;*

- ***Women with ambivalence about pregnancy, low self-esteem and relationship problems,*** *including techniques to promote a trusting relationship and develop problem-solving abilities within the family;*

- ***Women experiencing anxiety or depression,*** *including interventions ranging from social support, assisted self-help, brief non-directive counselling or referral for treatment;*

- ***Women who smoke, or who are overweight or obese,*** *including smoking cessation interventions or weight control strategies.*

Apart from the figure on page 26, demonstrating the Cheshire East Parenting Journey, there are no other materials available for women and their families that outline what they can expect to receive as part of the Healthy Child Programme, and the pathways they can choose to follow. These materials should be developed quickly, and promoted very widely including to all women who are either pregnant or are planning a pregnancy.

New Community Hubs for Personalised Maternity Care

A major redesign of maternity care is currently taking place in the NHS. The Cheshire and Merseyside Women's and Children's Partnership (an acute care collaboration vanguard set up by NHS England to link local hospitals together to improve their clinical and financial viability and reduce variation in care and efficiency) is working as an Early Adopter to implement the recommendations of the 2016 National Maternity Review: *Better Births*. This Partnership will be the delivery vehicle for the establishment of a single Local Maternity System (LMS) for Cheshire and Merseyside.

A local maternity system aims to ensure that women, their babies and their families have equitable access to the services they choose and need, as close to home as possible. To achieve this, the Cheshire and Merseyside Women's and Children's Partnership intends to bring together all providers involved in the delivery of maternity and neonatal care, develop a local vision for improved maternity services based on the principles of Better Births, co-design services with service users and local communities, and put in place the infrastructure needed to support services working together.

At the present time, the plans of the Cheshire and Merseyside Women's and Children's Partnership are highly focused on the NHS and do not fully consider the other stakeholders who are also working to achieve gains in maternal and newborn health. For example, the Partnership is intending to measure success by measuring improvements in the four maternity-related CCG outcomes (neonatal mortality and stillbirths, maternal smoking at time of delivery, women's experience of maternity services, and choice in maternity services). The Partnership does not appear to be considering other Outcomes Frameworks including the Public Health Outcomes Framework (low birth weight of term babies, breastfeeding initiation and prevalence, under-18 conceptions, pregnancy and newborn screening, and infant mortality).

One of the important recommendations of the National Maternity Review is that personalised maternity care should be delivered in local "community hubs" to help women to access care in the community from their midwife and a range of other agencies:

> *(Better Births 2016) Community hubs should be established, where maternity services, particularly ante- and postnatally, are provided alongside other family-orientated health and social services provided by statutory and voluntary agencies. Community hubs should work closely with their obstetric and neonatal unit(s).*

The concept of a maternity community hub is that it is a local centre where women can access various elements of their maternity care. *Better Births*[18] suggests that a community hub could be located in a children's centre, or in a freestanding midwifery unit, or be embedded in new at-scale models of primary care. Different providers of care can work from a community hub, offering midwifery, obstetric and other services that are easily accessible for women. Small teams of 4 to 6 midwives who are based in the community will become part of the core workforce of each community hub.

Other services based in maternity community hubs might be ultrasound services, voluntary services providing peer support for perinatal mental health, and smoking cessation services in some areas. Women will be able to meet and get to know the Early Years workers who will become more involved with them after childbirth. In some community hubs there may be birthing facilities. These community hubs will also need to provide timely access to personalised advice on smoking, alcohol, immunisation, breastfeeding and nutrition for every woman and her family **before, during and after** her pregnancy, which fits well with the Cheshire East Parenting Journey outlined above.

It is evident from the above that the development of maternity community hubs in Cheshire East will have considerable implications for the future development and co-location of the NHS, Local Authority, Voluntary Sector and Private Sector workforces. This means that Local Authority and CCG commissioners will need to work closely together within the Local Maternity System to plan how and where the new maternity community hubs should be developed inside the borough.

Properly designed maternity community hubs will become valued facilities for the local community and, as *Better Births* suggests, will lead to fuller integration of the family-orientated health and social services provided by statutory and voluntary agencies. Under Cheshire East's Local Plan, many towns in the Borough will be experiencing sustained population growth through new housing developments, which will attract more young families and drive up fertility rates. Over time, maternity community hubs sited in these towns will become more cost-effective because of this increased throughput.

Recommendations

3.1 The North West Coast Strategic Clinical Network Perinatal Mental Health Working Group for Cheshire and Merseyside should consider how clinical pathways for specialist perinatal mental health community services in Cheshire East might support a mother's inpatient care to be provided in the Manchester Mother and Baby Unit (located at Wythenshawe Hospital) or the South Staffordshire and Shropshire Mother and Baby Unit (located in Stafford), depending on where she lives;

3.2 Improve cross-sector partnership working to identify and respond to gaps in peer support provision and share best practice;

3.3 Develop cross-sector pathways between providers of perinatal mental health support which facilitate women to access the right support at the right time for them;

3.4 Consideration should be given to adding a new "Booking Stop" to the Cheshire East Parenting Journey at between 10 to 16 weeks gestation;

3.5 Consideration should be given to moving the current "Stop 2" on the Cheshire East Parenting Journey to 32 weeks instead of the current 36 weeks gestation;

3.6 Local materials should be developed for women and their families to outline what they can expect to receive as part of the Healthy Child Programme, and the pathways they can choose to follow. These materials need to be developed quickly, and promoted very widely including to all women who are either pregnant or a planning a pregnancy;

3.7 Local Authority and CCG commissioners in Cheshire East should work closely together within the Local Maternity System to plan how and where the new maternity community hubs should be developed inside the borough.

Early identification of need and risk

(Taken from page 17 of the Healthy Child Programme report)

It can be difficult to identify risks early in pregnancy, especially in first pregnancies, as often little is known about the experience and abilities of the parents, and the characteristics of the child. Useful predictors during pregnancy include:

- young parenthood, which is linked to poor socio-economic and educational circumstances;
- educational problems – parents with few or no qualifications, non-attendance or learning difficulties;
- parents who are not in education, employment or training;
- families who are living in poverty;
- families who are living in unsatisfactory accommodation;
- parents with mental health problems;
- unstable partner relationships;
- intimate partner abuse;
- parents with a history of anti-social or offending behaviour;
- families with low social capital;
- ambivalence about becoming a parent;
- stress in pregnancy;
- low self-esteem or low self-reliance; and
- a history of abuse, mental illness or alcoholism in the mother's own family.

Chapter Four

Aspects of Common Mental Illnesses

This section gives a brief overview of common mental illnesses including aspects of presentation and current treatments. The section is by no means comprehensive and it gives an indication of what is current and the most recent literature in specific areas.[19]

Anxiety Disorder

Previous evidence has demonstrated that general practitioners (GPs) fail to diagnose up to half of common mental disorders. A meta-analysis of 34,902 patients indicated that anxiety is no exception. The study showed that GPs' diagnostic accuracy increased from 30.5% to 63.6% when "assisted" i.e. using severity scales/instruments/diagnostic techniques.[20] In other words, without the use of this technique, GPs are picking up less than a third of cases. Use of these tools might improve detection of anxiety disorders in primary care.

A large systematic review (163,366 persons) published in 2014 concluded that various socio-demographic, psychosocial and mental – physical health risk factors are determinants of the onset of both panic and generalised anxiety disorders in the adult population. Specifically, these risk factors are age, female, few economic resources, smoking and alcohol problems for panic disorder and for anxiety the associated risk factors are age, divorce, widowed and few economic resources. The findings indicate possible areas for preventive interventions.[21]

The National Institute for Health and Care Excellence (NICE) advocates a "stepped care" approach. [22] [23] However, in terms of medication, the most cost-effective medicine will depend on the balance of its effectiveness and side-effects and how the latter dictate discontinuation.[24] A promising technique is therapist supported internet Cognitive Behavioural Therapy (CBT) for anxiety disorder in adults. This proved to be effective compared to waiting list or online discussion groups. Further research is still required to compare this to face-to-face CBT and also to identify the harms.[25]

Depressive Disorder

As above, NICE recommend a stepped care approach with the least intrusive, most effective intervention provided first, followed by a measured progression depending on condition and response.[26] Most recently (2016), the American College of Physicians produced guidelines for treatment based on a systematic review. The guidelines recommend either CBT or second generation antidepressants (e.g. mianserin) for major depressive disorder. Evidence for the other interventions such as psychotherapies, complementary and alternative medicines (acupuncture, omega-3 fatty acids, adenoysl methionine, St John's wort) and exercise was low quality.[27]

A much earlier systematic review (2011) confirmed that mindfulness-based CBT is a useful technique to prevent relapse in recurrent major depressive disorder (a 34% reduction in relative risk). This is a group based intervention consisting of training in mindfulness meditation in combination with CBT.[28] A systematic review published in the same year also showed that music therapy reduces depressive symptoms.[29]

Bipolar Disorder

A systematic review published in the British Journal of Psychiatry (2016) reviewed 55 trials with 6010 participants who had undertaken individual psychological interventions for bipolar disorder. Overall, there was a reduction of between 32% – 34% in post-treatment relapses and hospital admissions.[30]

On the other hand, group psychoeducation improves medication adherence and short-term knowledge about medication and also appears to be effective in preventing any relapse and manic/hypomanic relapse (Number Needed to Treat = 5 – 8) but not depressive relapse. Although the authors warned of limitations due to heterogeneity of their data, they concluded that group psychoeducation is effective in preventing relapse in bipolar disorder with less evidence for individually delivered interventions.[31]

Schizophrenia and Psychosis

The incidence of schizophrenia is different in men and women. It peaks in men aged 20 – 29 years with a median rate of 4.15 per 10,000 person – years. However, for women in the same age range, the median rate is 1.71 per 10,000 person-years. This peak is followed by a decline in incidence up to the age 60 years – a reduction that occurs more in men than women. This suggests different susceptibility in men and women at different stages of life.[32]

People with schizophrenia also tend to smoke more heavily than the general population. This contributes to high morbidity and mortality from smoking-related illnesses. A Cochrane review concluded that bupropion (Zyban) is effective as an aid to smoking abstinence without jeopardising mental state whereas varenicline (Champix) may do the same but the possibility of psychiatric adverse effects cannot be ruled out.[33] Similarly, patients with a first episode psychosis are known to have a very high prevalence of tobacco use (prevalence estimated at 58.9%).[34]

The mainstay of treatment for schizophrenia has been chlorpromazine for over 50 years. Although well established, the treatment is imperfect owing to its adverse effects.[35] A more recent mode of treatment is CBT although the evidence for this is not strong.[36 37] Similarly, there are insufficient data to identify differences in outcome between supportive therapy (which ranges from simple befriending to giving support for daily living) and standard care.[38] In its clinical guideline, NICE recommends provision of specialist mental health services, early intervention for psychosis service and crisis resolution and home treatment.[39]

Psychosis, which involves experiencing hallucinations and/or delusions, is one aspect of schizophrenia and can occur across a spectrum ranging from mild schizoid personality disorder at one end to severe schizophrenia at the other.[40] Theoretically, early intervention should improve current functioning and reduce symptomatology and reduce the risk of progression to full psychosis.[41] However, evidence for early intervention is inconclusive.[42] There is moderate quality evidence that CBT reduces transition to psychosis at 12 months.[43]

Eating Disorder

Anorexia nervosa carries high morbidity and significant mortality and is most common in young adult women.[44] However, emerging evidence suggests that eating disorders are surprisingly common in

older women to the extent that clinicians should be alert for eating and body image disorder even in women well beyond the younger age range.[45] The clinical context is further complicated as one study showed that anorexia and bulimia nervosa cases present to Accident and Emergency departments with a multitude of vague complaints.[46]

Regarding treatment, a review published in 2013 indicated that individual and group CBT are superior to waiting list for the treatment of body dysmorphic disorder. However the authors acknowledged the need for further head-to-head studies with appropriate controls.[46] Also, although anorexia nervosa is often preceded by excessive physical activity, a review written in the same year concluded that supervised exercise training and the comprehensive management of patients with anorexia nervosa appears to be safe and showed improvements in strength and cardiovascular fitness without any detrimental effect to observed anthropometry.[47]

Less encouraging is a Cochrane review (2015) which was unable to draw conclusions about individual psychological therapy in the outpatient treatment of adults with anorexia nervosa because of data limitations. Focal psychodynamic therapy (FPT) encourages people with anorexia to think about how early childhood experiences may have affected them with the aim of finding more successful ways of coping with stressful situations and negative thoughts and emotions.[44]

Of utmost concern are the implications of the Royal College of psychiatrists' MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa report.[48] The authors were aware of several cases of young people dying unnecessarily on medical units as a result of anorexia. Deaths can occur because of under- or over-feeding (re-feeding syndrome) in people whose general metabolic status is severely compromised. The College recommends that both medical and psychiatric ward staff are aware of the risk in these patients. Most adults should be treated in specialist eating disorder units and medical teams should have adequate support from psychiatry. In addition, commissioners should be aware of inadequate local provision and ensure robust plans are in place for adequately trained and resourced medical, nursing and dietetic staff. In essence, this means that the mental and physical needs of these desperately ill patients are met simultaneously.

Other Mental Illnesses

The classification of Post-Traumatic Stress Disorder (PTSD) has recently been updated in the new Diagnostic and Statistical Manual of Mental Disorders (DSM – 5) and includes symptoms clustered into 4 domains – intrusive symptoms, active avoidance, disturbed emotional states and alterations of arousal and reactivity. The condition has a lifetime prevalence of 10%.[49] Medications are modestly more effective than placebo to treat the symptoms and Selective Serotonin Reuptake Inhibitors (SSRIs) are considered a safe initial choice. However, prolonged exposure therapy and cognitive reprocessing therapies have been widely validated. In women with postnatal PTSD, the symptoms are similar to PTSD and CBT is effective in both.[50]

Exposure and ritual prevention using CBT is regarded as a standard treatment for Obsessive Compulsive Disorder.[51] NICE suggests that adults with anxiety, panic, PTSD, OCD or body dysmorphic disorder should receive psychological interventions based on a stepped care approach.[23]

Finally, the interconnectedness of various mental disorders is illustrated by a review published in 2014 which notes the relationship between adult ADHD and bipolar disorder as these present with

similar symptoms.[52] In the USA, ADHD affects 4.4% of adults and 1.4% for bipolar disorder. Around 27% of adults with ADHD have bipolar and up to 20% of adults with bipolar also have ADHD. Determining whether a patient has one or both is a complex task.

Chapter Five

Programmes to Improve Population Level Mental Health and Wellbeing

A variety of initiatives to improve mental wellbeing of the population have been developed.

Small improvements in wellbeing can help to decrease some mental health problems and also help people to flourish. The New Economics Foundation on behalf of Foresight, set out five actions (Five Ways to Wellbeing) to improve personal wellbeing:[53]

- connect;
- be active;
- take notice;
- keep learning;
- give.

Using insight research, the Cheshire and Merseyside Public Health Collaborative (Champs) have developed the Make Time Campaign[54] which is based on the Five Ways to Wellbeing Model. The existing five ways to wellbeing have been reframed into messages that better resonate with the public. The question 'When was the last time you …' was used for five posters (see overleaf) which provide ideas for activities, and are linked to the Five Ways to Wellbeing messages.

The mental health challenge is already showing that local authority member champions have the potential to raise the profile of mental health and wellbeing in local communities, to enable councils to integrate mental health into the full range of their policies and responsibilities, and to link up with other local leaders to foster partnerships and encourage action to promote mental health and life chances. The challenge was launched in September 2013 and so far over 35 councils have taken the challenge and appointed member champions for mental health. Consideration should be given to Cheshire East also signing up to this challenge.

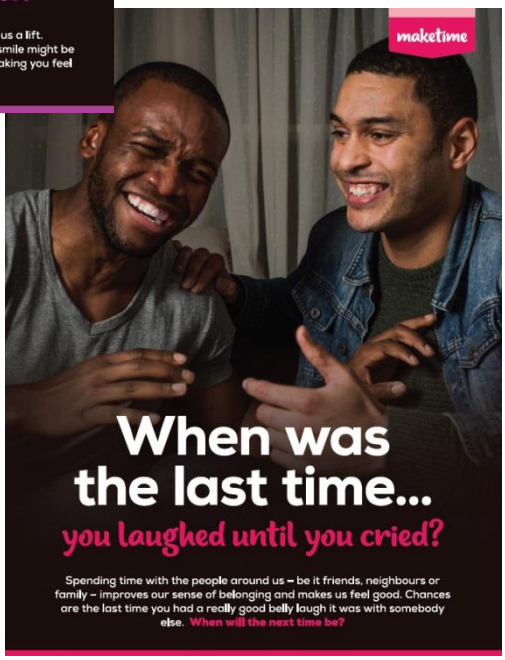
The National Institute for Health and Care Excellence (NICE) has produced guidelines to improve mental health in the workplace.[55] [56] These cover how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of line managers and are for employers, senior leadership and managers, human resource teams and all those with a remit for workplace health. They aim to create a supportive environment that enables employees to be proactive when and if possible to protect and enhance their own health and wellbeing, and to develop policies to support the workplace culture such as respect for work-life balance.


maketime
When was the last time...
you tried something new?
It's never too late to learn a new skill or take on a new challenge – like trying a new recipe, learning an instrument or taking that computer course. Doing it will make us feel proud. Some of your best memories might be thanks to a time when you decided to give something a go. When will the next time be?


maketime
When was the last time...
you noticed things around you?
It's not often that we stop to notice the world around us, think about how we're feeling or try to live in the moment. It may have been a while since you were curious or took some time to be aware of everything happening around you. When will the next time be?


When was the last time...
you made someone smile?
However we do it, doing something for someone else gives us a lift. Helping a friend or stranger could make their day. Just giving a smile might be enough. And that simple act of kindness can go a long way to making you feel good too. When will the next time be?


When was the last time...
you got up and out?
Being active isn't all about looking good, it helps us feel good too. Something as simple as going outside for a walk can make a positive difference to our mood. Discovering something you really like doing is the most important bit. When will the next time be?


maketime
When was the last time...
you laughed until you cried?
Spending time with the people around us – be it friends, neighbours or family – improves our sense of belonging and makes us feel good. Chances are the last time you had a really good belly laugh it was with somebody else. When will the next time be?

The Workplace Wellbeing Charter[57] has been adopted by Cheshire East Council. It is a statement of intent, showing commitment to the health of employees. Organisations using the Charter benefit in many ways including:

- The ability to audit and benchmark against an established and independent set of standards – identifying what the organisation already has in place and what gaps there may be in the health, safety and wellbeing of employees;
- Developing strategies and plans – The Charter provides a clear structure that organisations can use to develop health, safety and wellbeing strategies and plans;
- National recognition – The Charter award process is robust and evidence based. With over 1,000 organisations across England holding the award, the Workplace Wellbeing Charter is now widely recognised as the business standard for health, safety and wellbeing across England. The award helps to strengthen the organisation's brand and reputation, and supports sales and marketing activities.

The next section summarises the literature published in the last five years on general systems and models of care currently in use for the treatment of mental illness. It concentrates on evidence-based recommendations. There is also a focus on other aspects of mental health and illness taking into account risk factors, the wider determinants and the impacts on employment and physical health.

Overview of Evidence-based Practice

In 2013, the World Health Organisation set out its vision for a world in which mental health is valued, promoted and protected.[58] The overall goal is to promote mental wellbeing, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. One of the main objectives is to provide a comprehensive integrated and responsive mental health and social care service in community based settings. This involves integration of mental health care and treatment into general hospitals and primary care, continuity of care between different providers and levels of the health system, effective collaboration between formal and informal care providers and the promotion of self-care, for instance, through the use of electronic and mobile health technologies.

In a briefing document (2015), the King's Fund reviewed recent-history large scale transformations in the mental health sector and suggested that reconfigurations from the past have been implemented when the evidence base was limited. In future, therefore, there is a need to focus on using evidence to improve practice and reduce variation.[59] This theme is echoed by an editorial in the British Medical Journal (BMJ) which suggested that mental health policy documents in the past have tended to be aspirational rather than rational.[60]

The Royal College of Psychiatrists (2015) concur with the view that the best model of service delivery should be based on evidence that the model will deliver better care for patients – any proposed changes should be piloted first and then evaluated before wide-scale implementation.[61] The College also says that the principles underpinning a new service are ease of access, delivery of evidence-based treatment and continuity of care - ideally, patients should not be referred and assessed by different parts of the service before being provided treatment. The College goes on to say that

different service configurations may deliver the best outcomes in different areas. Finally, psychiatry is probably better served by having a generic community mental health team, with whom the patient is known and vice versa, although there is still a place for very specialist services such as perinatal, eating disorder and early intervention in psychosis. According to NICE, important aspects of effective care are a stepped care approach (a) and active involvement of the service user.[62 63 64]

(a) A stepped-care model provides the least intrusive, most effective intervention first, has clear and explicit criteria between the different levels and monitors progress to ensure the most effective interventions are delivered and the person moves up or down the pathway as needed.

Liaison Psychiatry

In a separate report (2013), the Royal College of Psychiatrists outlined their service model for liaison psychiatry.[65] This is a critical service (b) which should be integral to all acute hospitals. Staffing levels and skill mix need to be tailored to local factors and services require dedicated accommodation on the acute hospital site to ensure safety, privacy and dignity. Referrals should be accepted for any mental health problem that is moderate to severe and/or impairing physical health care.

(b) Liaison psychiatry addresses the mental health needs of people being treated in hospital for physical health problems. Such services are multidisciplinary, specialist mental health teams, skilled to address a range of mental health problems that arise in all clinical areas of acute hospitals. Some call for the expansion of this service into primary care.

However, in the National Audit Office report on preparations for improving access to mental health services (2016), it appears that only 7% of acute hospitals had liaison psychiatry operating 24/7 in 2014/15.[66] This is at odds with NICE guidance (2015) which suggests that every emergency department as a routine should have urgent access to a multidisciplinary liaison team which includes a consultant psychiatrist and registered psychiatric nurses and able to work with children and adults. A full mental health assessment should be available within one hour of the alert from the emergency department at all times.[67]

Vulnerable Groups and Domestic Abuse

A qualitative review (2012) searched for articles on hard to reach groups and their problems in accessing mental health services in primary care. The review identified 8 groups which included homeless, long-term unemployed, adolescents with eating disorders, depressed elderly, advanced cancer sufferers, patients with medically unexplained symptoms, asylum seekers and people from black and minority ethnic groups.[68] Many of the participants regarded their mental health problems as being rooted in social problems with resulting social isolation.

Another systematic review examined the mental health of sexual minorities. The majority of studies reported elevated risks for depression, anxiety, suicide attempts or suicide and substance related problems in this cohort. Bisexual individuals seem to be at highest risk.[69] Prevalence of psychiatric disorders which includes PTSD and major depression is also higher in soldiers than civilians.[70]

Adult victims of domestic abuse (all genders) commonly present with mental health problems. Including anxiety, depression, low self-esteem, inability to trust others, flashbacks, sleep

disturbances and emotional detachment. Other significant mental health impacts include the development of post-traumatic stress disorder, self-harming, and an increased risk of attempted or completed suicide (particularly in women). Services aim to prevent, identify and respond to incidents of domestic abuse. The Cheshire East Domestic Abuse Hub is a single 24/7 point of help, assessment and referral for anyone affected by domestic abuse – victim, perpetrator, young person, professional, or concerned member of the community.

Older People

Of particular concern is the mental health of older people. It has been estimated that around one third of older people experience problems with their mental health. Those without support i.e. who are socially isolated and/or physically unwell may experience significant mental distress.[71] It is not surprising that elderly patients with psychiatric illness commonly have comorbid medical conditions, the management of these are often sub optimal and can affect quality of life and increase mortality.[72] For many conditions such as cardiac disease, cerebrovascular disease, cancer, chronic kidney disease, chronic obstructive pulmonary disease and Parkinson's disease, there is emerging evidence that treatment can be effective in reducing depressive symptoms.[73] Collaborative care models appear particularly well suited to medically unwell older adults with benefits across both mental and physical health measures.

It has also been suggested that the current healthcare infrastructure isn't adequate to meet the present and much less so future need of the ageing population, particularly those with depression and physical health comorbidities.[74] Worryingly, it has been stated there is a gap in both policy and quality research evidence on how to meet the needs of this vulnerable group. Much of the literature originates from the USA with limited pockets of good practice in the UK.[75]

In addition, a UK systematic review suggested that community mental health teams are central to the provision of care for older people. However, limited evidence was found regarding the effectiveness of the core attributes of these teams which drive recommended policy directives. Further research is required.[76]

More specifically, severity of depression is significantly associated with poor quality of life in older people, a relationship which was stable over time.[77] A meta-analysis (2014) of 44 studies concluded that CBT is effective in late life depression.[78] However, a literature review from the USA concluded that expanding the use of antidepressants in older Americans hasn't been associated with notable decreases in the burden of geriatric depression.[79] Other work has shown that antidepressants reduce the risk of relapse but the benefits may not extend beyond 2 – 3 years. No interventions have been shown to reduce the long-term complications associated with depression and there is a need to develop preventive interventions which target risk factors.[80]

Mixed anxiety and depression is a more common presentation than depression alone, relapse rates are high and there is considerable under-treatment in the community.[81] It is currently unknown how current models will deal with this problem in the ageing population.[82] CBT is thought to be effective for anxiety alone but evidence suggests it might be less effective in the cohort of people older than working age.[83]

Physical Health

A BMJ editorial written in 2011 drew attention to the disparity between treatment of mental and physical illness. Only a quarter of mentally ill people across Europe receive any form of physical healthcare compared with 80% of people with diabetes – this is despite a much higher prevalence of illness in the former. Also, people with certain mental illnesses such as psychotic, affective, personality, drug related, and alcohol related disorders die on average about 20 years earlier than their mentally well counterparts.[84]

Two years later, a systematic review examined the impact of integrated mental and physical health services on general medical outcomes in people with serious mental illnesses.[85] The limited data available showed some positive outcomes in terms of process (e.g. increase in immunisation rates) but inconsistent results in terms of physical functioning. The relatively small number of trials (only 2/4 were deemed high-quality studies) and limited range of treatment models tested and outcomes reported point to the need for additional study in this area.

The King's Fund proposes 10 areas where integration is needed most, shown in the table below.

Prevention/public health	1. Incorporating mental health into public health programmes 2. Health promotion and prevention among people with severe mental illnesses
General practice	3. Improving management of 'medically unexplained symptoms' in primary care 4. Strengthening primary care for the physical health needs of people with severe mental illnesses
Chronic disease management	5. Supporting the mental health of people with long-term conditions 6. Supporting the mental health and wellbeing of carers
Hospital care	7. Mental health in acute general hospitals 8. Physical health in mental health inpatient facilities
Community/social care	9. Integrated support for perinatal mental health 10. Supporting the mental health needs of people in residential homes

The level of academic rigour utilised in producing this report is not clear. The report does suggest some ways of how these priorities could be tackled but the underpinning evidence is lacking. It should be noted that the King's Fund is not a "NICE accredited" evidence source neither has this specific report been subject to peer review.

Finally, the Royal College of Psychiatrists (2015) endorses the integration of physical and mental health care.[86] In a joint statement with the Royal Colleges of GPs and Physicians, the College proposes two considerations. These are co-location of physical and mental health care provision plus integration of mental health care provision into existing medical pathways and services – either primary or secondary care.

Chapter Six

Mental Health in People with Learning Disabilities

This chapter describes the mental health of people who are recorded by their general practitioner as having a learning disability. Learning disabilities are varied conditions, but are defined by three core criteria:

- Lower intellectual ability;
- Significant impairment of social or adaptive functioning;
- Onset in childhood.

The last two sections of this chapter, on depression and severe mental illness, borrow heavily from the findings presented in a recent preliminary report on a data collection designed to identify differences in the health and care of people with learning disabilities.[87]

Children and Young People with Learning Disabilities

There are several reasons why young people with learning disabilities are at greater risk of developing a mental health problem than those who do not have learning disabilities:

1. The intellectual impairment associated with learning disability reduces the child's capacity for finding creative and adaptive solutions to life's challenges;
2. Children and young people with learning disabilities are more likely to be in poverty and be socially disadvantaged;
3. They also experience higher rates of stressful life events and abuse than children and young people who do not have a learning disability;
4. Some causes of learning disability lead to vulnerability to particular mental health problems.

Although we explored mental health in some detail in the "Mental Health of Children and Adolescents with Learning Disabilities" chapter of the 2015 Public Health Report [88], it is worth reminding readers of this report that an analysis of the combined data from the two national epidemiological surveys of the mental health of children and adolescents in 1999 and 2004 has suggested that, when the above factors are taken into account, there is potential to reduce the increased risk of mental health problems associated with learning disabilities by at least two-thirds.[89]

In the 2014 Public Health Report, we first drew attention to a marked under-recording of moderate learning disability in schools in Cheshire East. In the following year, we found that although there had been an improvement in recording in primary schools between January 2014 and January 2015, there had been no equivalent increase in the secondary schools. By January 2016 the number of secondary school pupils with special educational needs due to moderate learning disability recorded by the Cheshire East annual schools census had fallen to just 138, many fewer than expected. This shortfall is mainly because secondary schools in Macclesfield, Congleton, Crewe and Wilmslow have fewer young people with moderate learning disability compared to secondary schools in other areas.

It is noteworthy that 3.46% of all pupils in England were recorded as having a moderate learning disability in January 2016. This figure is almost three times higher than Cheshire East, where only 1.23% of pupils were recorded by their school as having a moderate learning disability.

Pupils with Special Educational Needs in Cheshire East						
	January 2014		**January 2015**		**January 2016**	
	Mod LD	**Sev LD**	**Mod LD**	**Sev LD**	**Mod LD**	**Sev LD**
Primary schools	189	37	466	43	496	50
Secondary schools	130	10	159	16	138	21
Special schools	0	195	0	186	2	179
	319	**242**	**625**	**245**	**636**	**250**
Rate per 1,000 pupils						
	January 2014		**January 2015**		**January 2016**	
	C. East	**England**	**C. East**	**England**	**C. East**	**England**
Moderate LD	**5.9**	**15.6**	**11.6**	**28.6**	**12.3**	**34.6**
Severe LD	**4.5**	**5.0**	**4.5**	**5.1**	**4.8**	**5.5**
Severe Learning Difficulty includes Profound and Multiple Learning Difficulty						
SFR 26/2014, SFR 25/2015, SFR 29/2016. Special educational needs schools census						

Work that is currently being carried out by the Cheshire East Children's Team for the Special Educational Needs (SEN) Joint Strategic Needs Assessment (JSNA) is suggesting that a small number of pupils with moderate learning disability are being educated in schools outside the borough. However, even taking this into account, there is still likely to be an under-recording of young people with moderate learning disability in secondary schools within Cheshire East. A more accurate picture will become available when the work on this JSNA section has been completed.

As previously outlined, this under-recording is important because some young people with learning disability will require "reasonable adjustments" to be made to the services that they receive. For example, some young people with learning disabilities have reduced health literacy, and find it more difficult than others to understand issues such as what it means to be healthy, to have a healthy diet, the dangers of substance misuse, and the benefits of exercise.

If the young person's general practitioner does not know that they have a learning disability, these reasonable adjustments cannot be made and health inequalities will persist. In addition, young people with a learning disability are likely to need additional support to make the transition to adult life. Without a good understanding of their individual needs, it is more difficult to co-ordinate care around these needs, and to ensure continuity and the best outcomes.

We made the following three recommendations in last year's Public Health Report.

> *(2015) The Children's Joint Commissioning Team co-ordinate actions to tackle the shortfall in recording of children and young people with a moderate learning disability. This shortfall is concentrated in secondary schools in Macclesfield, Congleton, Crewe and Wilmslow, which is where efforts to recognise and record these young people need to be focused.*
>
> *(2015) The Children's Joint Commissioning Team initiate work to try to identify how many young people with moderate or severe learning disability are currently able to access mental health services that meet their needs.*

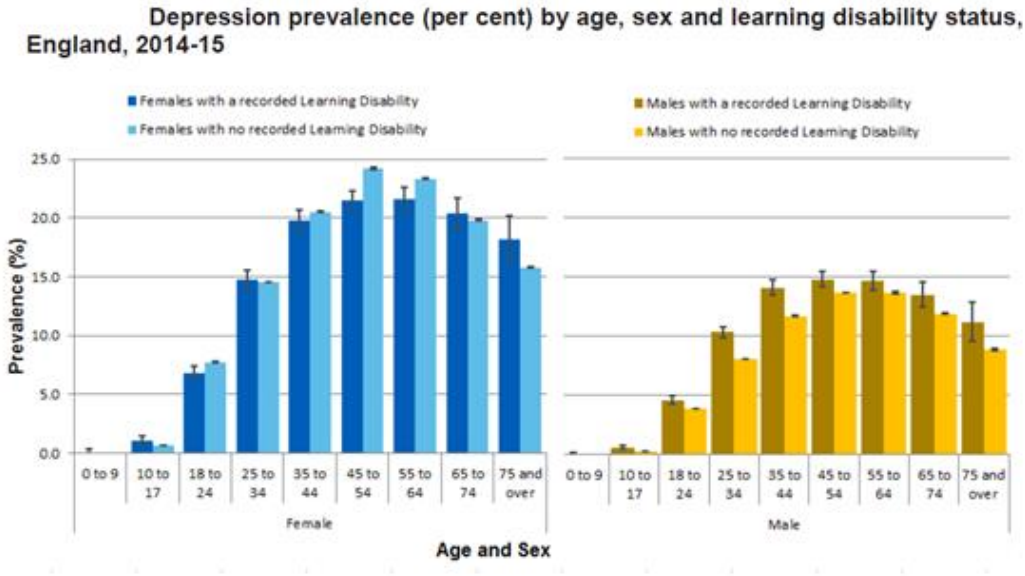
(2015) All Head Teachers in Cheshire East utilise a common approach to informing general practitioners about any child or young person that the school identifies as having a learning disability.

This year, we are recommending that this ongoing significant shortfall in recording of children and young people with a moderate learning disability in Cheshire East's secondary schools still needs to be tackled.

Depression and Learning Disability

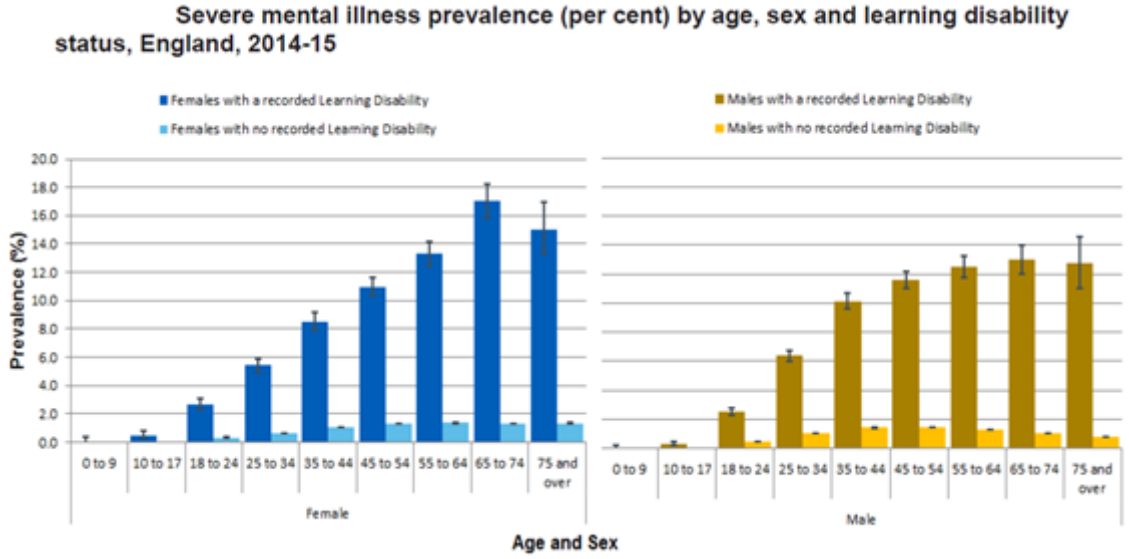
Depression is a major and treatable cause of distress and disability for people both with and without learning disabilities. In people with learning disabilities, particularly those with limited ability to communicate, it can be expressed in behavioural ways understood by carers or care staff as 'challenging'. This makes clarity about diagnosis particularly important.

The overall rate of having a diagnosis of depression in adults with learning disabilities (13.9%) is very similar to that for people without learning disabilities (14.5%). As shown in the chart, the rates for both groups rise with age until late middle age and then fall slightly in old age. For England as a whole, the number of cases in people with learning disabilities was just 4.3% above the number expected if general population rates had applied. Eastern Cheshire CCG had a standardised prevalence ratio for depression of 99.8% (similar to England), but South Cheshire CCG had a much higher ratio of 138.3% (i.e. this CCG had 38% **more** people with a learning disability and depression than expected). These ratios are based on 156 people who were recorded by general practitioners as having depression and learning disability, 61 in Eastern Cheshire CCG and 95 in South Cheshire CCG.



Severe Mental Illness and Learning Disability

People with learning disabilities are known to suffer more commonly with severe mental illnesses including schizophrenia, bipolar disorder and other less well defined psychotic conditions. However, exactly how much more commonly is difficult to assess since diagnosis of these conditions is substantially more difficult, particularly in those with more severe learning disabilities and little or no ability to communicate verbally. In people without learning disabilities, psychotic disorders are relatively uncommon in childhood, appearing usually in adolescence or young adulthood.



Overall, general practitioners across England recorded 7.8 per cent of people with learning disabilities as having severe mental illnesses (8.8 per cent in those aged 18 and over). This compared to 0.87 per cent of people without learning disabilities (1.1 per cent in those aged 18 and over). Adjusting for age and sex profile, the number of people with learning disabilities recorded as having a severe mental illness was 8.04 times what would be expected if national general population age and sex specific rates applied. 15.3 per cent of CCGs had a standardised prevalence ratio for severe mental illness that was significantly lower than the England figure and 13.2 per cent of CCGs had a ratio that was significantly higher.

Eastern Cheshire CCG had a standardised prevalence ratio for severe mental illness of 681% (lower than the England ratio of 804%) and South Cheshire CCG had a ratio of 737% (again lower than the England ratio of 804%). Some caution in interpretation is needed as these ratios are based on just 76 people who were recorded by local general practitioners as having both a severe mental illness and a learning disability (34 in Eastern Cheshire CCG and 42 in South Cheshire CCG), but this might also suggest that severe mental illness may not be being fully diagnosed in this group of people.

Nationally, the large variability in the rates of severe mental illness strongly suggests that this is being under-diagnosed (and possibly under treated) in some areas and over-diagnosed in others. This is an important issue in clarifying the appropriateness of use of antipsychotic and anti-depressant medications.

An audit of deaths that have occurred in people with a learning disability is currently in progress. This audit is being supported by the Cheshire East Public Health Team, and the report of the audit should be available by June 2017.

Recommendation

6.1 Steps should be taken to improve the ongoing significant shortfall in recording pupils with moderate learning disability in secondary schools in Macclesfield, Congleton, Crewe and Wilmslow. Head Teachers should be asked to inform the general practitioner about any child or young person that the school identifies as having a learning disability.

Chapter Seven

Serious Mental Illness and Psychosis

Serious mental illness covers a collection of conditions, including schizophrenia, bipolar disorder, psychotic depression and other less common psychotic disorders. Psychosis is characterised by hallucinations, delusions and a disturbed relationship with reality, and can cause considerable distress and disability for the person and their family or carers.

Early Intervention Services for First-episode Psychosis

The term first-episode psychosis is used to describe the first time a person experiences a combination of psychosis symptoms. Each person will have a unique experience and combination of symptoms. The core clinical symptoms are usually divided into 'positive symptoms', so called because they are added experiences, including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms', so called because something is reduced (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). A range of common mental health problems (including anxiety and depression) and coexisting substance misuse may also be present.

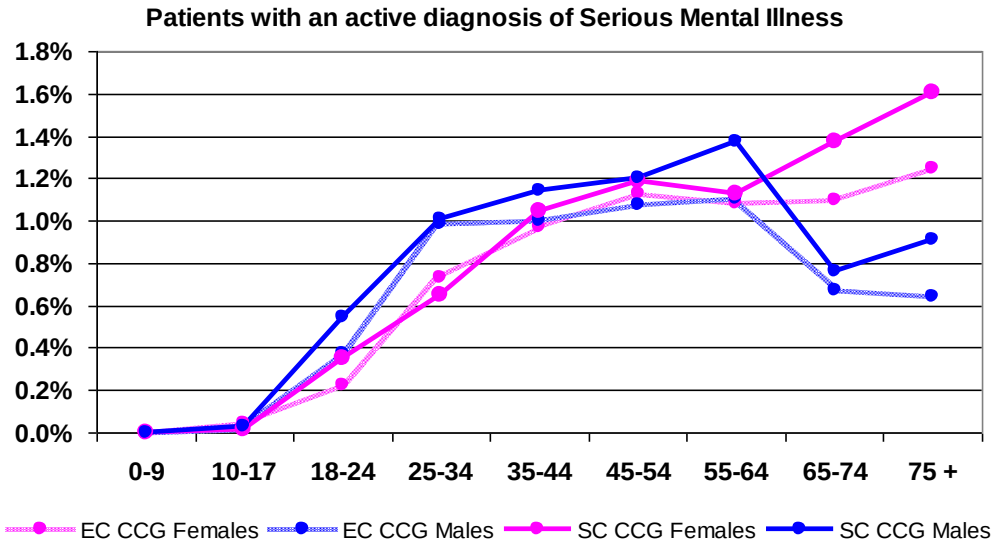
Typically, before their first-episode of psychosis, many people will experience a relatively long period of symptoms, which is described as being in an at-risk mental state. These may include:

- A more extended period of less severe psychotic symptoms;
- An episode of psychosis lasting less than seven days;
- An extended period of very poor social and cognitive functioning (perhaps accompanied by unusual behaviour including withdrawal from school or friends and family) in the context of a family history of psychosis.

First-episode psychosis is thought to affect about 38 people in Cheshire East each year, with most being aged between 15 and 35. Delays in providing treatment and support at this time can lead to poorer clinical and social outcomes over their whole lifetime. Early intervention services provided by dedicated multidisciplinary teams are strongly effective in improving outcomes and reducing future health service costs, particularly inpatient care costs.[90] The new Early Intervention in Psychosis waiting time standard requires that people experiencing a first episode of psychosis should have access to a NICE-approved care package within two weeks of referral.

Care of People with Serious Mental Illness

Cheshire East has over 3,100 people of all ages with a serious mental illness, comprising about 0.82% of the population. Although the frequency of serious mental illness is lower in both clinical commissioning group areas than nationally, the chart shows that rates are higher in South Cheshire CCG than in Eastern Cheshire CCG in almost all age groups. Illness rates increase with age and are higher in men than women, except over the age of 65 due to higher mortality in older men.



Public Health England has recently published a report providing data for each clinical commissioning group for a range of indicators across the psychosis care pathway.[91] The report brings together data from general practices (Quality and Outcomes Framework Serious Mental Illness Registers) and specialist mental health services (from the Mental Health and Learning Disabilities Data Set).

Although these indicators are based on measures of treated prevalence (counts of contacts with services) and not true prevalence, they highlight a number of significant local issues and concerns:

1. **variation in numbers of people with psychosis**. General practices in Eastern Cheshire CCG have **statistically significantly fewer people with serious mental illness** on their practice registers than nationally. Given the other data quality concerns for both primary and specialist mental health services locally, it is not possible to be confident at this time that this represents the true position for this clinical commissioning group;

2. **variation in access to a range of care and support interventions for people with psychosis**. The proportion of people with severe mental illness in primary care with a comprehensive care plan is significantly lower in both CCGs (indicator 5). The proportion of people with severe mental illness who have received the complete list of primary care physical health checks is also significantly lower in both CCGs (indicator 10). Another concern relates to indicator 6 (people with psychosis in specialist mental health services with a crisis plan in place), where data was suppressed for both CCGs because there were fewer than 5 people with such plans. As many of the other CCGs in the country had several hundreds of people with crisis plans, this either represents particularly poor data quality or a possibility that these crisis plans may not be in place;

3. **gaps in routine data relating to psychosis**. No specialist mental health services data could be reported for Eastern Cheshire CCG because of data suppression due to low data quality. This particularly affected indicators 3 (number of people with psychosis), 4 (people with psychosis who are on CPA), 6 (people with a crisis plan), 8 (people in employment) and 9 (people in settled accommodation);

4. **quality issues with current data relating to psychosis**. Both local clinical commissioning groups had some of the most **incomplete data from specialist mental health services** for any area nationally. Of people in scope, only 48% in Eastern Cheshire CCG and 50% in South Cheshire CCG were assigned to a care cluster, compared to 85% for England. The recorded number of people with psychosis known to specialist mental health services is significantly lower in South Cheshire CCG even though the number of people with severe mental illness known to general practitioners in South Cheshire CCG is not significantly different to England. In addition, both of the local clinical commissioning groups had a **statistically significantly higher number of people with severe mental illness who were exempt from physical health checks in primary care** (indicator 11). This raises concerns about the validity of the other four indicators that focus on primary care – indicators 5 (people with a comprehensive care plan), 10 (people with physical health checks), 12 (people who are current smokers) and 13 (women who have had a cervical screening test).

Excess Premature Mortality for people with Severe Mental Illness

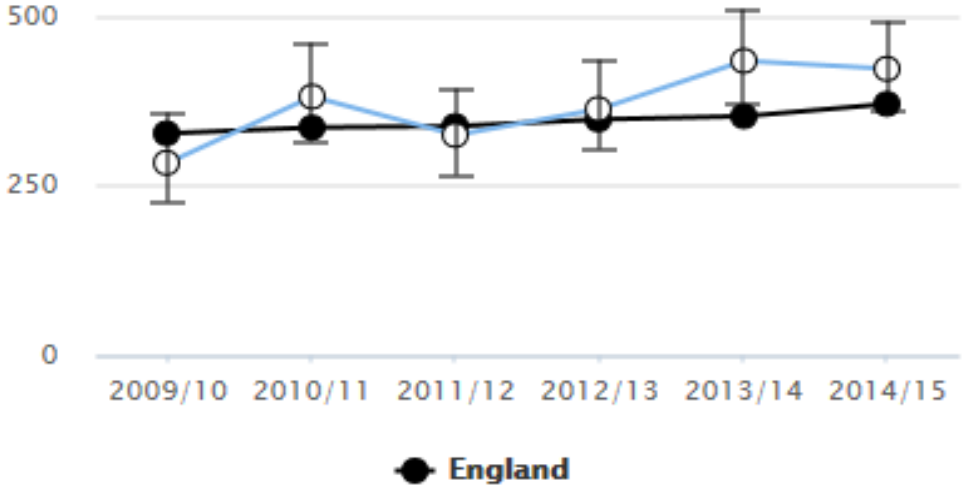
There is extensive published evidence that people with severe mental illness die between 15 and 25 years earlier than the average for the general population. The causes of premature death are mainly from chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory diseases. These physical conditions are associated with modifiable risk factors such as smoking, obesity and high blood pressure, and are also associated with side effects of psychiatric medication. However, they are seen as preventable with comprehensive assessment, treatment, and recommended safe monitoring of physical health and the side effects of medication.

This is why indicators 10 (people with severe mental illness who have received the complete list of primary care physical health checks) and indicator 11 (people with severe mental illness who were exempt from physical health checks) are of such importance. Indicators 10 and 11 are statistically significantly worse than England for both Eastern Cheshire CCG and South Cheshire CCG.

The excess under 75 mortality rate among adults with serious mental illness is a key outcome indicator for assessing the health of people with serious mental illness. People with serious mental illness are first identified from the Mental Health and Learning Disabilities Data Set. These records are then linked to the Primary Care Mortality Database to identify deaths amongst people with serious mental illness. For each local authority, the numerator is the observed count of deaths occurring amongst people with serious mental illness who are in the Mental Health and Learning Disabilities Data Set.

This indicator is only available at local authority level – it is not published for individual CCGs. For the latest available year, under-75 mortality among adults with serious mental illness in Cheshire East was 4.21 times higher than in the general population. This is a worse position than England where the ratio was 3.70 times higher.

Excess under 75 mortality rate in adults with serious mental illness: Ratio of observed to expected mortalities: Cheshire East



It should be noted that as the concerns about local mental health data quality relate to missing or inadequately coded data, there is a possibility that some people with serious mental illness are being excluded from this calculation, correction of which would have the effect of worsening the indicator. It is possible that the true position may be even worse than the indicator currently suggests.

Recommendations

7.1 Commissioners of mental health services (CCGs, NHS England and local authority commissioners) should consider within their quality and performance function or equivalent, whether there is a systematic data coding issue with their local mental health providers for severe mental illness and take appropriate action;

7.2 Local commissioners and providers should consider the variations in the local CCG performance on serious mental illness compared with peer CCGs, using comparative approaches such as RightCare to guide further enquiry.

NHS Eastern Cheshire CCG				
See descriptions of the rationales for the indicators at end of chapter	**Number of people**	**CCG rate / %**	**England rate / %**	**Comparison with England**
1. Estimated number of new cases of psychosis	20.29	16.5 per 100,000	24.2 per 100,000	no significant difference
2. Recorded number of people with severe mental illness	1646	0.80%	0.88%	significantly lower
3. Recorded number of people with psychosis	low data quality	low data quality	400.9 per 100,000	data suppressed due to low data quality
4. People with psychosis in specialist mental health services who are on CPA	low data quality	low data quality	51.77%	data suppressed due to low data quality
5. People with severe mental illness in primary care with a comprehensive care plan	1107	74.25%	77.20%	significantly lower
6. People with psychosis in specialist mental health services with a crisis plan in place	low data quality	low data quality	30.04%	data suppressed due to low data quality
7. People with psychosis admitted to hospital in an emergency	53	41.2 per 100,000	35.8 per 100,000	no significant difference
8. People with psychosis in specialist mental health services in employment	low data quality	low data quality	5.8%	data suppressed due to low data quality
9. People with psychosis in specialist mental health services in settled accommodation	low data quality	low data quality	83.16%	data suppressed due to low data quality
10. People with severe mental illness who have received the complete list of primary care physical health checks	392	28.5%	34.8%	significantly lower
11. People with severe mental illness who were exempt from physical health checks	706	15.49%	10.74%	significantly higher
12. People with severe mental illness who are current smokers	479	35%	40.5%	significantly lower
13. Women aged 25 to 64 years with severe mental illness who have had a cervical screening test	356	74.32%	71.6%	no significant difference
14. Excess premature mortality for people with severe mental illness (Cheshire East 2013/14)	506	4.334 times higher	3.518 times higher	significantly higher
Source: Psychosis Data Report. Public Health England. October 2016				

Indicator definitions can be found in Appendix D

NHS South Cheshire CCG				
See descriptions of the rationales for the indicators at end of chapter	**Number of people**	**CCG rate / %**	**England rate / %**	**Comparison with England**
1. Estimated number of new cases of psychosis	17.47	16.46	24.2 per 100,000	no significant difference
2. Recorded number of people with severe mental illness	1492	0.84%	0.88%	no significant difference
3. Recorded number of people with psychosis	525	360.21	400.9 per 100,000	significantly lower
4. People with psychosis in specialist mental health services who are on CPA	265	50.5%	51.77%	no significant difference
5. People with severe mental illness in primary care with a comprehensive care plan	1321	74.26%	77.20%	significantly lower
6. People with psychosis in specialist mental health services with a crisis plan in place	low data quality	low data quality	30.04%	data suppressed as fewer than five cases
7. People with psychosis admitted to hospital in an emergency	36	27.7 per 100,000	35.8 per 100,000	no significant difference
8. People with psychosis in specialist mental health services in employment	35	6.7%	5.8%	no significant difference
9. People with psychosis in specialist mental health services in settled accommodation	225	84.9%	83.16%	no significant difference
10. People with severe mental illness who have received the complete list of primary care physical health checks	286	30.1%	34.8%	significantly lower
11. People with severe mental illness who were exempt from physical health checks	490	12.21%	10.74%	significantly higher
12. People with severe mental illness who are current smokers	375	39.6%	40.5%	no significant difference
13. Women aged 25 to 64 years with severe mental illness who have had a cervical screening test	283	71.83%	71.6%	no significant difference
14. Excess premature mortality for people with severe mental illness (Cheshire East 2013/14)	506	4.334 times higher	3.518 times higher	significantly higher
Source: Psychosis Data Report. Public Health England. October 2016				

Indicator definitions can be found in Appendix D

Chapter Eight

Smoking and Mental Illness

Smoking Prevalence

Smoking rates in individuals with depression or anxiety are thought to be twice as high as those in the general population, and are three times higher in those with schizophrenia and bipolar disorder.[92] In 2014/15 general practices in Cheshire East identified that 36.8% (854 out of 2,317) of adults with a severe mental illness were current smokers.[93] By comparison, the overall rate of smoking among the general adult population in Cheshire East is 12.4% (95% CI 10.4-14.6) which is significantly lower than England where prevalence rates are 16.9% (95% CI 16.6-17.1).[94]

When reviewed at clinical commissioning group level, the rate of smoking among adults with a severe mental illness in NHS South Cheshire CCG is 39.6% (95% CI 36.5-42.7 – not significantly different) and in NHS Eastern Cheshire CCG is 35.0% (95% CI 32.5-37.5 – significantly lower), compared to 40.5% (95% CI 40.4-40.7) for England. [93]

Excess Risk of Smoking

The impact of high smoking rates on individuals with mental illness leads to a significantly higher risk of dying from a smoking related disease. It is estimated that the excess risk of dying for all tobacco-linked diseases combined is 2.45 (95% CI 2.41–2.48) for schizophrenia, 1.57 (95% CI 1.53–1.62) for bipolar disorder, and 1.95 (95% CI 1.93–1.98) for severe depression.[95] This also contributes heavily to the overall additional burden of death experienced by this group of people, which was discussed in chapter seven.

Stopping Smoking

Smoking is an important factor behind the health inequalities that are experienced by people who have a chronic mental illness.[92] Stopping smoking offers a range of benefits for these individuals including improvements in physical health, mental health and quality of life. The cost savings also offer the potential to improve access to higher quality food and social activities. As well as benefits to the individual, there are also significant potential savings to be achieved for the NHS by supporting mental health patients to stop smoking. It is estimated that treating smoking related illnesses in people with mental illness costs the NHS £720 million each year.[96]

Patients with a severe mental illness can find it particularly challenging to stop smoking. It is often assumed by health professionals that this client group uses nicotine as a form of self-medication, but there is little evidence to support this.[97] Patients with schizophrenia and depression report the experience of craving and withdrawal as the primary reason they continue to smoke.[98] An exception to this is individuals with bipolar disorder who do report using smoking as a way of coping with the symptoms of their mental illness.[97] Managing cravings, withdrawal symptoms and lack of ability to cope with negative affect are some of the main reasons found to influence quit attempts in this client group.

Support from Professionals

It is crucial that health professionals in primary care assess all patients smoking status and offer very brief advice and access to appropriate treatment for those patients who are current smokers. Everyone who works in primary care should complete the free online training in Very Brief Advice.[99] This training ensures that smoking can be quickly and easily integrated into each consultation without it having a significant impact on the time available for each patient.

To ensure that patients are given the greatest opportunity to successfully quit smoking, services need to be designed to meet this client group's needs. Community based specialist stop smoking services need to work in close partnership with community mental health services to establish clear referral pathways between the services. For those within secondary care services, support should commence prior to admission if the admission is planned or immediately upon admission in an emergency situation. Support should continue throughout the patient's stay in secondary care as outlined in the NICE (2013) Smoking: acute, maternity and mental health services public health guidance.[100] It should also be recognised that abstinence may not initially be possible, so harm reduction interventions as outlined in the NICE (2013) smoking harm reduction guideline should be provided.[101] It is also important that mental health services adopt a supportive and encouraging culture. It is clear that supporting individuals with a chronic mental illness to stop smoking will have a significant benefit for both the individual and the NHS. Successfully quitting smoking should be recognised by mental health service providers as something that is achievable and beneficial for patients.

Following the evidence the local specialist stop smoking service, a part of the One You Cheshire East Services[102] has been commissioned to provide a specialist mental health stop smoking service. This service is exclusively designed for those identified as having a mental illness. It is provided in the community and includes a harm reduction programme (with pharmacotherapy support for a longer period of time) for those that find it difficult to follow the standard 12 week quit programme. The capacity of the service means that the outcome of this intensive programme is 58 quits per year.

The local mental health service provider – Cheshire and Wirral Partnership Trust - supports their patients to quit and works with specialist service to support those attending the local mental health resource centres.

Recommendations

8.1 As the main commissioners of stop smoking services for Cheshire East, Public Health should work with the specialist stop smoking service to develop their approaches to meet the specific needs of individuals with different forms of mental illness. Performance measures should include the number and proportion of smokers with serious mental illness who are engaged with the service, and outcomes for this group;

8.2 Cheshire East should consider enhancing this service with further investment in order to increase the number of people with a mental illness receiving support and hence achieving an increase in the number of quits for this group of people;

8.3 Mental health services should ensure that a holistic approach is taken when assessing patients and reviewing their care plans. Lifestyle related behaviours such as physical activity, diet, alcohol use and tobacco are all crucial to ensuring that patients do not continue to be at increased risk of premature mortality due to risk factors that are preventable. The integrated approach to lifestyle services provided through One You Cheshire East must be made available to all those receiving mental health services;

8.4 All mental health service staff should continue to receive training in very brief advice as well as providing stop smoking support. Where possible, but especially within inpatient facilities, stop smoking support to patients should be integrated within mental health services. This stop smoking support should range from harm reduction measures such as provision of nicotine replacement therapy on admission, to structured behavioural support and pharmacotherapy for those who want to achieve abstinence;

8.5 All primary care professionals should assess all patients smoking status and offer very brief advice, using the free online training in Very Brief Advice.[99] Smokers should be signposted to the appropriate service – community services (this includes those with low level mental illness) and specialist services for those with a severe mental illness.

Chapter Nine

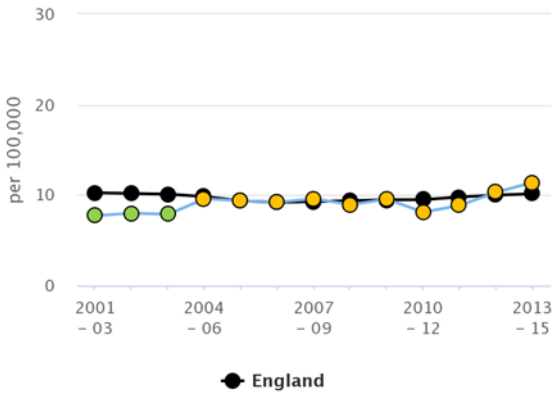
Suicide and Self-harm

The prevention of suicide is like a jigsaw. It requires many pieces to be fitted together in their correct positions. (Adapted from Public Health England's Local Suicide Prevention Planning resource [103])

The Occurrence of Suicide in Cheshire East

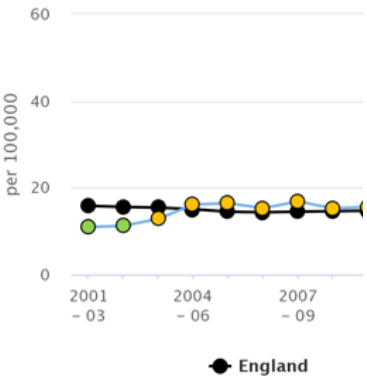
The national definition of suicide includes deaths with an underlying cause of intentional self-harm or an injury or poisoning of undetermined intent. In England, it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves.

Suicide rate (Persons)

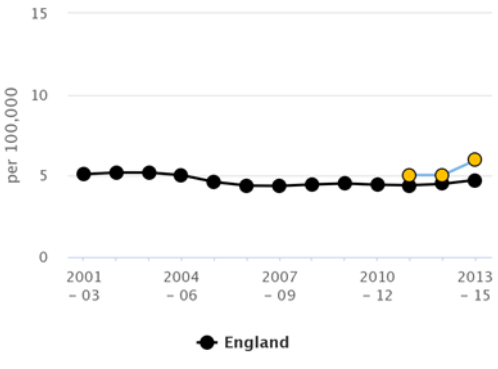


Cheshire East had 115 deaths (85 male, 30 female) from suicide and injury of undetermined intent during the period 2013-2015, an average of 38 deaths per year. The death rate in Cheshire East has recently increased and is currently around 12% higher than the equivalent national rate. Suicide rates in males have increased but remain similar to nationally. Over the recent years for which data has been published, suicide rates in women in Cheshire East have been higher than England.

Suicide rate (Male)



Suicide rate (Female)



During the five year period from 2010 to 2014, the majority (60%) of male suicides in Cheshire East were in men aged between 35 and 64 years. 20% of men were younger than 35 and 20% were older than 65. The figures for women are similar but with a slightly higher proportion of women over 65.

The Cheshire and Merseyside Suicide Reduction Network

The Cheshire East Council Public Health Team is an active part of The Cheshire and Merseyside Suicide Reduction Network (CMSRN) which was formed in 2008 to seek greater co-ordination of responses to and understanding of patterns of suicide. In 2013 the CMSRN came under the collective leadership of the Cheshire Merseyside Directors of Public Health. CMSRN consists of four components: a Partnership Board, an Operational Group, Local Suicide Prevention Groups and a Stakeholder Network. The four components take an integrated approach to a strategic direction and the systematic implementation of action plans and robust provision of effective prevention, treatment and crisis services.

In 2015 the NO MORE Zero Suicide Strategy[104] was published with the key aims of developing Suicide Safer Communities, for healthcare to transform to achieve zero suicides, to support those bereaved and ensure the efforts of the network are sustained.

Outcomes from Year One of the Strategy are:

- Joint Cheshire and Merseyside Suicide Audits have provided the evidence for shared action planning;
- AMPARO, a suicide liaison service, has been jointly commissioned;
- Three Mental Health Trusts have transformed their partnership working;
- Primary Care suicide prevention training is being delivered at scale.

To be effective suicide prevention strategies and interventions need to be multi-disciplinary, combining a range of integrated interventions that build individual and community resilience and target groups of people at heightened risk of suicide.

The Canadian 'Suicide Safe Communities' model has been adopted by Cheshire & Merseyside, Greater Manchester and Brighton and is gaining traction across the UK. The 'Suicide Safer Communities' model has nine pillars that incorporate this multi-disciplinary approach: leadership, intelligence, awareness, training, community interventions, clinical interventions, support for those bereaved, evaluation and sustainability.[105]

The Local Suicide Prevention Group in Cheshire East aims to co-ordinate action across Cheshire East to reduce suicide and self-harm; to ensure communities and individuals are equipped to get the support they need at the right time to prevent further harm.

The Group has a Suicide Reduction Action Plan which aligns to the priorities of the National Suicide Reduction Strategy and the Cheshire and Merseyside Zero Strategy.

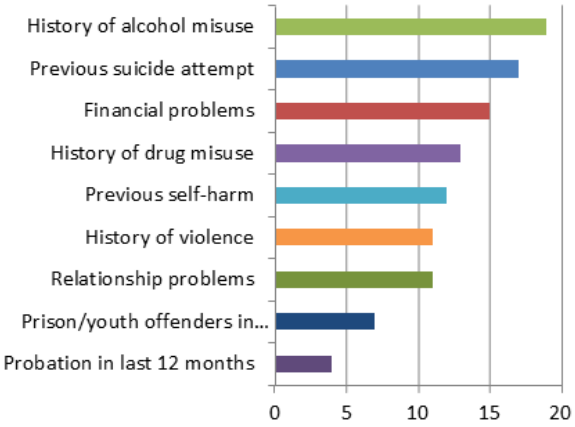
Cheshire East Suicide Audit

Suicide risk reflects wider inequalities in society, and there are marked differences in suicide rates according to people's social and economic circumstances. Specific groups of people at higher risk of suicide are those living in poorer communities and young and middle-aged men. Specific factors which are known to increase the risk of suicide are misuse of alcohol and drugs, long term physical health problems, being in the care of mental health services, being in contact with the criminal justice system and having a history of self-harm. Other population risk factors are social isolation and significant life events, for example domestic violence, marital break-up, unemployment, homeless and leaving care.

During early 2016, a member of the public health team carried out a suicide audit which included all inquests with a suicide, open or narrative verdict from November 1st 2014 to October 31st 2015. 45 cases were audited and included 33 suicide verdicts, 7 open verdicts and 5 narrative verdicts. The most common method of suicide was hanging/strangulation which accounted for 39% of deaths. This was closely followed by self-poisoning which accounted for 30% of deaths.

80% of the cases in the audit had at least one known risk factor, as illustrated in the diagram below. Most of these risk factors correspond closely with the national risk factors summarised above, although financial problems were present in a higher than expected proportion of cases locally.

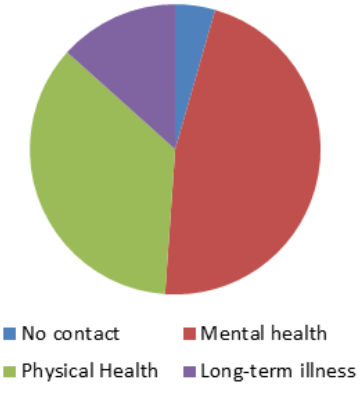
Presence of Known Risk factors



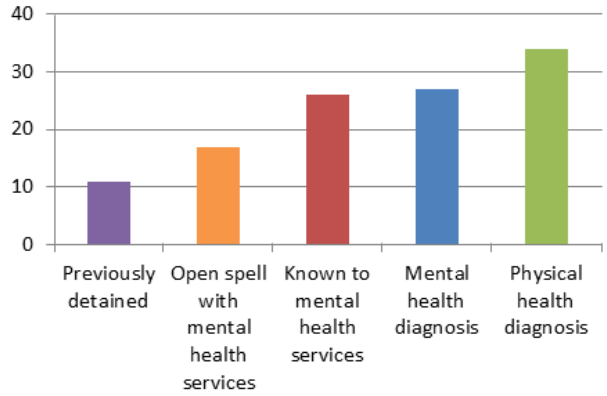
Summary of Most Recent Contact with Services

	GP contact	Mental health contact
Within 1 week	6	8
Within 1 month	20	14
Within 3 months	28	16
Within 6 months	34	18
Within 1 year	39	20
More than 1 year	4	4
No contact	2	21

Reason for Last GP contact



Health Status



Suicide audits identify that many people who die present to their GP in the months prior to their death. The reasons for their presentation have been found to be physical as well as mental illness. This identifies the importance of assessing emotional wellbeing regardless of the primary cause of presentation. In general practice depression screening instruments such as the Patient Health Questionnaire (PHQ-9) are commonly used. It is currently unclear though what the agreed procedure is when a patient answers positively to the question "Do you ever have thoughts that you would be better off dead or thoughts about hurting yourself in some way?"

The recent suicide audit suggested that a suicide risk assessment process is carried out in primary care but a review of case notes identified that this process is often not formally documented. It is suggested that clinicians should document the information that has been considered as part of the risk assessment process. This includes any identified warning signs, protective and risk factors, such as information about the thoughts they have been having, any plans they have made, and past experiences of suicide attempts. This information should then be considered alongside other information such as psychiatric history and treatment to inform the action taken to support the patient's safety.

Real-time Suicide Surveillance

Real-time suicide surveillance is a process that alerts relevant professionals where the circumstances of the death suggest suicide in advance of the Coroners' conclusion. [104] Suicide surveillance can:

1. Be linked to systems that provide timely support to people who have been bereaved or affected by a suspected suicide;
2. Provide intelligence that enables the public health team and/or a multi-agency suicide; prevention group to respond quickly to emerging patterns that could indicate clusters, increasing trends or new methods of death. [105]

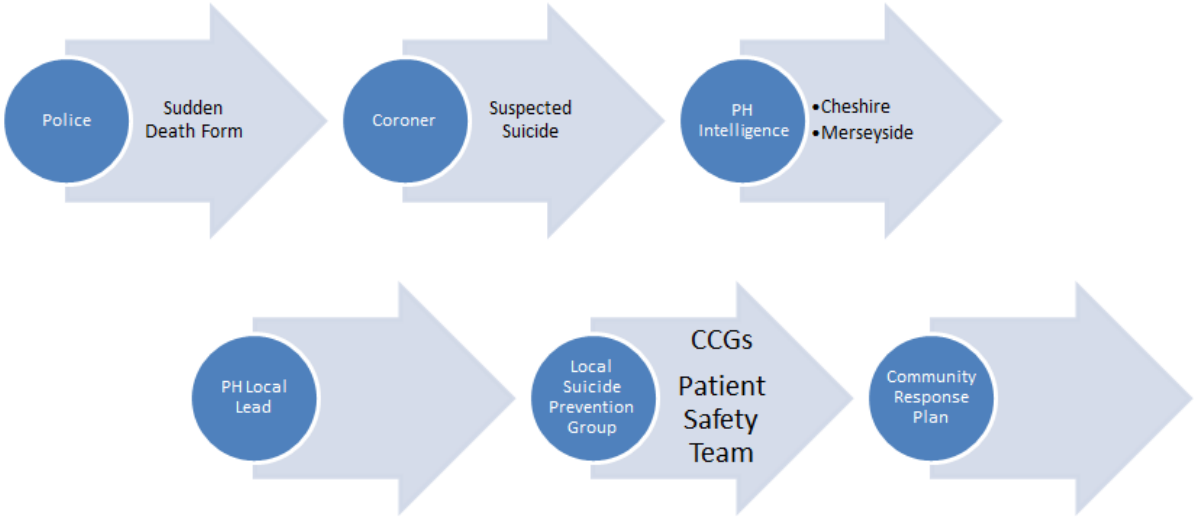
National studies indicate that there are two potential models for real-time suicide surveillance. One can be led by Coroners and the other can be led by the Police who are often the first responders at the scene of a death.

To be effective, either model of real-time surveillance requires the existence of a multiagency partnership that can consider the real-time data in a timely way. A system-wide response process is also required that sets out the agreed triggers and protocols for escalating further action, with clearly set out roles and responsibilities. The potential benefits and limitations are listed below.

Potential benefits	Potential limitations
Provision of timely and appropriate support to people affected: family, community, workplace, social and virtual	Requires considerable partner engagement, information sharing protocols and effective administration, to secure timely, accurate and detailed information
Identification and response to potential suicide clusters and contagion among a particular community or area	Requires agreeing when and how to respond to changing trends and what level of variation is normal so as to ensure measured and effective responses
Identification of any increasing or decreasing suicide patterns within the area including the emergence of new methods	Notified deaths are not confirmed suicides – and may be proven subsequently not to be suicide
Responding to increasing suicides within institutions (e.g. hospitals, prisons, schools) and particular communities	
Identifying any high frequency locations within the area	
Supporting continuous quality improvement of suicide prevention strategies and action plans	

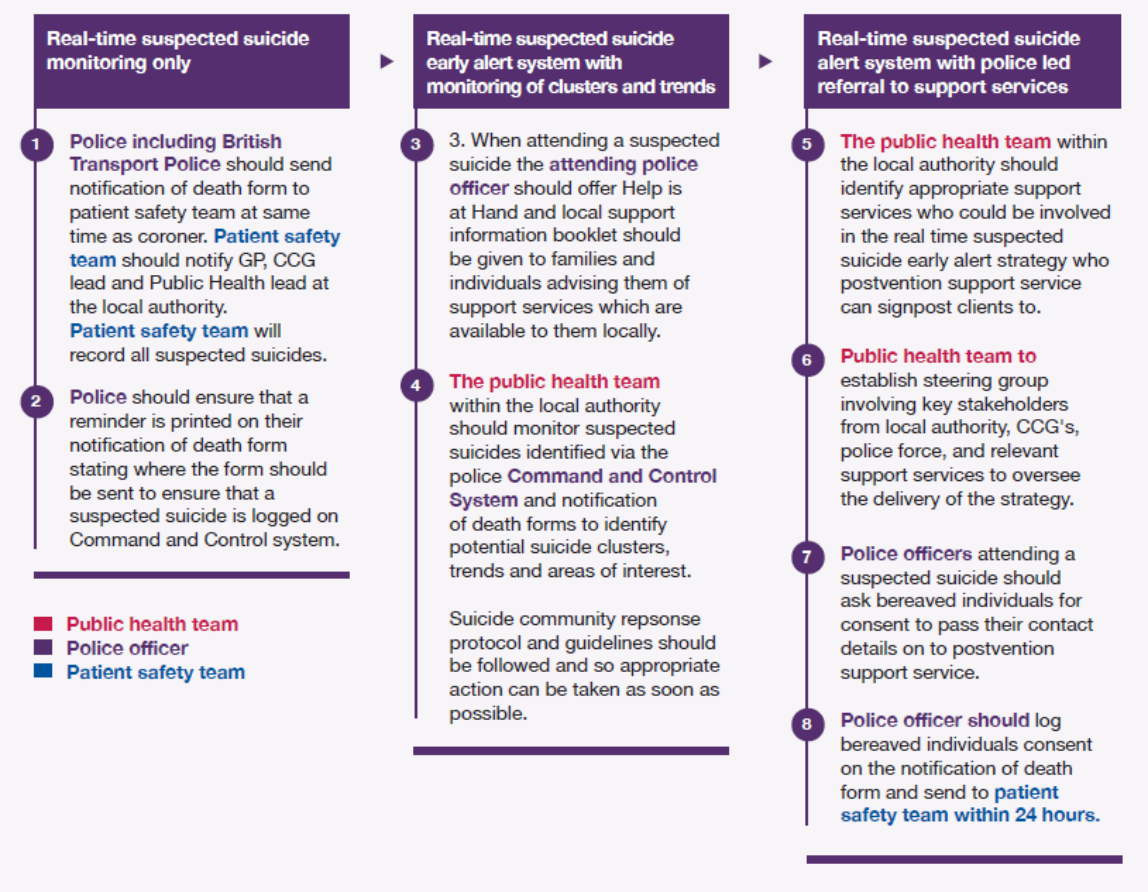
The Cheshire and Merseyside Public Health Collaborative "ChaMPs" is currently developing a real-time surveillance system for Cheshire and Merseyside.[106] The proposed pathway is long and complex and relies on two public health intelligence leads (one for Cheshire and one for Merseyside) receiving information from the Coroner via secure email and then acting on this information in a timely manner. The local public health team then puts arrangements in place to ensure that there is a same-day assessment and response for these notifications throughout the working week.

Diagram: Proposed real-time surveillance system for Cheshire and Merseyside



Other models also exist, and the following example illustrates different elements of a police-led response that may vary according to the desired outcomes of the surveillance system.[107] Note that this approach does not directly involve the Coroner as part of the communication pathway, and it would probably lead to a more timely response than the Cheshire and Merseyside model.

Diagram: Potential model for real-time suicide surveillance



The Public Health Intelligence team in Cheshire East has already carried out considerable planning and development work in preparation for introducing a new suicide surveillance system.[108] It would be feasible for such a system to become operational within just a few months of the decision being taken by the Cheshire East Suicide Prevention Group.

A consensus statement is available specifically about information sharing and suicide prevention.[109] It is helpful to agree a protocol between the relevant multi-agency partners to support effective suicide prevention planning and delivery. An agreement would usually outline the need for each involved organisation to co-operate and provides the legal basis, as well as operational guidelines, for how information will be shared. It ensures that all parties have confidence in what and how the data is being used, as well as ensuring data protection measures are in place. The value of information sharing applies not just to an individual death by suicide or suicidal crisis but also to broader community-based suicide surveillance activities. A Data Sharing Protocol is currently being developed by the Cheshire and Merseyside Public Health Collaborative and will in due course be given to Cheshire East Council to approve.

Supportive Response to Suicide

An effective suicide strategy should have a range of services in place to support those bereaved by suicide, or who are experiencing relationship difficulties, or experiencing financial difficulties. There are currently two support services in place in Cheshire East, both of whom are engaged with the Cheshire East Suicide Prevention Group and support the Suicide Prevention and Response Strategy.

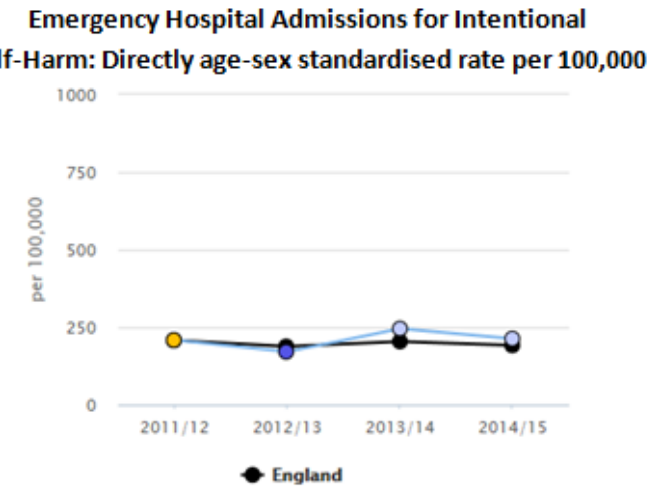
- **Suicide postvention support** – this service is currently provided by Amparo, who are alerted by the Coroner, Police or other professional following a suspected suicide. The initial contact to the bereaved person is within 24 hours of the notification and Amparo will also accept referrals from the bereaved person themself or third parties. Amparo complete a full needs assessment with the individual which highlights their needs and they may then refer the individual to relevant statutory services such as social care or the welfare rights/benefits team, or other support services such as such as Papyrus, the Samaritans and Life Links. Counsellors working for Amparo offer one to one individual support, help with any media enquiries, give practical support around dealing with the police and the Coroner, help with overcoming the isolation experienced, and contacting and signposting to local services;
- **A critical response team for primary and secondary schools** – who support the family and colleagues of the person who has taken their life.

Emergency Hospital Admissions for Self-Harm

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides. We drew attention to the characteristic and patterns of self-injury and self-harm among teenagers and young adults in last year's public health report. We have since published information about patterns of accident and emergency attendances and hospital admissions up to the age of 24 on pages 3, 4 and 10 of the JSNA section on "Self-injury in young people under 25 years" referred to earlier in this report.

Cheshire East had a statistically high number of emergency hospital admissions for self-harm in both 2013/14 and 2014/15, when 874 and 749 people respectively were admitted to hospital after having deliberately harmed themselves.

Primary and secondary care health services are key partners in tackling this high rate of self-harm.



These services come into contact with high risk groups such as people who have long-term mental health problems, people who are misusing drugs and or alcohol, or are feeling isolated or depressed. Suicide prevention strategies must therefore consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

Recommendation

9.1 As part of the new approaches to real-time suicide surveillance, the Cheshire East Public Health Intelligence Team should create a new Suicide Prevention Database that is directly accessible to the Cheshire East suicide lead and the Director of Public Health. The database should have defined processes to capture and collate the following information about suspected suicides:

- coroner-related information such as substances specified in self-poisoning deaths;
- contact with primary care services including reasons for the contact and frequency;
- demographic and family details such as age, gender, ethnicity and family structure;
- social, educational, occupational, residential and workplace characteristics;
- contacts with acute hospital services such as A&E attendance and inpatient admission;
- psychiatric history and psychological assessments.

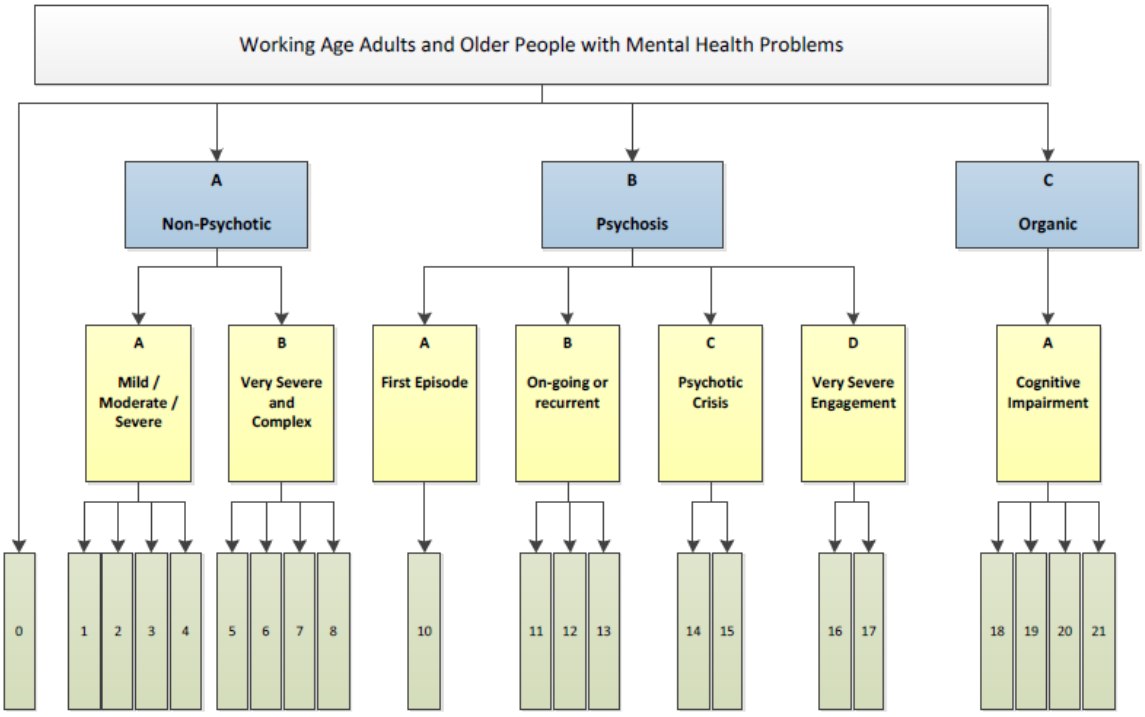
Appendix A – Mental Health Commissioning Currencies

We have chosen to include a technically-focused Appendix in this Public Health report because of the very poor quality of the mental health service data that we used for the children and young people's JSNA, and more recently for the adult mental health JSNA. In chapter seven we remarked how Public Health England also struggled to analyse the data from local specialist mental health services.

We believe that the importance of data quality in examining variations in mental health provision and outcomes should be more widely understood.

Mental Health Care Clusters

Mental health care clusters are the nationally mandated currency for mental health. They cover most mental health services for working age adults and older people. Care clusters allow mental health services to group people together based on their needs. There are currently 21 care clusters, further grouped into three 'super classes' based on much broader similarities in need – Non-Psychotic, Psychosis and Organic, as illustrated in the diagram.



It is recommended that packages of care, based on NICE and other best practice guidance, be agreed for each cluster and translated into cluster based service specifications. It is good practice for commissioners and providers to involve service users, carer groups and general practitioners in this process. The approach aims to:

- Support providers to better understand the care they provide to patients and the resources used to deliver that care;
- Support clinicians to make decisions that deliver the best possible outcomes for patients and improve the quality of care provided;

- Provide information which will enable commissioners and patients to compare provider organisations and to make well-informed decisions.

Assigning Service Users to the Care Clusters

The initial assessment can be triggered in a number of ways, as part of a general practitioner or mental health practitioner referral, in response to a specific request by an organisation such as the police or social services, or through service user self-referral. These initial assessments can be classified in two ways, according to how the assessment was initiated and whether an individual is allocated to a care cluster or not. An assessment may include electronic solutions such as telephone consultations and telemedicine, in addition to a face-to face meeting.

For payment purposes, initial assessment is deemed to be complete once a cluster is assigned or a patient is signposted to other services. If accepted for treatment, the service user will be allocated to a cluster. An electronic decision support tool is available to assist the clinician in allocating a service user to the correct cluster. This should ideally be embedded within clinical systems and used as a part of routine clinical recording. At various points throughout the service user's care, this allocation will be reviewed.

Using the Mental Health Clusters for Payment

Care clusters and initial assessments must be used as the currencies in the standard contract between commissioners and providers, except where providers and commissioners agree an alternative payment approach. An episodic payment approach provides payments to a provider for an individual patient's episode of care, and can help providers and commissioners to better understand the care they provide and the resource used to deliver that care.[110]

For 2017-19, NHS Improvement and NHS England have made changes to the local pricing rules to require providers and commissioners of adult and older adult mental healthcare to adopt either a capitated or episodic/year-of-care payment approach. In either approach, a proportion of prices must be linked to the achievement of locally agreed quality and outcome measures.[111] (2)

Each of the cluster currencies has a maximum review period, as illustrated in the table below. This means that a reassessment should have taken place at the end of the period to check whether the current cluster is still appropriate or whether a new cluster should be assigned. Most of the clusters lend themselves to a year-of-care payment, and for the others the maximum review period should be the indicative episode of care for payment.

All the currencies are independent of setting, and therefore there should be an incentive for providers to care for patients as close to home as possible, in the least restrictive and most cost-effective setting appropriate.

Cluster	Cluster label	Max cluster review period	Suggested payment approach
0	Variance group cluster allocation not initially possible	6 months	Episode
1	Common mental health problems (low severity)	12 weeks	Episode
2	Common mental health problems	15 weeks	Episode
3	Non-psychotic (moderate severity)	6 months	Episode
4	Non-psychotic (severe)	6 months	Year of care
5	Non-psychotic (very severe)	6 months	Year of care
6	Non-psychotic disorders of overvalued Ideas	6 months	Year of care
7	Enduring non-psychotic disorders (high disability)	Annual	Year of care
8	Non-psychotic chaotic and challenging disorders	Annual	Year of care
10	First episode in psychosis	Annual	Year of care
11	Ongoing recurrent psychosis (low symptoms)	Annual	Year of care
12	Ongoing or recurrent psychosis (high disability)	Annual	Year of care
13	Ongoing or recurrent psychosis (high symptoms and disability)	Annual	Year of care
14	Psychotic crisis	4 weeks	Cluster episode (at first presentation)
15	Severe psychotic depression	4 weeks	Cluster episode (at first presentation)
16	Dual diagnosis (substance abuse and mental illness)	6 months	Year of care
17	Psychosis and affective disorder difficult to engage	6 months	Year of care
18	Cognitive impairment (low need)	Annual	Year of care (annual review)
19	Cognitive impairment or dementia (moderate need)	6 months	Year of care (annual review)
20	Cognitive impairment or dementia (high need)	6 months	Year of care
21	Cognitive impairment or dementia (high physical need or engagement)	6 months	Year of care

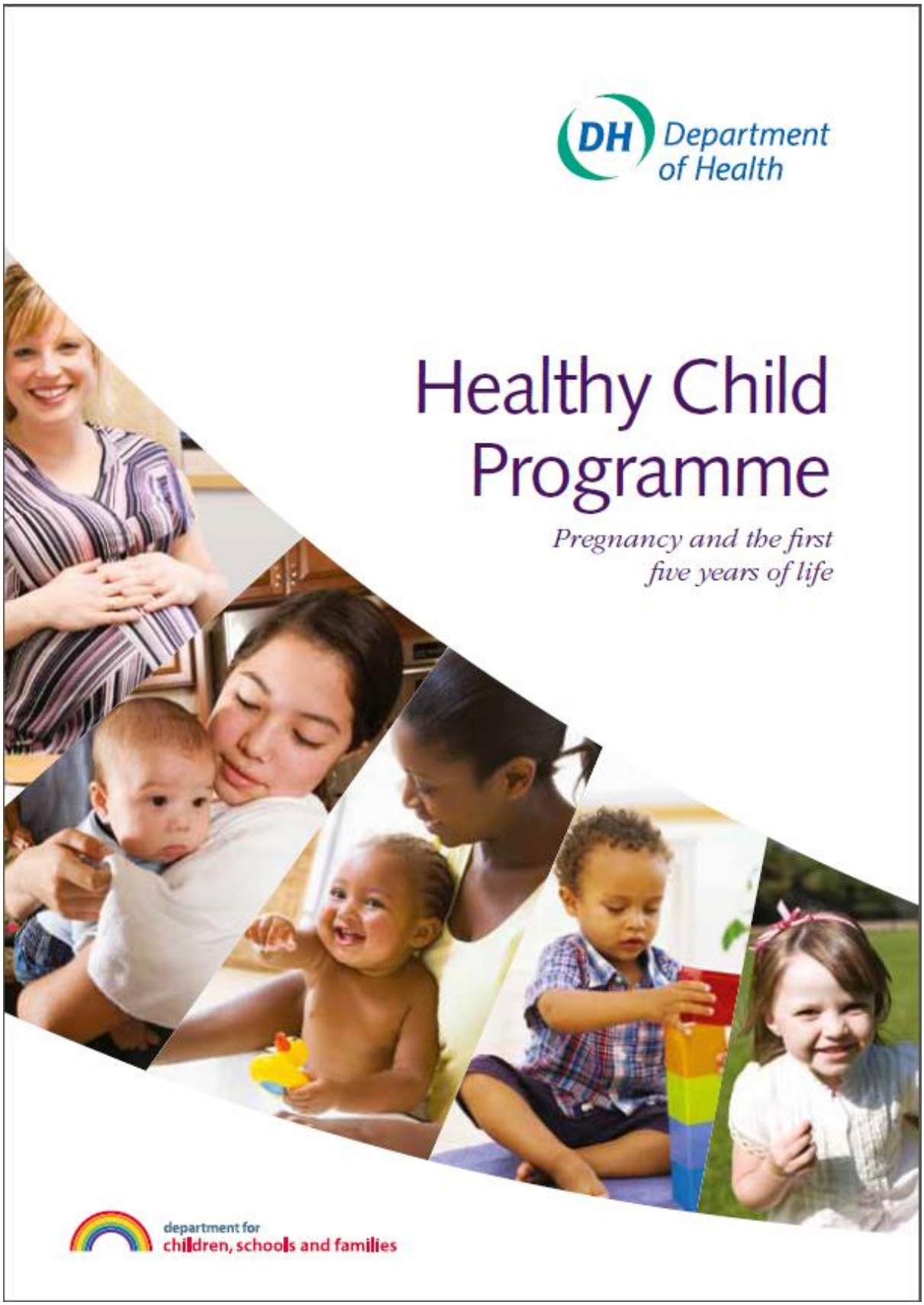
Appendix B - Coverage of the health visitor antenatal check and health visitor new birth visit in Cheshire East

	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2
Face to face HV contacts at 28 weeks	302 (34.6%)	255 (29.1%)	339 (35.5%)	346 (41.6%)	90 (9.2%)	120 (11.7%)
Face to face HV new birth visits by 14 days	830 (94.9%)	832 (95.3%)	837 (95.4%)	925 (96.9%)	785 (94.5%)	795 (81.1%)
Estimated pregnancies at 28 weeks	873	877	955	831	980	1024
Infants who turned 30 days	875	873	877	955	831	980
Source: Health Visitor Service Delivery Metrics at www.chimat.org.uk/transfer						

It is suspected that data quality issues are affecting the Quarter 1 and Quarter 2 figures for Face to face HV contacts at 28 weeks, following the introduction of a new I.T. system.

Appendix C - Healthy Child Programme. Pregnancy and the first years of life.

Department of Health Guidance



UP TO 28 WEEKS

Pregnancy

Universal

Promotion of health and wellbeing

- A full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy by a midwife or maternity healthcare professional.
- Notification to the HCP team of prospective parents requiring additional early intervention and prevention (see page 17).
- Routine antenatal care and screening for maternal infections, rubella susceptibility, blood disorders and fetal anomalies. Health and lifestyle advice to include diet, weight control, physical activity, smoking, stress in pregnancy, alcohol, drug intake, etc. See NICE guidance on antenatal care CG6 (National Collaborating Centre for Women's and Children's Health, 2003).
- Distribution of *The Pregnancy Book*[11] to first-time parents; access to written/online information about, and preparation for, childbirth and parenting; distribution of antenatal screening leaflet.
- Discussion on benefits of breastfeeding with prospective parents – and risks of not breastfeeding.
- Introduction to resources, including Sure Start children's centres, Family Information Services, primary healthcare teams, and benefits and housing advice.
- Support for families whose first language is not English.

Preparation for parenthood

To begin early in pregnancy and to include:

- information on services and choices, maternal/paternal rights and benefits, use of prescription drugs during pregnancy, dietary considerations, travel safety, maternal self-care, etc.; and
- social support using group-based antenatal classes in community or healthcare settings that respond to the priorities of parents and cover:
  - the transition to parenthood (particularly for first-time parents); relationship issues and preparation for new roles and responsibilities; the parent–infant relationship; problem-solving skills (based on programmes such as Preparation for Parenting, First Steps in Parenting, One Plus One[12]);
  - the specific concerns of fathers, including advice about supporting their partner during pregnancy and labour, care of infants, emotional and practical preparation for fatherhood (particularly for first-time fathers);
  - discussion on breastfeeding using interactive group work and/or peer support programmes; and
  - standard health promotion.

11 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107302

12 www.oneplusone.org.uk/

Pregnancy

UP TO 28 WEEKS

Progressive (including Universal)

Ambivalence about pregnancy, low self-esteem and relationship problems

Problems should be addressed using:

- techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/ motivational interviewing; the Family Partnership Model;[13] and the Solihull Approach[14]):
  - establish what each parent's individual support needs are;
  - provide one or two structured listening support contacts;
  - work in partnership with families to develop problem-solving skills;
- support to access antenatal care; and
- preparation for parenthood (which could include separate sessions for fathers only).

Women experiencing anxiety/ depression in addition to the problems above

- If no previous episode of depression or anxiety: social support (individual or group-based, including antenatal groups and parenting classes); assisted self-help (computerised cognitive behavioural therapy; self-help material presented to a group or individuals by a health worker/ paraprofessional).
- For women with previous episodes of non-clinical symptoms of depression and anxiety: brief (four to six weeks), non-directive counselling delivered at home (listening visits[15]) by skilled professionals, and access to local social support; or referral for brief psychological treatments (such as cognitive behavioural therapy or interpersonal therapy).

Women who smoke

Women who smoke should be offered:

- smoking cessation interventions, including behavioural interventions combined with social support and incentives for achievement, and telephone counselling (NHS helplines);
- involvement of partners, if they agree, in the implementation of smoking-reduction/ cessation programmes; and
- additional strategies, such as planning of smoke-free environments for children (e.g. areas within the home that are smoke-free).

Women who are overweight or obese

Women who are overweight or obese should be offered:

- weight control strategies to reduce risks to both mother and baby;
- advice about healthy eating and physical activity; and/or
- referral to weight management services.

Breastfeeding

- Discussion on infant feeding and support to tackle practical barriers to breastfeeding.
- Discussion of benefits and drawbacks for mother and child.
- Discussion with the prospective father.

13 www.cpcs.org.uk/
14 www.solihull.nhs.uk/solihullapproach/

15 Listening visits are defined as unstructured, client-led discussions involving the counsellor in: active listening; reflection; providing empathic responses; encouraging the expression of experiences and accepting the emotions expressed; and not offering information or advice.

Pregnancy

AFTER 28 WEEKS

Universal

Promotion of health and wellbeing

- Ongoing identification of families in need of additional support using criteria identified above (see page 33).
- As for pregnancy up to 28 weeks.

Preparation for parenthood

- As for pregnancy up to 28 weeks (see page 33).
- Distribute the *Parent's Guide to Money* information pack, designed to help expectant parents plan their family finances.[17]

Involvement of fathers

- As for pregnancy up to 28 weeks (see page 33).

Antenatal review for prospective mother and father with HCP team

- Focus on emotional preparation for birth, carer–infant relationship, care of the baby, parenting and attachment, using techniques such as promotional interviewing (see page 23) to:
  - identify those in need of further support during the postnatal period; and
  - establish what their support needs are.
- Inform about sources of information on infant development and parenting, the HCP and Healthy Start.
- Distribute newborn screening leaflet.
- Provide information in line with Department of Health guidance on reducing the risk of SIDS.
- Distribute and introduce personal child health record.

Progressive (including Universal)

- As for pregnancy up to 28 weeks (see page 34).

For parents at higher risk

- As for pregnancy up to 28 weeks (see page 35).

17 Information on the *Parent's Guide to Money* is available at www.fsa.gov.uk

AFTER 28 WEEKS

Pregnancy

Progressive (including Universal)

For parents at higher risk

Including at-risk first-time young mothers; parents with learning difficulties; drug/ alcohol abuse; domestic violence; serious mental illness.

At-risk first-time young mothers

- Intensive, evidence-based programmes that start in early pregnancy, such as the Family Nurse Partnership programme.[16]
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks recommended for pregnant adolescents.

Parents with learning difficulties

- Information on support available to parents with learning disabilities, and assistance in interpreting information and accessing other sources of support.
- Specialist multi-agency support should include individual and group-based antenatal and parent education classes, and home visiting.
- Further support designed to address the parent's individual needs might include speech, language and occupational therapy.

Drug abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- HCP team to contribute to care package led by specialist service.
- Doula programmes (a combination of home visiting, role modelling and community support) may also help to prevent attrition and increase sensitivity of mothers who are in recovery.

Alcohol abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- HCP team to contribute to care package led by specialist service.

Domestic violence

- Follow local guidelines.
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- HCP team to contribute to care package led by specialist service.

Serious mental illness

- Referral of one or both parents to specialist mental health/perinatal mental health service.
- HCP team to contribute to care package led by specialist service.

16 Currently being piloted in England.

Appendix D – Psychosis Report Indicator Definitions

1. Estimated number of new cases of psychosis. This indicator is an estimate of the number of new, clinically-relevant cases of first episodes of psychosis among people aged 16-64. The actual demand for severe mental health care services, including early intervention services, will likely be higher than the predictions, given a degree of people who will consume service resources and who may require some form of mental health care intervention, but who are not found to meet clinical criteria for severe mental illness.

2. Recorded number of people with severe mental illness. The number of people on a general practitioner mental health register (people diagnosed with schizophrenia, bipolar disorder or other psychoses or on lithium therapy) expressed as a percentage of the total GP register population for all ages.

3. Recorded number of people with psychosis. The number of people in scope for mental health currencies at the end of November 2015 assigned to the psychosis supra cluster expressed as a rate per 100,000 resident population. There are some issues with data quality as only 85% of people in scope for Mental Health currencies were assigned to a care cluster.

4. People with psychosis in specialist mental health services who are on CPA. The number of people in scope for mental health currencies at the end of November 2015 assigned to the psychosis supra cluster (clusters: 10 to 17) who had an open care programme approach episode at the end of November 2015.

5. People with severe mental illness in primary care with a comprehensive care plan. Up to half of people who have a serious mental illness (SMI) are seen only in a primary care setting, it is important therefore that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record. Patients on the SMI register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a plan for care. The consultation should include the views of the person with SMI, and relatives or carers where appropriate. This indicator reflects good professional practice and is supported by NICE guidelines.

6. People with psychosis in specialist mental health services with a crisis plan in place. People with mental health problems should have the same rapid access to high quality care as people with physical health problems. In 2014 the Crisis Care Concordat formed to plan improvement to the crisis care that people received. The Concordat describes what people experiencing a mental health crisis should be able to expect of public services (health, local authority and criminal justice) that respond to their needs and is arranged around: access to support and prevention before crisis point; urgent and emergency access to crisis care; the right quality of treatment and care when in crisis; recovery and staying well, and preventing further crises. Monitoring levels of people with a crisis plan will identify the first stages of ensuring good professional practice in the planning of crisis care for people with psychosis.

7. People with psychosis admitted to hospital in an emergency. Emergency admissions to hospital can be avoided if local systems are put in place to identify those at risk prior to attendance and target primary care services, as well as to identify those emergency department attendees better

cared for outside of hospital and provide a safe route into more appropriate community care. Monitoring emergency hospital admissions gives an indication of the effectiveness of local health and care services in working better together to support people's health and independence in the community and reducing the number of unplanned admissions to hospital.

8. People with psychosis in specialist mental health services in employment. It is estimated that just 5-15% of people with schizophrenia are in employment, and people with severe mental illness are six to seven times more likely to be unemployed than the general population. Employment is an important factor in supporting the recovery process. The Five Year Forward View for Mental Health highlights the importance of stable employment in contributing to good mental health.

9. People with psychosis in specialist mental health services in settled accommodation. Housing is an important factor in supporting the recovery process. The Five Year Forward View for Mental Health highlights the importance of stable housing contributing to good mental health but people with mental health problems are less likely to be home owners and far more likely to live in unstable environments. Monitoring levels of people in settled accommodation will identify where people with psychosis are being supported to enable them to lead full and independent lives.

10. People with severe mental illness who have received the complete list of primary care physical health checks. People with mental health problems such as psychosis are at increased risk of poor physical health and premature mortality. The causes of premature death are mainly from chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory diseases. These physical conditions are associated with modifiable risk factors such as smoking, obesity and high blood pressure and are seen as preventable with recommended monitoring of physical health together with appropriate interventions and treatment. NICE quality standard QS808 includes Quality Statement Six: Assessing physical health. This requires evidence of local arrangements to ensure adults with psychosis or schizophrenia receive comprehensive physical health assessments on a regular basis, with a focus on cardiovascular disease risk assessment. There are six advised cardiometabolic assessments: family history, smoking, body mass index (BMI), blood glucose, blood lipids and blood pressure. NICE guidelines CG1786 includes recommendations on continuing to check for physical health problems and covers relevant NICE guidance on treatment of those identified as having high blood pressure, abnormal lipid levels, being obese, or have diabetes and/or cardiovascular disease.

11. People with severe mental illness who were exempt from physical health checks. An exception relates to registered patients who are on the relevant disease register who should be included in the indicator denominator, but who are excepted by the GP practice on the basis of one or more of the exception criteria as set out in General Medical Services Statement of Financial Entitlements Directions. The concept of exception reporting is to ensure that GP practices are not penalised on practice achievement, for example, where patients have been recorded as being invited to attend for review, but have refused. However, where exceptions are applied this may result in people with SMI who are in most need, and need outreach to be brought into appointments, being excluded from physical health checks. Seeking to understand why some areas have higher rates of QOF exceptions and sharing models of good practice in offering enhanced services and outreach to these harder to reach patients would greatly benefit this patient group?

12. People with severe mental illness who are current smokers. People with mental health problems such as psychosis are at increased risk of poor physical health and premature mortality. One of the main causes of premature death is respiratory disease which is associated with modifiable risk factors such as smoking, and is seen as preventable with recommended monitoring of physical health together with appropriate interventions and treatment.

13. Women aged 25 to 64 years with severe mental illness who have had a cervical screening test. This indicator encourages practices to ensure that women with schizophrenia, bipolar affective disorder or other psychoses are given cervical screening according to devolved national guidelines.

14. Excess premature mortality for people with severe mental illness. There is extensive published evidence that people with severe mental illness, such as schizophrenia, die between 15 and 25 years earlier than the average for the general population. The causes of premature death are mainly from chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory diseases. These physical conditions are associated with modifiable risk factors such as smoking, obesity and high blood pressure, and are also associated with side effects of psychiatric medication. However, they are seen as preventable with comprehensive assessment, treatment and recommended safe monitoring of physical health and the side effects of medication. This indicator covers deaths age 18-74 that occurred between 1/4/2013 to 31/3/2014 among people who were in contact with MHMDS from 1/4/2011 to 31/3/2014.

Appendix E - Data Tables for Suicide and Self-Harm rates in Cheshire East

Suicide Rate (Persons)

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2001 - 03	●	73	7.7	6.0	9.7	11.2	10.3
2002 - 04	●	75	8.0	6.3	10.0	10.7	10.2
2003 - 05	●	75	7.9	6.2	9.9	10.9	10.1
2004 - 06	●	92	9.6	7.7	11.8	10.8	9.8
2005 - 07	●	90	9.4	7.5	11.5	10.7	9.4
2006 - 08	●	89	9.2	7.4	11.4	10.3	9.2
2007 - 09	●	93	9.6	7.7	11.8	10.7	9.3
2008 - 10	●	88	8.9	7.2	11.0	10.5	9.4
2009 - 11	●	94	9.6	7.7	11.7	10.8	9.5
2010 - 12	●	79	8.1	6.4	10.1	10.8	9.5
2011 - 13	●	87	8.9	7.1	10.9	11.3	9.8
2012 - 14	●	104	10.3	8.4	12.5	11.5	10.0
2013 - 15	●	115	11.4	9.4	13.7	11.3	10.1

Source: Public Health England (based on ONS source data)

Compared with benchmark ● Better ● Similar ● Worse

Suicide Rate (Male)

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2001 - 03	●	51	10.9	8.1	14.4	17.1	15.9
2002 - 04	●	51	11.2	8.3	14.8	16.3	15.6
2003 - 05	●	59	12.9	9.7	16.6	16.9	15.4
2004 - 06	●	73	16.1	12.5	20.4	17.0	15.1
2005 - 07	●	75	16.4	12.8	20.7	17.1	14.5
2006 - 08	●	69	15.3	11.8	19.5	16.5	14.4
2007 - 09	●	77	16.9	13.2	21.1	17.0	14.5
2008 - 10	●	71	15.3	11.9	19.3	16.8	14.6
2009 - 11	●	74	15.6	12.3	19.6	17.2	14.7
2010 - 12	●	57	12.2	9.2	15.8	17.3	14.8
2011 - 13	●	62	13.3	10.1	17.1	18.2	15.5
2012 - 14	●	78	16.0	12.6	20.0	18.2	15.8
2013 - 15	●	85	17.2	13.7	21.3	17.6	15.8

Source: Public Health England (based on ONS source data)

Suicide Rate (Female)

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2011 - 13	●	25	5.0	3.2	7.5	4.7	4.4
2012 - 14	●	26	5.0	3.3	7.4	5.1	4.5
2013 - 15	●	30	6.0	4.0	8.5	5.3	4.7

Source: Public Health England (based on ONS source data)

Emergency Hospital Admissions for Intentional Self-Harm: Directly age-sex standardised rate per 100,000

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2011/12	●	685	208.3	192.7	224.8	271.8	207.9
2012/13	●	614	170.8	157.4	185.0	245.3	188.0
2013/14	○	874	245.4	229.3	262.4	271.5	204.0
2014/15	○	749	213.1	198.0	229.1	257.7	191.4

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

Compared with benchmark ● Better ● Similar ● Worse ● Lower ● Similar ○ Higher ○ Not Compared

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Chapter Two

References for this section are web links, and are shown within the chapter.

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NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Alcohol-Related Harm Reduction Plan and Position Statement
Date of meeting:	28th March 2017
Written by:	Guy Kilminster
Contact details:	01270 686560 Guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Director of Public Health

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision X
Why is the report being brought to the board?	To secure the Board's support and secure the adoption of the Plan		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well Living and Working Well Ageing Well All of the above √		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness √ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding √ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	• To support the adoption of the Position Statement and Forward Plan • To support the Implementation Plan • To agree to the establishment of an Implementation Group to oversee the delivery of the actions		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The Plan has been developed through a multiagency stakeholder group.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	Formal Public Consultation undertaken in 2016 and this has informed the final plan
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Alcohol Harm affects individuals, families, businesses and communities and costs some £136 million a year. Reducing excessive consumption will contribute to beneficial outcomes across a number of areas and for different stakeholders. This will include reducing demand on the health and emergency services and local Council services. It will also contribute to a sustainable and prosperous night-time economy.

Cheshire East Health and Wellbeing Board

Date of Meeting:	**28th March 2017**
Report of:	Director of Public Health - Fiona Reynolds
Subject/Title:	Alcohol-Related Harm Position Statement and Forward Plan
Portfolio Holder:	Councillor Paul Bates

1. Report Summary

1.1. Excessive consumption of alcohol continues to cause harm to individuals, families and communities within Cheshire East. The Alcohol-Related Harm Position Statement and Forward Plan (Appendix One) and its associated Implementation Plan (Appendix Two) sets out a multiagency response to work in partnership to reduce the impacts and costs associated with excessive consumption. Safe, sensible, social drinking is enjoyed by many and our local night-time economy is made up of many responsible businesses. However, more needs to be done to reduce the numbers of people who drink too much (whether that is in a binge drinking session or through sustained consumption over a period of time) and to better manage and control the supply of that alcohol. This will improve outcomes for individuals, families and communities and reduce the associated costs of alcohol-related harm to businesses and the public sector, which in Cheshire East is over £136 million a year.

2. Recommendation

2.1. **That the Alcohol Harm Position Statement and Forward Plan be adopted and its Implementation Plan supported by the Board.**

2.2. **That the Board approves the Alcohol Harm Plan Steering Group transitioning into a formally established Implementation Plan Delivery Group (as a sub-group of the Board) to oversee the delivery of the Plan.**

3. Other Options Considered

3.1. The other option would be to continue to work on alcohol harm in a disparate and uncoordinated way, with good work being done, but less effectively than if it was better connected across partners and communities.

4. Reasons for Recommendation

4.1 Alcohol-related harm affects many of the residents and businesses of Cheshire East. The impacts of alcohol-related harm are estimated to cost the public sector and businesses in Cheshire East over £136 million[1]. This includes health and crime associated costs and lost productivity. The variety of issues that stem from alcohol-related harm have led to overstretched Ambulance, Police and Accident and Emergency departments dealing with alcohol-related incidents and to subsequent delays in responding to the needs of other people.

The facts about our levels of alcohol consumption and its negative impacts, demonstrate that action needs to be taken. For example:

Locally -

- Young people in Cheshire East have suggested that, amongst other things, more needs to be done to raise awareness of the problems that alcohol causes young people.
- More young people in Cheshire East have tried alcohol at age 15 compared to the national average with female adolescent drinking in particular being a concern. Therefore parental influence and preventing or delaying the age of first use of alcohol for young people needs to be a priority.
- Alcohol specific hospital admissions of under 18 year olds, are high in Cheshire East compared to other areas of the country.
- The numbers of young people (14 – 17 year olds) in Cheshire East, self-reporting as regularly binge drinking, has increased from 11% in 2013 to 17% in 2015 and there has been a reduction in the numbers who are worried about the long term health effects of drinking alcohol (Young Persons Alcohol and Tobacco Survey 2015)
- There were 173 alcohol related deaths in 2013
- There are increasing numbers of adults in Cheshire East being admitted to hospital every year as a result of their alcohol use. Between 2008 and 2015 admissions increased by 27%. In 2014-15 there were 7550 alcohol related hospital admissions[2].
- There were 1717 alcohol related crimes in Cheshire East in 2012-2013[3]

4.2 The Position Statement and Forward Plan has been drafted to support the actions of many organisations working to reduce levels of consumption and promote safe, sensible and social drinking. It brings together national policy and local aspiration and sets a direction for activity across Cheshire East over the next two years.

As a 'Residents First' Council, we are working with a wide range of partners to focus upon activity that will bring positive outcomes to the families, communities and businesses of Cheshire East. Reducing excess alcohol consumption is the overarching aim and our priority outcomes are:

[1] Champs Public Health Collaborative Cheshire East Alcohol factsheet June 2016
[2] Champs Public Health Collaborative Cheshire East Alcohol factsheet June 2016
[3] Champs Public Health Collaborative Cheshire East Alcohol factsheet June 2016

- To reduce alcohol-related health harms
- To reduce alcohol-related hospital admissions
- To reduce alcohol-related crime, anti-social behaviour and domestic abuse
- To support a diverse, vibrant and safe night time economy
- To improve our co-ordination/partnership work to ensure that all the other priorities are achieved efficiently and effectively.

The Alcohol Harm Position Statement and Forward Plan has been structured around five key themes that encompass the diverse areas that are affected by alcohol-related harm. By focusing on Prevention, Protection, Treatment, Recovery, and Enforcement and Control it demonstrates the range of work that is already underway and sets out clear ideas and plans for improvement.

The Plan will be overseen by the Cheshire East Health and Wellbeing Board, but with a reporting line for information to the Cheshire East Community Safety Partnership. It is proposed that the Strategy Steering Group remains in existence but becomes the Implementation Plan Delivery Group with responsibility for overseeing the actions set out in the Plan. The Board is asked to support this proposal.

5. Background/Chronology

5.1. Cheshire East Council has been concerned about levels of alcohol-related harm for a number of years. As part of the Cheshire and Warrington sub-region the Council has worked with Cheshire West and Chester and Warrington Councils and Cheshire Police, to raise the profile of the issue and build a consensus for appropriate joint working on interventions designed to reduce levels of consumption and associated impacts.

5.2. Within the Cheshire and Merseyside NHS Sustainability and Transformation Plan (STP), published October 2016, there is an identified priority to reduce alcohol harm. This is being supported by the Directors of Public Health across Cheshire and Merseyside.

5.3. The Cheshire East Alcohol Harm Reduction Plan will build upon work done to date and the strategic thinking evidenced in the STP, to ensure a holistic and co-ordinated response to the issues.

6. Wards Affected and Local Ward Members

6.1. **All**

7. Implications of Recommendation

7.1. **Policy Implications**

7.1.1. A co-ordinated approach to reducing alcohol harm will bring benefits to individual, families, communities and businesses. Achieving the outcomes set out in the Plan will have positive impacts on local communities, the economy and people's health and wellbeing, three of the Council's priority outcomes.

7.2. **Legal Implications**

7.2.1. The proposals are consistent with legal requirements, namely that under the Health and Social Care Act 2012, local government has a statutory public health role, including responsibility for improving the health of their population as well as leadership of the Health and Wellbeing Board. The HWB is the key forum for supporting local authorities in their duty to commission alcohol misuse prevention and treatment interventions.

7.3. **Financial Implications**

7.3.1. The costs of alcohol harm to the public sector in Cheshire East are estimated at some £136 million. Reducing this cost is critical at a time when all service budgets are stretched and resources are diminishing. There will not be a requirement for additional investment to achieve the outcomes set out in the Plan, but rather a better use or re-prioritisation of existing resources.

7.4. **Equality Implications**

7.4.1. We know that it is the poorer members of our communities who suffer the highest levels of alcohol-related harm. If we do not act now to reduce alcohol-related harm then increases in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend on wholly avoidable illness.

7.5. **Rural Community Implications**

7.5.1. The negative impacts of alcohol harm are not limited to town centres. Impacts on individuals, families, communities and businesses in rural areas can be as profound. The specific needs of our rural communities will be considered as part of the initial mapping to determine if there are specific concerns that we need to address.

7.6. **Human Resources Implications**

7.6.1. There are no specific impacts regarding the HR resource required to implement the Plan. As with finance it is more about better use of existing resources. However there are potential wider workforce benefits to be had for all organisations if members of staff are supported to drink in a safe, sensible and sociable way.

7.7. **Public Health Implications**

7.7.1. There will be significant benefits to individual and population health if less alcohol is consumed within Cheshire East. Excessive consumption of alcohol is a causal factor in some 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression.

7.8. **Implications for Children and Young People**

7.8.1. Protecting children and young people is a priority for the council and its partners and alcohol harm can impact upon them in many ways. Whether it is through their own drinking behaviours or that of parents / carers, children and young people become vulnerable and at risk through excessive consumption. A number of the actions within the Plan are specifically focussed upon children and young people because of the local evidence of excessive consumption and associated harms.

7.9. **Other Implications (Please Specify)**

7.9.1. In addition to its impacts upon health alcohol is associated with significant social harms such as violence, domestic abuse and road traffic accidents.

8. Risk Management

8.1. Risks in relation to the Implementation Plan will centre upon the delivery of actions, making the necessary progress and engaging effectively with all stakeholders.

9. Access to Information/Bibliography

9.1. Appendix One – Alcohol Harm Reduction Position Statement and Forward Plan

9.2. Appendix Two – Implementation Plan

10. Contact Information

Contact details for this report are as follows:

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1

Reducing Alcohol Harm in Cheshire East: A Position Statement and Forward Plan

V5.0 Final Draft 1502017

Approval/Amendment History:

Version	Date	Author	Amendment History
V1.0	15.10.2015	Callum Helman/Guy Kilminster	First consultation draft
V2.0	11.11.2015 12.11.2015 17.11.2015	Guy Kilminster	First consultation draft amended to incorporate exec summary and amends from Lucy Heath, Gerard Buckley, Shelley Brough.
V3.0	11.07.2016	Guy Kilminster	Updated with information from Charlotte Simpson, Shelley Brough and Champs.
V4.0	25.10.2016 23.01.2017	Guy Kilminster	To incorporate amends post consultation
V0.5	08.02.2017 10.02.2017	Guy Kilminster	Proof reading corrections and data updates

Executive Summary

Alcohol-related harm affects many of the residents and businesses of Cheshire East. The impacts are estimated to cost the public sector and businesses in Cheshire East over £136 million[1]. This includes health and crime associated costs and lost productivity. The variety of issues that stem from alcohol-related harm have led to overstretched Ambulance, Police and Accident and Emergency departments dealing with alcohol-related incidents and to subsequent delays in responding to the needs of other people.

The facts about our levels of alcohol consumption and its negative impacts, demonstrate that action needs to be taken. For example:

Locally -

- Young people in Cheshire East have suggested that, amongst other things, more needs to be done to raise awareness of the problems that alcohol causes young people.
- More young people in Cheshire East have tried alcohol at age 15 compared to the national average with female adolescent drinking in particular being a concern. Therefore parental influence and preventing or delaying the age of first use of alcohol or drugs for young people needs to be a priority.
- Alcohol specific hospital admissions of under 18 year olds, are high in Cheshire East compared to other areas of the country.
- The numbers of young people (14 – 17 year olds) in Cheshire East, self reporting as regularly binge drinking, has increased from 11% in 2013 to 17% in 2015 and there has been a reduction in the numbers who are worried about the long term health effects of drinking alcohol (Young Persons Alcohol and Tobacco Survey 2015)
- There were 173 alcohol related deaths in 2013
- There are increasing numbers of adults in Cheshire East being admitted to hospital every year as a result of their alcohol use. Between 2008 and 2015 admissions increased by 27%. In 2014-15 there were 7550 alcohol related hospital admissions[2].
- There were 1717 alcohol related crimes in Cheshire East in 2012-2013[3]

Nationally -

- 22,482 people died from alcohol-related causes in 2012[4]
- Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence.
- 70% of night time and 40% of daytime admissions to A&E are caused by alcohol[5]
- 10% of accidental deaths have alcohol as a contributory factor[6]
- 33% of fatal fires involve alcohol[7]
- Alcohol plays a part in 30% of domestic abuse cases, 40% of child protection cases and 74% of child mistreatment cases;[8]

[1] Champs Public Health Collaborative Cheshire East Alcohol factsheet June 2016
[2] Champs Public Health Collaborative Cheshire East Alcohol factsheet June 2016
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[8] Institute of Alcohol Studies website, Alcohol, Domestic Abuse and Sexual Assault

- 43% of assaults on Police officers are alcohol related[9].

The Position Statement and Forward Plan has been drafted to support the actions of many organisations working to reduce levels of consumption and promote safe, sensible and social drinking. It brings together national policy and local aspiration and sets a direction for activity across Cheshire East over the next two years.

As a 'Residents First' Council, we are working with a wide range of partners to focus upon activity that will bring positive outcomes to the families, communities and businesses of Cheshire East. Reducing excess alcohol consumption is the overarching aim and our priority outcomes are:

- To reduce alcohol-related health harms
- To reduce alcohol-related hospital admissions
- To reduce alcohol-related crime, anti-social behaviour and domestic abuse
- To support a diverse, vibrant and safe night time economy
- To improve our co-ordination/partnership work to ensure that all the other priorities are achieved efficiently and effectively.

This document has been structured around five key themes that encompass the diverse areas that are affected by alcohol-related harm. By focusing on **Prevention, Protection, Treatment, Recovery, and Enforcement and Control** it will demonstrate the range of work that is already underway and sets out clear ideas and plans for improvement.

The Plan will be overseen by the Cheshire East Health and Wellbeing Board, but with a reporting line for information to the Cheshire East Community Safety Partnership.

[9] Champs Public Health Collaborative Cheshire East Alcohol factsheet June 2016

Delivering on Outcomes

As excessive alcohol consumption has negative impacts across a wide range of policy and service priorities, developing a robust partnership approach is essential to the successful delivery of the plan. The various policy and structural changes within public services over the last few years and the continued financial pressures accentuate the need for a cohesive approach.

Decisions around investment and commissioning intentions (what we spend public money on) will be considered within this partnership approach. Decisions will be evidence based and represent value for money.

The Position Statement and Forward Plan will be supported by a delivery plan outlining a partnership programme of actions to support defined outcomes. This will be reviewed annually to ensure that it remains current and is responsive to changing need, changes in national policy, legislation and evidence.

Delivery of the plan will be overseen by the Health and Wellbeing Board but with a reporting line for information to the Cheshire East Community Safety Partnership. The Board will provide leadership and influence other strategic agendas and programmes as appropriate. They will monitor and manage performance of the plan and address challenges and barriers to delivery. The overall implementation will be co-ordinated by the local authority with engagement from all key partners.

Consultation Feedback

Between 8th August and 3rd October 2016, Cheshire East Council consulted residents and other stakeholders on the draft version of the Alcohol Harm Position Statement and Forward Plan. The aim was to gain feedback on the draft Plan and understand public perceptions in Cheshire East regarding alcohol harm.

The draft document was made available online with paper versions also available on request. Those who wished could send their comments about the Plan to the Council via an online survey, email or by post.

226 responses were received, the vast majority (223) through the online survey. 53% of online respondents were male and 47% female. 58% of respondents were aged 55 and over.

A large majority (88%) of respondents agreed with the five key themes of the Plan. Similarly the Priority Outcomes all received significant support (all over 80% with exception of ‘Supporting a diverse, vibrant and safe night time economy’ – 75%). When respondents were invited to add other priorities there was an emphasis upon the responsibility of retailers of alcohol and the need for improved education for children and young people, their parents and carer’s and older people on the risks of excessive consumption. There was also recognition that well run pubs have a role to play. Views on our ‘Goals for the Future’ were generally positive, although Minimum Unit Pricing has opponents as well as advocates. Concerns were expressed regarding the resourcing of the Plan and the need for the Implementation Plan to include clear targets and actions. Points on the use of jargon and acronyms, and corrections to grammar were all noted.

Needs Assessment

The excessive consumption of alcohol is often a symptom rather than a cause of vulnerability among people. Many people have broader difficulties that can be compounded by drugs and alcohol and that need addressing at the same time. It is difficult to accurately record drinking behaviours and levels of alcohol consumption but the following sections indicate Cheshire East's levels of alcohol use. Further information is included in the alcohol and drugs section of the Joint Strategic Needs Assessment[10] .

Starting and Developing Well

Pregnancy:

Applying the 2010 national infant feeding survey to Cheshire East[11] estimates that:

- 1,500 women drank during pregnancy and 112 drank more than two units per week
- Mothers aged 35 or over (52%), from managerial and professional occupations (51%) or from a White ethnic background (46%) were more likely to drink during pregnancy

Young people:

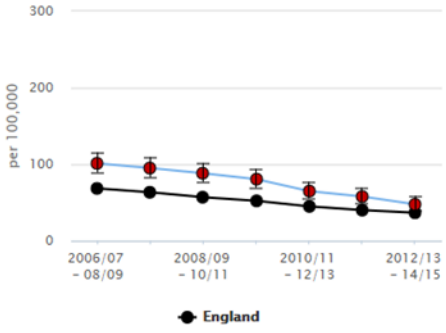
In February 2014, 1,595 11 - 18 year olds took part in the annual 'Make Your Mark' ballot. Young people in Cheshire East highlighted their top concerns locally which included drugs and alcohol. They suggested that more needs to be done to raise awareness of the problems that alcohol and drugs cause young people.

The evidence suggests that higher numbers of young people (aged 14-19) in Cheshire East compared to nationally or the North West are drinking to harmful levels.

Alcohol-specific hospital admissions in under-18s are high in Cheshire East compared to other areas of the country. Although these are decreasing, 2012-2015 rates were still significantly higher in Cheshire East (47.6 per 100000) than England (36.6 per 100000). Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcoholic liver cirrhosis.

5.01 - Persons under 18 admitted to hospital for alcohol-specific conditions Cheshire East Crude rate - per 100,000

Export chart as image Hide confidence intervals



Period		Count	Value	Lower CI	Upper CI	North West	England
2006/07 - 08/09		233	101.2	88.6	115.0	115.6	68.4
2007/08 - 09/10		218	95.0	82.8	108.5	104.2	63.3
2008/09 - 10/11		201	88.2	76.4	101.3	94.9	56.9
2009/10 - 11/12		182	80.5	69.2	93.0	85.5	52.1
2010/11 - 12/13		146	64.8	54.7	76.2	71.9	44.9
2011/12 - 13/14		130	57.8	48.3	68.7	60.4	40.1
2012/13 - 14/15		107	47.6	39.0	57.5	53.5	36.6

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

[10] http://www.cheshireeast.gov.uk/social_care_and_health/jsna/jsna.aspx

[11] National Infant Feeding Survey 2010 applied to Cheshire East birth data 2013-14

The 2015 North West young person's alcohol and tobacco survey received responses from 334 young people in Cheshire East. Key findings include:

- The percentage of 14-17 year olds who drink alcohol at least once a week has fallen since 2013, although the rates are slightly higher in Cheshire East (15%) compared to the North West region results (12%).
- Since 2013 there has been an increase in the number of 14-17 year olds in Cheshire East regularly binge drinking. It now stands at 17% compared to 12% for the North West.
- A third of young people in Cheshire East (33%) are not really worried about the long term health effects of drinking alcohol (down from 43% in 2013).
- 47% of young people aged 14-17 in Cheshire East claim never to have drunk alcohol, which is similar to the North West rate of 46%. This has increased from 19% in the 2013 survey, possibly due to the larger proportion of 14 year old respondents; over half of Cheshire East respondents were 14 years old in 2015.
- Perhaps also reflecting the younger sample profile, there is a decrease in the percentage claiming to drink in pubs/clubs (from 26% down to 14%), but a slight increase in the percentage drinking outside.
- The proportion of young people in Cheshire East drinking alone has increased from previous years to 11%.
- The proportion of 14-17 year olds in Cheshire East claiming to be aware of drinking dens or party houses in their local area, has increased from 19% in 2013 to 28% in 2015.

The 'What About YOUth', 2014 lifestyle survey of 15 year olds in England found that in Cheshire East, 8.4% are regular drinkers (higher than the England average of 6.2%) and 19.1% have been drunk in the last 4 weeks (higher than the England average of 14.6%[12]. Nearly three quarters (73.3%) of 15 year olds locally have ever tried an alcoholic drink (compared with 62.4% for England as a whole).

Living Well

Guidance from the National Institute for Health and Clinical Excellence (NICE)[13] suggests population benchmarking estimates of:

• Over 24% of the population drink in a hazardous or harmful way (where drinking increases someone's risk of harm or causes directly related health problems). This equates to 73,213 people aged 16 years and above who are hazardous or harmful drinkers in Cheshire East.
• Alcohol dependence affects 4% of 16-65 year olds. This equates to 9,497 dependent drinkers aged 16-65 years old in Cheshire East

Modelled estimates of binge drinking from 2006-08 suggest that 22% of over 16 year olds binge drink[14] (compared to 17% of Cheshire East 14-17 year old survey respondents). 22% equates to 68,000 people in Cheshire East.

[12] Public Health England (2016). Health behaviours in young people – What about YOUth survey? http://fingertips.phe.org.uk/profile/what-about-youth
[13] https://www.nice.org.uk/guidance/CG115/chapter/Introduction

[14] Cheshire East JSNA Overview: http://www.cheshireeast.gov.uk/pdf/social-care-and-health/ce-lh-indicators-quintile-analysis.pdf

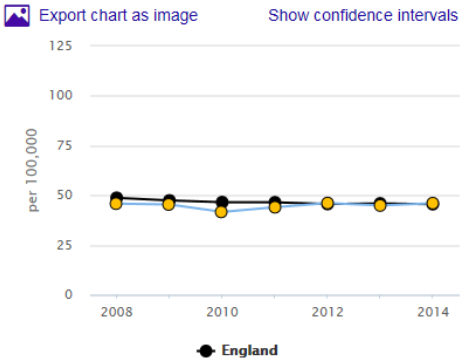
During 2014/2015, 473 over 18 year olds were in specialist treatment for alcohol misuse. Of those people accessing treatment for alcohol, 42% successfully completed their treatment[15].

Whilst it is not possible to fully quantify the impact of alcohol misuse across Cheshire East a number of indicators provide evidence of harm.

Alcohol-related mortality

There is a higher proportion of preventable liver disease in Cheshire East than the national average. There were 178 deaths from preventable liver disease in Cheshire East during 2013-15. The Public Health England definition of the preventable liver disease indicator states that liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence.

4.01 - Alcohol-related mortality (Persons) Cheshire East — Directly standardised rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	North West	England
2008		165	45.8	39.0	53.4	59.5	48.7
2009		169	45.4	38.7	52.7	58.2	47.4
2010		156	41.7	35.3	48.7	55.7	46.5
2011		167	44.0	37.5	51.2	56.6	46.5
2012		176	46.1	39.4	53.3	55.4	45.6
2013		175	44.9	38.4	52.0	55.4	45.9
2014		184	46.0	39.5	53.1	55.6	45.5

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

Alcohol -related hospital admissions

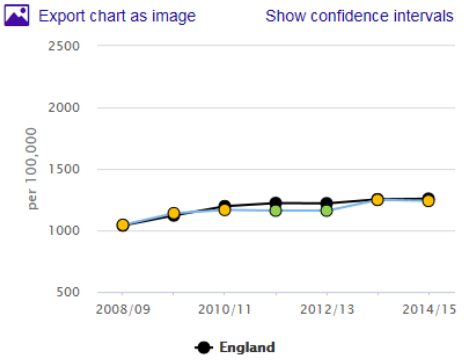
There are increasing numbers of people in Cheshire East being admitted to hospital every year as a result of their alcohol use. Between 2008 and 2015 admissions increased by 27%.
Further investigation into the specific conditions shows that Cheshire East benchmarks poorly compared to England for admission episodes for:

- Alcohol-related mental and behavioural disorders in males and females

[15] Public Health England (2016). Local Alcohol Profiles for England. http://fingertips.phe.org.uk/profile/local-alcohol-profiles/

7.01 - Persons admitted to hospital for alcohol-related conditions (Broad) (Persons) Cheshire East

Directly standardised rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	North West	England
2008/09		3,800	1,045	1,012	1,079	1,291	1,040
2009/10		4,182	1,140	1,105	1,175	1,403	1,122
2010/11		4,335	1,167	1,132	1,203	1,471	1,197
2011/12		4,360	1,161	1,127	1,197	1,484	1,222
2012/13		4,417	1,161	1,127	1,196	1,491	1,220
2013/14		4,786	1,249	1,213	1,285	1,546	1,253
2014/15		4,818	1,240	1,205	1,276	1,565	1,258

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Alcohol-related recorded crime

- During 2014/15 there were 838 alcohol-related crimes of violence recorded in Cheshire East; there has been an average of 68 crimes per month since April 2012, predictably ranging from 34 to 104 per month[16].
- There were 537 drink driving arrests and 281 drunk and disorderly arrests during 2014/15[17] and alcohol was a consistent feature in at least 14% of high risk domestic abuse cases.[18]

Impact of alcohol on fire incidents

- The Department for Communities and Local Government (DCLG) carried out a study in 2011 into fires that occurred in people's homes. This showed that alcohol misuse resulted in 2,656 fires (around 9% of all fires), resulting in 60 deaths and 1,267 injuries. Where alcohol was a contributory factor, 49% of fire incidents resulted in casualties, compared to 14% for other fire incidents. The estimated cost of fires, where alcohol was suspected to be a contributing factor, was almost £131 million. This compares to just over £286 million for other type of fire.[19]

Benefit claimants

- In 2015, 230 people were claiming incapacity, severe disablement allowance or employment and support allowance due to alcoholism. Rates are lower than for the North West and England.

Ageing Well

- Approximately 11,000 older people drank more than the recommended amounts.[20]

[16] Monthly data supplied by Cheshire East Police

[17] Monthly data supplied by Cheshire East Police

[18] Cheshire East Domestic Abuse JSNA – September 2016

[19] Department of Health – written evidence to Health Committee (2011)

[20] IAS (2013) Older people and Alcohol Factsheet applied to 2011 census data

- Alcohol has been identified as one of the three main causes of falls. There were 2,063 emergency hospital admissions for injuries due to falls in people aged 65 years and over in Cheshire East in 2014/2015.[21]

Our Approach To Date

A Summary of what we are already doing in Cheshire East:

- **'One You Cheshire East' (Lifestyle Commissioning) – Alcohol**
  Lifestyle and wellness services are accessed using a variety of different routes. This can be confusing both to members of the public and professionals who work with them to improve their health and wellbeing. Our aim is to do things in a new way by introducing an 'Integrated Wellness and Lifestyle Support System'. This will give local people more control over how they access services, and more choice over the services they access. The 'Integrated Support System' has a range of components such as:
    - Assessment and Co-ordination help, advice and support
    - Lifestyle and Wellness Support including: Physical Activity, Holistic Lifestyle Coaching, **Alcohol Harm Reduction**, Tobacco Control & Stop Smoking, Healthy Eating, and some Sexual Health services

- **Stepping Stones Specialist Substance Misuse Service**
  Cheshire and Wirral Partnership NHS Foundation Trust (CWP) is the lead provider for the Cheshire East Substance Misuse Service 'Stepping Stones' for which the contract was awarded in November 2014. Stepping Stones takes a life-course approach, supporting adults and young people with substance misuse problems. CWP have also sub-contracted to a number of voluntary and community sector organisations to deliver interventions to support individuals to achieve recovery such as employment training, school based support and mutual aid.

- **Business Advice courses for local businesses about licensing law**
  These courses are voluntary and catered to the individual businesses and the concerns they have. They are designed to offer an easy way for businesses to ensure that they comply with the relevant legislation. This saves money and time in the long run as any potential issues are fixed before they develop into something more problematic.

- **Test purchasing with underage volunteers**
  This approach is intelligence led and used to target businesses that are believed to be selling alcohol to underage people.

- **Children's alcohol & tobacco survey**
  This is done every two years and assesses our young people's relationship with alcohol and tobacco. The information garnered from such surveys can indicate areas for improvement in our approach. 334 responses were received in the 2015 survey.

[21] Public Health England (2016). Public Health Outcomes Framework. http://www.phoutcomes.info/

- **Enforcement against counterfeit alcohol**
  Ensuring that any alcohol sold is licensed and genuine is vitally important in ensuring that our areas alcohol supply can be monitored and kept in the hands of adults. It is also important in minimising the harm caused by alcohol as counterfeit alcohol can damage people's health far more acutely than legal equivalents.

- **Community Alcohol Network (CAN)**
  The CAN is a partnership organisation that was born out of the successful pilot of the CAP (Community Alcohol Partnership) in Crewe South. It is a Council-wide initiative designed to bring together several council departments, the police and community safety teams. It is designed to offer a universal approach to problem premises with multiple issues. It has already had some notable success.

- **Working to Introduce the Cardiff Model of data sharing**
  The Cardiff Model of data sharing is a mechanism for sharing information between the Police, Accident and Emergency departments and local Council Licensing departments. It has been proven to reduce the numbers of alcohol related incidents in a town or city centre that result in either an arrest or a presentation at an A&E Department.

- **TWISTA peer mentoring scheme**
  This is a scheme aimed at vulnerable and at risk young people. The idea was to ensure they got support in a way that benefitted them without having to go through more formal routes. In this programme, a volunteer becomes the peer-mentor of a young person and helps with the pastoral side of their care.

- **Recovery based accommodation**
  This is a plan to better utilise the housing facilities already being used by some residents at the moment. It became clear that the service we provided did not cater for those with complex needs and was not co-ordinated enough to give the best results. It is hoped that by restructuring our current service we can provide a more coherent service that reduces the number of readmissions and radically improves the number of people recovering and becoming independent again.

- **ACPO Alcohol Harm Reduction Week**
  This is an event, run by the police, that raises awareness of licensing procedures that need to be followed.

- **High Profile visits to hotspot premises**
  This is a form of deterrence that demonstrates an awareness of the local environment. It also acts as a great tool for ensuring that any problems are not related to the premises serving the alcohol.

- **Operation Americas**

This is an initiative led by Neighbourhood Policing Units. It involves running licensing focused weekends.

- **ARC Angel**
  ARC angel is a multi-agency approach to tackling alcohol related crime that utilises powers given to the police by the Anti-Social Behaviour, Crime and Policing Act 2014. It is a standards based approach aimed at improving community relationships with alcohol and using enforcement where appropriate.

- **School Liaison Visits**
  This work is carried out by the police in order to help prevent alcohol harm in the future. It involves talking to school children about the use and damage of alcohol.

- **NAVIGATE Scheme**
  This scheme aims to target persistent offenders who pose the greatest threat to the safety and confidence of their community. Many of these have substance misuse issues, including alcohol.

- **CCTV service**
  Utilised as a form of deterrent for a variety of crimes and is placed in hot-spot areas throughout town centres in Cheshire East. It also provides evidence for further action on specific people, premises or establishments.

- **Community Warden Service**
  The Community Warden Service was established to address public concerns in relation to crime and disorder and tackle issues in relation to anti-social behaviour. This is achieved by working in partnership with the local community and its partners to provide a safer environment in which to live, work, and visit. The provision of a uniformed community patrol offers and promotes community reassurance leading to a reduction in crime and, most importantly, the community's perception of crime.

- **Multi-Agency Action Groups**
  The MAAG process has developed from Safer Cheshire East Partnership's "Tasking and Co-Ordination" (T&C) process. It involves a range of issues and problems that arise from time to time via regular analysis of current trends and nominations of specific issues (which are assessed) from agencies which are members of the Group.

- **Street Pastors**
  Street pastors are trained volunteers from local churches who care about their community. They patrol in teams of men and women, usually from 10pm – 4am on a Friday and Saturday night, to care for, listen to and help people who are out on the streets. They work together with other partners in the night-time economy to make communities safer.

- **Manchester Mediation Service**

This is a commissioned company who deliver mediation intervention for neighbour disputes around anti-social behaviour and other such things.

- **Anti-Social Behaviour Team**
  The Safer Cheshire East Anti-Social Behaviour Team work with partnership agencies to tackle this sort of behaviour, and draw up and amend standards of practice to make sure ASB is tackled as effectively as possible within Cheshire East. They utilise multiple tools and measures to help reduce the amount of anti-social behaviour across Cheshire East. These tools include, letters to parents, acceptable behaviour contracts, referral to preventing offending panel, community protection notices etc.

- **Cheshire Fire and Rescue Service**
  Cheshire Fire and Rescue Service Operational staff and Advocates have a good awareness of alcohol-related harm. Cheshire Fire & Rescue Service Prevention staff were trained in 2012 by CHAMPS for tier 1 Alcohol Harm and Brief Intervention. This training assisted Operational staff to identify alcohol-related dwelling fires and refer cases onto Prevention staff who then engaged more effectively with householders about the links between fire and alcohol, and especially the significant dangers of cooking whilst under the influence of alcohol.

  From time to time, the identification of an alcohol-related dwelling fire and the more specialized post fire follow-up gives rise to the identification of more complex underlying issues requiring the Service to engage with social workers, mental health professionals, care providers etc.

  NHS England (Cheshire and Merseyside Sub-Region) has asked Cheshire Fire and Rescue Service to address some key local health issues as part of the expansion of current Home Fire Safety work (conducted in the home setting) in to a broader Safe and Well assessment. Alcohol reduction has been identified as one of the issues Cheshire Fire and Rescue Service can help support through Safe and Well visits.

Our Ambition

Health First, the evidence-based alcohol strategy for the UK[22], recommends that action needs to be taken on the pricing of alcohol, the licensing of alcohol, the marketing of alcohol, drinking and pregnancy and drink driving as these five issues are strong drivers of alcohol-related harm. Many of their recommendations can only be implemented through national policy; however activity can take place locally to contribute to improved outcomes within Cheshire East.

There are a number of priority areas that we intend to focus upon over the next two years to build upon the good work already underway, but to help to co-ordinate even more effectively the efforts of partners to reduce alcohol related harms.

Goals for the future:

[22] 'Health First: an evidence-based alcohol strategy for the UK', University of Stirling, March 2013

G1 A coherent multi-agency approach with an effective action plan that covers all services – to create an effective framework for encouraging multi-agency approaches to dealing with the issues surrounding alcohol related harm. Bringing services together in such a way will help us to improve outcomes and create a more efficient and personalised service for residents.

G2 Minimum Unit Pricing (MUP) – working with Cheshire and Merseyside authorities to support the introduction of MUP, subject to the outcome of the alcohol industry legal challenge to the introduction of a MUP in Scotland. The Advocate General of the European Court of Justice has offered the opinion that the Scottish Alcohol Minimum Unit Price does not contravene European Law (3rd September 2015), but that it would only be legal if it can be demonstrated that no other mechanism exists to achieve the same desired outcome. The introduction of MUP would need to demonstrate "additional advantages or fewer disadvantages by comparison with the alternative measure". The European court is expected to take at least a further six months to issue its final ruling, before the case is referred back to the Court of Session in Edinburgh.

G3 Improved engagement with local alcohol retailers in order to promote responsible retailing.

G4 Working closely with the Clinical Commissioning Groups and Acute Hospitals to further develop Hospital Alcohol Liaison Services.

G5 Consistent messaging about alcohol harm and positive drinking behaviours across services – development of a coherent brand and concise and clear messaging, that all organisations would use in any promotional activity related to reducing alcohol harm. Development of a coordinated alcohol communications plan agreed by all partners.

G6 A focus upon improved education and awareness raising amongst children and young people and their parents/carers in relation to the harms of alcohol.

G7 To undertake further work to better understand capacity and demand for treatment within the borough.

G8 Develop the wider use of identification and brief advice across the borough by non-specialist universal services and within other commissioning areas including Healthchecks, and the Integrated Lifestyle and Wellness Support System.

G9 Embedded 'Recovery' in communities across the borough. We need to have a clear understanding of our local recovery assets and where they can be developed further. By taking an 'Assets Based Community Development' (ABCD) approach we can build recovery in our communities. Developing our local assets to enable individuals to engage in meaningful community based activities; we want to enable individuals to build their recovery capital through volunteering, education, training, employment, housing, family, friends, and wider health services. Local examples include: the development of volunteering opportunities through a network of visible 'Recovery Champions' through our specialist substance misuse service, and our recovery based accommodation pilot.

G10 We have an ambition to develop some recovery accommodation in the area. The provision of such a service would offer people with complex needs a safe place to come and receive the help and support they need. The accommodation would also act as the perfect vessel to utilise

effective multi-agency working to improve outcomes and keep the work cost effective. The recovery based accommodation pilot will be jointly commissioned by public health and housing, to provide sustainable accommodation and recovery at a community level.

G11 A shift from long term treatment to prevention and recovery within our Specialist substance Misuse service, with clear seamless pathways between treatment and recovery.

G12 Licensing Review - The Council recently (July 2016) considered whether it is appropriate to implement a Late Night Levy (LNL) or Early Morning Restriction Orders (EMRO) together with other powers at our disposal to protect residents from crime, anti-social behaviour and noise nuisance caused by irresponsible licensed premises and irresponsible drinkers; to promote the reduction in the levels of alcohol use/misuse by Children and Young People and to reduce the incidence of alcohol related harm. At this point in time it was deemed inappropriate to progress a LNL or EMRO. However it was agreed to review the need for a Cumulative Impact Policy for certain areas. Our ambition is to ensure that the residents of this area are provided with the best solution for them regarding licensing.

CLeaR Self Assessment

To help with the development of our Alcohol Harm Reduction Implementation Plan and the process of prioritisation, we shall as a first action undertake the Public Health England (PHE) Alcohol CLeaR self-assessment. The self-assessment tool and supporting materials have been developed by PHE to support an evidence based response to preventing and reducing alcohol related harm at a local level.

What is CLeaR?

CLeaR is an evidence-based improvement model which stimulates discussion among partners about local opportunities for improving outcomes through effective collaborative working. It helps alcohol partnerships determine how the local structures and processes currently in place support a reduction in alcohol-related harm.

It is designed to be used by local authorities, the NHS, those involved in the criminal justice system, and voluntary sector agencies—working together across local alcohol partnerships with accountability to health and wellbeing boards, and/or community safety partnerships. Involving service users and carer representatives in the process will be beneficial and provide additional assurance.

CLeaR stands for the three linked domains of the model. These domains are underpinned by the central core of local priorities and objectives, which encourage alcohol partnerships to consider how the broader aims of local government, the NHS, the police and other partners complement, and support, a place-based approach to improving the outcomes associated with alcohol-related harm.

- Challenge of local services that deliver interventions to prevent or reduce alcohol-related harm – this domain reviews operational practice against current evidence about the most effective components of alcohol interventions, as outlined in NICE guidance and other publications.

- Leadership – this domain considers the extent to which strategic leadership is supporting comprehensive action to reduce alcohol harm. It looks at local structures and arrangements to assess whether commissioning decisions are informed by a robust understanding of local need and to evaluate the strength of partnership working, and the governance structures underpinning this.
- Results – this domain looks at the data used locally to evidence the outcomes delivered by the partnership against national and local priorities and reflects on emerging local trends.

The alcohol CLeaR model offers:

- a free-to-access, self-assessment tool that can assist local partnerships in evaluating the effectiveness of structures and arrangements that support local services to address and reduce alcohol-related harm and in identifying opportunities for improvement and action planning
- a chance to benchmark local work to reduce alcohol-related harm over time
- an opportunity to identify and showcase good and innovative practices locally and to share this learning with others

The key principles of self-assessment are:

- simplicity – individual questions in the self-assessment should be quick and easy to complete
- collaboration – the self-assessment is best completed collaboratively through discussion with partners
- evidence-based responses – participants are encouraged to consider the local evidence, and to reflect on national and international evidence, before recording the basis for their choices
- honesty – completion of the self-assessment should be a transparent and open process

The use of a self-assessment tool that allows partnerships to challenge services, provide leadership and examine results (CLeaR) has been shown to be an effective approach in tobacco control. The alcohol CLeaR uses the same methodology to give alcohol partnerships the same benefits.

The alcohol CLeaR tool was developed by experts with a background in alcohol policy, commissioning or delivery. Its content was shaped by the evidence base as set out in NICE guidance and existing PHE tools and resources, in particular the alcohol stocktake tool and the JSNA commissioning prompts, published within the annual JSNA support packs. The tool was piloted and then revised to reflect learning from the pilot sites.

Prevention

Overview

'Prevention', through evidence-based interventions, aims to delay the first use of alcohol, deter people from developing drinking problems and reduce the harm of alcohol use. In addition to the harmful impact of alcohol misuse on health and wellbeing, the 'hidden harm' caused by alcohol misuse can also lead to unemployment, domestic violence and child neglect.

Alcohol prevention is multifaceted with various factors at different levels, from individual behaviour and choice, which can be combined with wider community, environmental, social, cultural and economic influences.

Effective prevention helps to reduce or remove individual and community level risk factors such as family conflict, parental or sibling alcohol use or economic deprivation. While enhancing protective factors such as strong family bonds, strong support structures, self-efficacy, problem solving skills, constructive interests and activities.

Cheshire East Council Public Health have recently commissioned an integrated Substance Misuse Service (SMS) for young people and adults, which was awarded to Cheshire and Wirral Partnership NHS Trust (CWP) as the 'Lead Provider' to coordinate the delivery of SMS across a number of providers. The integrated SMS is called 'Stepping Stones' and it aims to reduce the harm to people misusing alcohol.

Evidence suggests that higher numbers of young people (aged 14-19) in Cheshire East are drinking to harmful levels compared to nationally. Therefore 'Early Intervention' and a 'Life-course' approach are also key to prevention. Stepping Stones provides targeted interventions for Young People and their families and also offers interventions within schools. There is a strong evidence base supporting the influence of protective factors such as parents/carers and schools play a key role in preventing young people from developing alcohol problems. 'One You Cheshire East', the Integrated Lifestyle and Wellness Service will also deliver universal prevention for Young people in these areas. Parents/carers can also be a risk factor in terms of the health and safeguarding impact on children who live with parents who drink to harmful levels.

There is also a need to enable and educate young people and adults to make healthy lifestyle choices that don't include harmful behaviour, such as excessive drinking. Again the Integrated Lifestyle and Wellness Service will provide a choice of help, advice and support in a range of ways.

What needs to be done?

We need to reduce the high levels of harmful drinking in Cheshire East compared to the national picture. This will be achieved through improved education and alcohol prevention interventions targeted at various levels from individuals, families and wider communities.

Key priorities for alcohol prevention in Cheshire East include:

- Reducing the number of Young People who are drinking to harmful levels.
- Reducing the number of alcohol-related hospital admissions in Cheshire East.
- Redressing the balance from treatment to prevention – Local alcohol services need to shift from focus on the treatment of alcohol misuse, towards prevention.
- Assets Based Community Development (ABCD) to build on the protective factors of individuals, families and communities to prevent alcohol misuse.

ABCD is a set of values and principles which:

- *Identifies and makes visible the health-enhancing assets in a community*
- *Sees citizens and communities as the co-producers of health and well-being, rather than the recipients of services*
- *Promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment*
- *Identifies what has the potential to improve health and well-being*
- *Supports individuals' health and well-being through self- esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources*
- *Empower communities to control their futures and create tangible resources such as services, funds and buildings*

An asset can be defined as: any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being.

Other assets include the following:

- *the practical skills, capacity and knowledge of local residents*
- *the passions and interests of local residents that give them energy for change*
- *the networks and connections – known as 'social capital' – in a community, including friendships and neighbourliness*
- *the effectiveness of local community and voluntary associations*
- *the resources of public, private and third sector organisations that are available to support a community*
- *the physical and economic resources of a place that enhance well-being.*

- Evidence based behaviour change interventions through a choice of help, advice and support services; more specifically an alcohol 'Identification and Brief Advice' (IBA) service as part of the 'One You Cheshire East' Integrated Lifestyle & Wellness Support System. The Brief Advice also needs to focus on the impact of parental drinking on children and young people, to prevent and delay young people from drinking and alcohol.

- The Cheshire East Local Safeguarding Children Board have recommended that we need to raise awareness of the hidden harm and safeguarding implications of children living with parents/carers who are drinking to harmful levels.

Protection

Overview

Public services have a responsibility to work together to safeguard and promote the wellbeing of children and young people and vulnerable adults. This Impact Area focuses on reducing the harmful use of alcohol by young people and reducing the number of children affected by parental alcohol misuse.

Alcohol misuse among young people can have serious consequences. There are strong links between high levels of consumption and other risk factors such as offending, teenage pregnancy, child sexual exploitation, truancy, school exclusion and illegal drug misuse. Children and young people who misuse alcohol are at greater risk of suffering negative health and social outcomes compared to adults, because they have not yet fully developed physically or mentally. Young people in Cheshire East are more likely to have an alcoholic drink with 73.3% of young people in Cheshire East compared to 62.4 % nationally.[23] However Cheshire East benchmarks well for pupil absence and teenage pregnancy and is similar for England on first time entrants to the criminal justices system. Parental alcohol misuse and related domestic violence can adversely affect the physical, mental and psychological development and wellbeing of young people and lead to a range of poor outcomes. The Local Children's Safeguarding Board's Neglect Strategy being published in 2017 will highlight a factor in adolescent neglect that can see children and young people being allowed to drink large amounts of alcohol.

Maternal alcohol misuse during pregnancy is linked to a number of mental and physical disabilities that can affect infants into childhood.[24]

Improvements in the evidence has helped raise awareness and understanding of these issues and informed responses at both the national and local level. Parental alcohol misuse is now firmly established as a risk factor that needs to be addressed within child protection and safeguarding work within the borough.

What needs to be done?

- A programme of education and awareness raising needs to be in place to ensure that parents / carers, children and young people are aware of the consequences and potential harms of alcohol use among young people. Parents / carers must also be aware of the possible impact of their own alcohol use on their children. This includes ensuring that they are aware of the risks of supplying young people with alcohol.

- The progress made through the Early Intervention and Prevention work already done in Cheshire East needs to be built upon. This will improve access for families to engage with Children's centres and ensure that Parenting Programmes have capacity to work with families where alcohol misuse is a key issue. It will also improve access and engagement of

[23] What about YOUth Survey 2014

[24] Drinkaware (2015) Young People's and their Parents Drinking Behaviour and their attitudes in the UK https://www.drinkaware.co.uk/research/our-research-and-evaluation-reports/drinkaware-monitor-young-people-report/

parents requiring treatment for alcohol misuse including those where there are child protection concerns.

- Cheshire East is developing a Parent Journey through integrated working between Children's Early Help services and Public Health commissioned 0-19 services. This will include systematic assessment of 0-5s and their parents. The assessment will include the AUDIT C. It will also include systematic promotion of healthy lifestyles including appropriate alcohol consumption.

- Responses to young people's alcohol misuse must be integrated within other initiatives to improve outcomes for children and young people. Specialist services must be in place for those young people who need them.

- Cheshire East has developed an emotionally healthy schools programme targeting secondary schools. We are part of two national pilots: a CAMHS school link pilot and an extension to vulnerable children. The extension to vulnerable children will involve systematic identification of vulnerable children in the school footprint, systematic assessment of need and multiagency appropriate responses. This will include young people who misuse alcohol.

- All key services working with parents and their children need to be equipped to identify parental alcohol abuse. A training programme for social care teams is being developed and delivered by the Cheshire East Substance Misuse Service.

- In 2014-15 alcohol misuse of a parent/carer was identified in 427 out of 3,627 children's assessments. Only 76 of these parents were involved in alcohol and drugs services. A bid has been made to the Complex Dependency programme to support a deep dive to understand the needs of these different families and whether the appropriate parents are reaching services.

- Links between specialist alcohol services and domestic violence services must be improved to promote collaborative and integrated service provision. Support must be in place for children and young people affected by parental alcohol misuse and domestic violence. The Complex Dependencies bid also includes links with Domestic Abuse.

- Alcohol and Drugs, Mental Health and Domestic Abuse are three key causes of children's social care involvement in families. The LSCB offers comprehensive training around domestic abuse. We are exploring how we can deliver mental health training. We need to also find a way to deliver alcohol and drugs training to the wider safeguarding audience.

Treatment

Overview

'Treatment' of alcohol misuse generally involves three evidence based steps, identification and brief intervention/second level psycho-social interventions, detoxification and recovery.

The first phase of treatment for those who are **dependent** on alcohol is controlled and supervised detoxification. Detoxification is then followed by a recovery programme, which can include a number of interventions such as counselling, psychosocial support (behaviour change), prescribing, mutual aid, peer support, building on assets/strengths/protective-factors, information, advice and education. Treatment can be provided via inpatient supported treatment accommodation or while the individual lives in the community.

Stepping Stones delivers specialist treatment services for dependant drinkers in Cheshire East, offering harm reduction and appropriate health assessment for blood borne viruses and sexually transmitted disease, to help with recovery from addiction, behaviour change, and support to withdraw and become alcohol free. Stepping Stones provides 'step up and step down' treatment and support that is seamless, co-ordinated and monitored, with follow up review arrangements post service exit to monitor achievements of a life free from alcohol, and learning from relapse. At the end of March 2015 there were a total of 458 dependent drinkers receiving treatment from Stepping Stones.

In order to prevent adults from becoming dependent on alcohol and to therefore reduce the demand for specialist treatment, it is important to also target interventions to those who are **Hazardous drinkers** (Hazardous drinking usually refers to drinking above the recommended lower-risk levels but without, yet, showing evidence of harm to health) and also **Harmful drinkers** (Harmful drinking refers to those already experiencing or showing evidence of health harms, but not showing evidence of alcohol dependence).[25]

What needs to be done?

- Enhance, with CCGs and Acute Hospitals, the development of hospital alcohol liaison services.
- The development of an effective alcohol treatment and referral pathway between GPs and the specialist substance misuse service
- To undertake further work to better understand capacity and demand for treatment within the borough.
- Develop wider use of identification and brief advice across the borough by non-specialist universal services and within other commissioning areas including Healthchecks, and the 'One You Cheshire East' Integrated Lifestyle and Wellness Support System.

[25] NHS Choices, Alcohol misuse http://www.nhs.uk/conditions/Alcohol-misuse/Pages/Introduction.aspx

- The principles of prevention and recovery need to be embedded within our treatment workforce.

- Clear, visible pathways between treatment and recovery will enable individuals, families and communities to engage and to provide the recovery networks that are needed to achieve the benefits of recovery in communities.

Recovery

Overview

'Recovery' includes giving people the support they need to move towards being alcohol free and to maintain this ideally for life. Key contributing factors for recovery are having a home, employment / volunteering, and supportive networks. Effective recovery planning is essential and needs to embrace these factors in addition to treatment and wider health and wellbeing considerations.

Alcohol misuse services in Cheshire East have predominantly focussed on specialist treatment. The newly commissioned Substance Misuse Service (SMS) 'Stepping Stones' aims to concentrate more on progress towards recovery, particularly for those in long term treatment. The partnership approach delivered by Stepping Stones will make it easier for people who may use more than one service and/or require different interventions at times within their 'recovery journey' from alcohol misuse, or at relapse.

To support individuals to achieve their journey towards recovery, Stepping Stones makes good use of asset based community development, promoting self-care and actively supporting the development of and linkage with mutual aid. Some of the recovery based, behaviour change interventions and mutual aid delivered by community based organisations through Stepping Stones include, Acorn Recovery (Reduction and Motivation Programme (RAMP) and Dependency Emotional Attachment Programme (DEAP)), Intuitive Thinking Skills training such as Skills-Tu Employment and Emerging Horizons.

What needs to be done?

- Redress the balance from treatment to prevention and recovery:- local Alcohol services have been predominantly focussed on the specialist treatment of alcohol misuse. Stepping Stones aims to shift the focus more towards reducing the harm of alcohol misuse (prevention) and supporting people to become alcohol free (recovery). Stepping Stones has been developed to be more oriented towards recovery, to reduce the number of individuals who have historically remained in long term treatment, also to ensure that new entrants to treatment are able to move onto recovery and abstinence. We also need to ensure that wider providers and settings have a responsibility for supporting recovery.

- Develop an 'Assets Based Community Development' approach that aims to build on our local community strengths and therefore the key contributing factors in recovery.

- Improve accommodation options: - There is a lack of local suitable accommodation, which is a significant risk to an individual's ability to achieve and sustain their recovery. We need to commission an accommodation model which provides a safe temporary home to enable Cheshire East residents without accommodation and currently using alcohol in an uncontrolled manner to recover to the point where they can start to work towards maintaining an independent tenancy. In addition we need to work with the Registered Providers to ensure a co-ordinated approach to supporting individuals at risk of losing their accommodation because of alcohol related causes and we need to respond to the needs of

people who continue to use alcohol despite losing access to rented accommodation, for example through Housing Options.

Enforcement and Control

Overview

We are committed to securing the safety and amenity of communities within the Cheshire East area, whilst facilitating a sustainable alcohol and entertainment industry. We also recognise that our residents deserve a safe and desirable environment in which to work and live. We recognise the importance of well-run licensed premises in a vibrant and diverse local economy. We will do all we can to promote the safety of our residents and visitors.

We intend to work proactively with the Cheshire Police and other enforcement agencies. This will include intelligence led late night visits and the monitoring of problem premises.

Proportionate targeting of agreed problem and high-risk licensed activities needing greater attention will be applied. A corresponding lighter touch for well run, lower risk premises will also be applied.

The Review of licences or certificates provides a key protection for the community where the Licensing Objectives are being undermined. The Licensing Authority will provide advice to members of the public and responsible authorities on the review process.

Strategic use of local information can be employed to target specific crime 'hot spot' areas. In particular, hospital Emergency Departments can make a significant contribution to reducing community violence through working with their local Community Safety Partnership to share data about alcohol related violence.

What needs to be done?

Enforcement

- All the relevant tools and powers must be used to address alcohol related crime and anti-social behaviour with a specific emphasis on early intervention. Cheshire East should work with national and regional partners to engage in new and emerging programmes where there is evidence of effectiveness.

- Through the use of Mandatory Licensing Conditions we will be able to utilise a variety of measures that act as a strong deterrent to breaching the conditions; warnings, cautions and prosecutions can be utilised against premises that breach their licensing conditions. It is also worth noting that very similar punishments are available for people who are in the possession of fake identification documents.

- People who commit alcohol related crime must be supported to engage with relevant alcohol services. First time offenders attending court as a result of their alcohol misuse should be offered early interventions to reduce re-offending and address alcohol concerns early. For more persistent and chaotic offenders a CBO must be employed to address alcohol related offending and alcohol misuse.

- All agencies responsible for commissioning alcohol treatment services for offenders must work together to ensure a full ranges of interventions can be provided to the residents of Cheshire East.

- It is vitally important that we look at the effect alcohol has on incidents of domestic abuse. Last year we have conducted one Domestic Homicide Review and contributed to a second. In both of these incidents alcohol use by the perpetrator played a significant role in the antecedents to the murders.

- We are currently working under the guidance and action plans set out in the Domestic Abuse Strategy 2014-16 document. Our provision for Domestic Abuse vision is realised under six key priorities. They are Prevention and Early Intervention, Protection, Provision, Partnership, Participation, and Performance. The strategy offers a holistic approach to tackling domestic abuse through the encouragement of partnership work and inter-service co-operation.

Control

- We will work closely with Cheshire Police and other enforcement agencies to ensure that businesses and individuals comply with the relevant legislation. This will include a number of different measures being utilised to ensure positive outcomes for our residents.

- Regular visits to licensed premises will be included to ensure that they are being operated in accordance with the terms of their respective licenses. There will also be intelligence led late night visits and regular monitoring of problem premises to ensure that the area is constantly providing a thriving but safe night time economy.

- A programme for test purchasing, guided by intelligence gathered from multiple reputable sources, will be instigated with the help of underage volunteers. This form of test purchasing plays an integral role in our area's ability to protect young people from the harm caused by excessive alcohol consumption.

- Through the Trading Standards team, there is also scope for ensuring that alcohol labelling and measurements are compliant with relevant legislation. Trading standards also offer Business Advice packs that are catered individually to businesses that use them. They can cover any topic that the business owners are unsure about; be it licensing conditions, spotting real identification or other similar issues. This is an important preventative tool in our arsenal as we do not want to unfairly target businesses who are trying to comply with all the relevant legislation.

Cross Cutting Enablers

Communication

Effective communication across partners and with the community will support further development and implementation of the plan. Through the Cheshire East Community Safety Partnership and the Health and Wellbeing Board, communication with individuals, communities and businesses will be undertaken to raise awareness of the work underway to reduce alcohol related harms. We will seek their views on how alcohol impacts them, how we can improve our responses and how they can support action to address these issues. We will communicate with a wide range of partners and stakeholders, including local councillors, local businesses and service providers in the public and third sector, to ensure the successful delivery of the plan. A multi agency Communications Strategy will be developed.

Workforce Development

We need to ensure that all organisations and services engaged in the implementation of the plan have sufficient staff with the knowledge and skills required to deliver the relevant services. This includes skills around Identification and Brief Advice and the safeguarding of young people and vulnerable adults affected by alcohol. We need to ensure that we promote workforce development through regular training and opportunities for skill sharing and exchange throughout the system.

Improving Understanding

We are committed to improving our understanding of how alcohol misuse impacts Cheshire East.

We will collect and utilise data to inform our approaches in Cheshire East. We will evaluate new services and approaches to improve the evidence about what works in reducing alcohol related harm.

Relevant National Policy

It is vitally important that this Position statement and Forward Plan is based on, responds to and incorporates current policy and legislation. The most significant influencers on our thinking have included:

- **Licensing Act, 2003;** *HM Government*
  This legislation has been the cornerstone of Alcohol Licensing legislation since its introduction in 2003. Its primary goal was to replace the nation's outdated laws with what was deemed to be a 21st Century licensing system.

- **Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions: An EU strategy to support Member States in reducing alcohol related harm, 2006;** *Commission of the European Communities*
  This policy document was written in 2006 and offers a clear outline of areas that could be tackled to reduce the harm caused by alcohol. It was roundly criticised for its lack of industry focused policy but given the scope of this local strategy it offers a useful, in-depth analysis of the different areas of our services that alcohol can have an impact upon.

- **Selling Alcohol Responsibly: the new mandatory licensing conditions, 2010;** *Home Office*
  This guidance outlines new mandatory licensing conditions and allows for a local approach to age verification policies and price promotions.

- **Drug Strategy – Reducing Demand, Restricting Supply, Building Recovery, 2010;** *HM Government*
  This approach is aimed primarily at ensuring people who are dependent on any substance, like alcohol, are cared for throughout their progression from vulnerability to independent living. It focuses on improving these outcomes to reduce alcohol related admissions to hospital - better for the individual and reducing costs to the health service.

- **Breaking the Cycle – Effective Punishment, rehabilitation and sentencing of offenders, 2010;** *Ministry of Justice*
  It proposes that by tackling dependencies, such as alcohol dependency, in prison populations the number of reoffenders, and prison numbers as a whole, would drop. By breaking this cycle the number of prisoners and the number of crime and health incidents related to alcohol would reduce.

- **Healthy Lives Healthy People – Our Strategy for public health in England, 2010;** *Dept. of Health*
  Published as part of the preparation for the Health and Care Act (2012), its focus was to make public health more community orientated so that it could shape its work around the needs of local people. The main outcome was the shift of public health into local authorities. Other elements of the Act introduced the local Health and Wellbeing Boards and Clinical Commissioning Groups.

- **Police Reform and Social Responsibility Act, 2011;** *HM Government*
  This piece of legislation was brought in to support the Licensing Act of 2003 by giving local areas new powers including tools such as a late-night levy and the ability to restrict opening hours in problem establishments.

- **No Health without Mental Health: a cross-government mental health outcomes strategy for people of all ages, 2011;** *Dept. of Health*
  This outlines a framework for improving the diagnosis and treatment of mental health in people, particularly those who already have other needs being addressed within the system. This approach aims to offer a more holistic approach to care and hopes to get practitioners to join the dots between mental health concerns and substance dependence more regularly. It is also hoped that such an integrated approach would lead to better outcomes for those involved.

- **Government Alcohol Strategy, 2012;** *HM Government*
  This document signalled a new approach to alcohol consumption and the culture of "irresponsible drinking". Its focus was primarily aimed at reducing binge drinking and reducing alcohol related crime and alcohol related health issues. It also includes the drinks industry in plans to help combat these important issues.

- **The Troubled Families Programme – Financial Framework for Payment by Results Scheme for Local Authorities, 2012;** *Dept. for Communities and Local Government*
  This is another approach designed to tackle those with multiple needs and provides a framework for providing local interventions to families. This has a direct link to those who are affected by alcohol misuse and dependency.

- **Improving Outcomes and Supporting Transparency; a public health outcomes framework for England 2013-2016, 2012;** *Dept. of Health*
  The suggested framework is designed to help public health departments become more effective at delivering and supporting local action against certain local health issues such as specific sicknesses, domestic abuse, premature mortality or health improvement.

- **Health first: An evidence based alcohol strategy for the UK, 2013;** *Alcohol Health Alliance UK et al.*
  This is an ambitious document that sets out a range of initiatives that would allow the focus of Alcohol Harm Prevention work to move towards a treatment based service and away from the criminal aspects. It highlights desires to introduce a 50p minimum unit price, lower the limit for drink driving in England to 50mg/100ml, which would bring it in line with Scotland's law, and restrictions on alcohol advertisement and sales among a whole host of other ideas to help prevent harm caused by alcohol.

- **Anti-Social Behaviour, Crime and Policing Act, 2014;** *HM Government*

This act provides the police with new powers to tackle crime and anti-social behaviour. They now have dispersal powers requiring people causing disorder or committing an act of anti-social behaviour to leave the area. They also have closure powers that can be used against problem premises and Criminal Behaviour Orders that can be used to restrict the night time activity of those involved in anti-social behaviour if they have previously been convicted of a criminal offense. They can also be required to attend an alcohol rehabilitation course.

- **From Evidence into Action: Opportunities to protect and improve the nation's health, 2014 (Priority 3 - Reducing Harmful Drinking);** *Public Health England*
  The Public Health priorities of the newly formed Public Health England include reducing harmful drinking through a number of planned actions that centres on using Alcohol as a trailblazer for a new, whole system approach. The goal is a system that works and offers a return of investment so that organisations can invest in evidence-based policy with confidence. The priorities detail ways in which current tools and approaches can be integrated with new frameworks and initiatives to offer the best, most cost-effective methodology for reducing alcohol related harm.

- **Service user involvement: A guide for drug and alcohol commissioners, providers and service users, 2015;** *Public Health England*
  Service users' involvement in the design and delivery of services has contributed significantly to the evolution of effective drug and alcohol treatment systems. This guide builds on guidance published by the National Treatment Agency (NTA) in 2006, 1 looking at the evidence base, the different levels of involvement, and the impact of involvement on service users and treatment effectiveness.

- **The Public Health Burden of Alcohol and the Effectiveness and Cost –Effectiveness of Alcohol Control Policies: An Evidence Review, December 2016**; *Public Health England*
  This review was commissioned by the Department of Health, which asked Public Health England (PHE) to provide an overview of alcohol-related harm in England and possible policy solutions. The report offers a broad and rigorous summary of the types and prevalence of alcohol-related harm, and evidence for the effectiveness and cost-effectiveness of alcohol control policies. Effectiveness is defined as the degree to which an intervention reduces the public health burden (health, social, and economic) of alcohol. The findings are interpreted within the English context and will be relevant to academics and researchers, public health professionals and policymakers in the health and non-health sectors.

APPENDIX ONE

Current Commissioned Substance Misuse Services

http://www.cwp.nhs.uk/services/2540-cheshire-east-substance-misuse-service

http://www.acornrecovery.org.uk/

http://www.intuitivethinkingskills.co.uk/

http://www.expandingfutures.co.uk/

http://www.emerginghorizons.org/training-courses/recovery-and-substance-misuse/

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DRAFT

Reducing Alcohol-Related Harm in Cheshire East:
A Position Statement and Forward Plan

Implementation Plan

2017- 2019

The Reducing Alcohol-Related Harm Position Statement and Forward Plan has been drafted to support the actions of many organisations working to reduce levels of consumption and promote safe, sensible and social drinking. It brings together national policy and local aspiration and sets a direction for activity across Cheshire East over the next three years.

As a 'Residents First' Council, we are working with a wide range of partners to focus upon activity that will bring positive outcomes to the families, communities and businesses of Cheshire East. Reducing excess alcohol consumption is the overarching aim and our priority outcomes are:

- To reduce alcohol-related health harms
- To reduce alcohol-related hospital admissions
- To reduce alcohol-related crime, anti-social behaviour and domestic abuse
- To support a diverse, vibrant and safe night time economy
- To improve our co-ordination/partnership work to ensure that all the other priorities are achieved, efficiently and effectively.

Priority: G1	**A coherent multi-agency approach with an effective action plan that covers all services**
Lead for Delivery:	Director of Public Health

ACTIVITY

Ref	Action	Review date	Lead
G1.1	Undertake the Public Health England (PHE) Alcohol CLeaR self-assessment in Cheshire East.	October 2017	Charlotte Simpson
G1.2	Engage with NHS England Five Year Forward View Local Delivery System (across Wirral, Cheshire West and Chester and Cheshire East) to co-ordinate actions to reduce alcohol-related harm.	March 2018	Guy Kilminster
G1.3	Engage with the Champs Public Health Collaborative Reducing Alcohol Harm workstream to identify activity that can be delivered more effectively and efficiently across Cheshire and Merseyside, learning from best practice in the sub-region.	October 2017	Charlotte Simpson

Priority: G2	**Minimum Unit Pricing**
Lead for Delivery:	Director of Public Health

ACTIVITY

Ref	Action	Review date	Lead
G2.1	Engage with regional and local partners to explore consensus for supporting Minimum Unit Pricing	October 2017	Guy Kilminster
G2.2	Stay informed about progress of legal challenge to MUP in Scotland	July 2017	Guy Kilminster

Priority: G3	Improved Engagement With Local Retailers
Lead for Delivery:	Principal Manager: Regulatory Services and Health

ACTIVITY

Ref	Action	Review date	Lead
G3.1	Provide Business Advice packs to support businesses in complying with legislation	October 2017	TBC
G3.2	Explore the use of Local Voluntary Agreements to restrict the sales of high strength products (part of the Champs Public Health Collaborative Reducing Alcohol Harm through Licensing work-stream)	March 2018	Kim Evans/Guy Kilminster
G3.3	Support the 'Enforcement of current law' work-stream of the Champs Public Health Collaborative Reducing Alcohol Harm through Licensing work-stream, to work with alcohol retailers to reduce the numbers of already drunk people being served.	October 2017	Kim Evans

Priority: G4	Develop Hospital Alcohol Liaison services
Lead for Delivery:	Director of Commissioning

ACTIVITY

Ref	Action	Review date	Lead
G4.1	Review current provision and capacity as part of the recommissioning of substance misuse services	In line with re-commissioning timeline	Shelley Brough
G4.2	Undertake options appraisal for enhancement of Service considering resource implications.	In line with re-commissioning timeline	Shelley Brough

Ref	Action	Review date	Lead
G4.3	Prepare business case for Service enhancement	In line with re-commissioning timeline	Shelley Brough

Priority: G5	**Develop a coherent brand and concise and clear messaging related to reducing alcohol harm**
Lead for Delivery:	Director of Public Health/Head of Communications

ACTIVITY

Ref	Action	Review date	Lead
G5.1	Review current branding and messaging in use nationally through Public Health England, One You and Change 4 Life as well as by local partners and explore potential to adopt existing branding in a more coherent way.	October 2017	Guy Kilminster
G5.2	Develop (subject to G5.1) the branding/messaging for future use across partners.	December 2017	TBC
G5.3	Initiate roll out and use of new branding/messaging	March 2018	TBC

Priority: G6	**Raise awareness amongst children and young people and their parents / carers of alcohol-related harms**
Lead for Delivery:	Director of Children's Services

ACTIVITY

Ref	Action	Review date	Lead
G6.1	Develop the programme of education and awareness raising to ensure that parents are aware of the consequences and potential harms of alcohol use	March 2018	TBC

Ref	Action	Review date	Lead
	among young people. Parents must also be aware of the possible impact of their alcohol use on their children. This includes ensuring that parents are aware of the risks of supplying young people with alcohol.		
G6.2	Review existing activity to raise awareness of children and young people about the consequences and potential harms of alcohol use and use the results to better co-ordinate and enhance interventions promoting safe drinking.	December 2017	Lesley Seal
G6.3	Take action to improve access for families to engage with Childrens Centres and ensure that Parenting Programmes have capacity to work with families where alcohol misuse is a key issue.	December 2017	Jonathan Potter/Jo Sutton/Shelley Brough
G6.4	Take action to improve access and engagement of parents requiring treatment for alcohol misuse including those where there are child protection concerns.	December 2017	Jonathan Potter/Jo Sutton/Shelley Brough
G6.5	Develop the Parent Journey through integrated working between Children's Early Help Services and Public Health commissioned 0-19 services. This to include systematic assessment of 0-5s and their parents with the assessment including the AUDIT C. It will also include systematic promotion of healthy lifestyles including appropriate alcohol consumption.	March 2018	Jonathan Potter/Jo Sutton
G6.6	All key services working with parents and their children need to be equipped to identify parental alcohol abuse. A training programme for social care teams will be developed and delivered by the Cheshire East Substance Misuse Service.	March 2018	Shelley Brough
G6.7	Monitor the implementation and use of the Multi-Agency Guidance on Tackling the Toxic Trio (domestic abuse, mental ill-health and substance misuse)	October 2017	Judith Gibson
G6.8	A programme for test purchasing, guided by intelligence gathered from multiple reputable sources, will be instigated with the help of underage volunteers. This form of test purchasing plays an integral role in our area's ability to protect young people from the harm caused by excessive alcohol consumption.	October 2017	Tracey Bettany

Priority: G7	Better Understand capacity and demand for treatment services
Lead for Delivery:	Director of Commissioning / Director of Public Health

ACTIVITY

Ref	Action	Review date	Lead
G7.1	Actions to be determined as part of re-commissioning programme		Shelley Brough
G7.2			
G7.3			

Priority: G8	Develop the wider use of identification and brief advice across the borough
Lead for Delivery:	Director of Public Health

ACTIVITY

Ref	Action	Review date	Lead
G8.1	Develop wider use of identification and brief advice across the borough by non-specialist universal services and within other commissioning areas including Healthchecks, and the 'One You Cheshire East' Integrated Lifestyle and Wellness Support System.	March 2018	Sheila Woolstencroft
G8.2	Seek opportunities to embed identification and brief advice wherever possible in healthcare services.	December 2017	PH Commissioners
G8.3	Support Providers in their work towards the national CQUINS (in Community Services 2017 – 18 and Acute Services 2018 – 19) related to IBA, the training of frontline staff and evidencing of delivery.	March 2018	TBC

Priority: G9	Embed 'Recovery' in communities

Lead for Delivery:	Director of Commissioning / Director of Public Health

ACTIVITY

Ref	Action	Review date	Lead
G9.1	Review current 'Recovery' assets and opportunity to develop further	October 2017	Shelley Brough
G9.2	Build 'Community Recovery' into service specification for re-commissioning of Substance Misuse Services	In line with re-commissioning timeline	Shelley Brough

Priority: G10	**Develop Recovery Accommodation in Cheshire East**
Lead for Delivery:	Director of Commissioning / Director of Public Health

ACTIVITY

Ref	Action	Review date	Lead
G10.1	Review Recovery Accommodation Pilot and use learning to influence thinking for future commissioning	December 2017	Shelley Brough / Karen Carsberg
G10.2	Work with the Registered Providers to ensure a co-ordinated approach to supporting individuals at risk of losing their accommodation because of alcohol related causes and we need to respond to the needs of people who continue to use alcohol despite losing access to rented accommodation, for example through Housing Options.	March 2018	Shelley Brough / Karen Carsberg

Priority: G11	**Initiate a shift from long term treatment to prevention and recovery within the Specialist Substance Misuse Service**
Lead for Delivery:	Director of Commissioning / Director of Public Health

ACTIVITY

Ref	Action	Review date	Lead
G11.1	The development of an effective alcohol treatment and referral pathway between GPs and the specialist substance misuse service	March 2018	Shelley Brough
G11.2	The principles of prevention and recovery need to be embedded within our treatment workforce	December 2017	TBC
G11.3	Establish clear, visible pathways between treatment and recovery that will enable individuals, families and communities to engage and to provide the recovery networks that are needed to achieve the benefits of recovery in communities.	March 2018	Shelley Brough

Priority: G12	**Reduce alcohol harm through licensing**
Lead for Delivery:	Director of Public Health / Head of Communities

ACTIVITY

Ref	Action	Review date	Lead
G12.1	Engage with the Champs Public Health Collaborative Reducing Alcohol Harm through Licensing work-stream to identify activity that can be delivered more effectively and efficiently across Cheshire and Merseyside, learning from best practice in the sub-region. (see G1.3)	October 2017	Guy Kilminster/Charlotte Simpson
G12.2	Consider use of Cumulative Impact Policies in certain areas of Cheshire East	March 2018	Kim Evans

Ref	Action	Review date	Lead
G12.3	Through the use of Mandatory Licensing Conditions we will be able to utilise a variety of measures that act as a strong deterrent to breaching the conditions; warnings, cautions and prosecutions can be utilised against premises that breach their licensing conditions.	October 2017	Kim Evans
G12.4	Regular visits to licensed premises will be included to ensure that they are being operated in accordance with the terms of their respective licenses. There will also be intelligence led late night visits and regular monitoring of problem premises to ensure that the area is constantly providing a thriving but safe night time economy.	October 2017	Kim Evans

IMPACT (To be drafted)

Performance Measure	What does it show?	Thresholds		
		Requires Improvement	Good	Outstanding

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Cancer Strategy for South Cheshire and Vale Royal
Date of meeting:	28th March 2017
Written by:	Charlotte Simpson
Contact details:	charlotte.simpson@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Simon Whitehouse

Executive Summary

Is this report for:	Information ☒	Discussion ☐	Decision ☐
Why is the report being brought to the board?	For information		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well ☐ Living and Working Well ☐ Ageing Well ☐ All of the above ☒		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☒ Accessibility ☒ Integration ☐ Quality ☒ Sustainability ☐ Safeguarding ☐ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To note the multi-agency working and priorities for improving local cancer outcomes		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	South Cheshire and Vale Royal CCG Governing Body		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	Draft Strategy has been discussed at South Cheshire and Vale Royal CCG Clinical Senate which includes public and patient representatives and has been discussed in public communications and outreach work.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	• Reduction in the overall growth in the number of all cancer cases • Improved survival of people diagnosed with cancer • Improved quality of life of patients after treatment and at the end of life

Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 28th March 2017

Report of: Director of Public Health

Subject/Title: Cancer Strategy for South Cheshire and Vale Royal

Portfolio Holder: Cllr Paul Bates

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1. Report Summary

1.1. A Cancer Strategy for South Cheshire and Vale Royal (2016-2020)

2. Recommendation

2.1. Health and Wellbeing Board is asked to note the Cancer Strategy for South Cheshire and Vale Royal.

3. Other Options Considered

3.1. There are no other options considered.

4. Reasons for Recommendation

4.1. This local cancer strategy is aligned with and provides a vehicle for the delivery of the national cancer strategy.

5. Background/Chronology

5.1. In July 2015, 'Achieving world-class cancer outcomes: a strategy for England 2015-2020' was produced by the Independent Cancer taskforce. This is the national cancer strategy. It proposed 6 strategic priorities over a 5 year time period:

- Spearhead a radical upgrade in prevention and public health
- Drive a national ambition to achieve earlier diagnosis
- Establish patient experience as being on a par with clinical effectiveness and safety
- Transform our approach to support people living with and beyond cancer

- Make the necessary investments required to deliver a modern high-quality service
- Overhaul processes for commissioning, accountability and provision

5.2. At around the same time, an All Party Parliamentary Group Report on Cancer (published June 2015), highlighted NHS Vale Royal CCG as having the worst 1 year survival from cancer in England in 2012 (63.7% compared to 69.3% for England) and NHS South Cheshire CCG as the fourth lowest 1 year survival for lung, breast and colorectal cancer across England in 2012.

5.3. The Cancer Commissioning Board thus took the decision in December 2015 to re-focus its work programme on early detection of cancer and to develop a local Cancer Strategy that covers the next 5 years, to ensure that the local work programme/ action plan not only reflects but is in line with the national strategy.

5.4. The Cancer Commissioning Board has representation from key stakeholders including Cheshire East Council and Cheshire West and Chester Council Public Health; NHS South Cheshire CCG and NHS Vale Royal CCG (including Chief Executive, Cancer Commissioner and Macmillan GP Cancer Leads); Mid-Cheshire Hospitals NHS Foundation Trust (including Cancer Lead), Macmillan, Healthwatch and Cancer Research UK. The Board reports to CCG Clinical Commissioning Executive and NHS England.

5.5. In 2016, the Cancer Commissioning Board has been overseeing the implementation of the work plans of four work streams:

- Ambitions and Performance
- Reducing the growth in the number of cancer cases
- Improving Survival
- Improving the quality of life of patients after treatment and at the end of life (not included in the improving survival work stream)

5.6. Work of the Cancer Commissioning Board this year has included the initiation of an Action on Cancer project aimed at improving early detection of cancer and involving the launch of a social marketing campaign, community engagement and recruitment and training of community cancer champions, support for national Be Clear on Cancer campaigns, practice based audits on cancer diagnosis, actions to improve bowel cancer screening, delivery of education and training to primary care staff, the launch of new suspected cancer referral forms in line with new NICE guidance and the development of a CCG Cancer Dashboard to enable the tracking of progress

5.7. The aim of the attached document is to provide a public facing document which outlines the framework in which Cancer Commissioning Board

partners are working to in order to improve cancer outcomes locally. The document itself is being re-designed.

5.8. Cheshire East Council Public Health team is currently leading on the development of a Joint Strategic Needs Assessment on cancer. Access to data had caused a delay in progress but this is now due for publication in early 2017 as per the JSNA work programme. This needs assessment will inform further development and refinement of the Cancer Commissioning Board work plans. Furthermore, it will inform the development of work to improve cancer outcomes in Eastern Cheshire.

5.9. The Cancer Taskforce recommended the establishment of Cancer Alliances to drive and support improvement and integrate care pathways, using a dashboard of key metrics to understand variation and support service redesign. They will sit within their STP governance locally so that they become the 'cancer work stream' of STPs. Work on the Cheshire and Merseyside Cancer Alliance to develop a Cheshire and Merseyside Strategy has started; however it is worth noting that only one cancer pathway from South Cheshire flows to Merseyside hospitals, many patients instead flowing to Greater Manchester hospitals. Cheshire and Merseyside Cancer Alliance will bring together clinical and other senior leaders locally across Cheshire and Merseyside to:

•plan for and lead the delivery of the Taskforce's ambitions locally; and
•reduce variation in outcomes and in access to high quality, evidence based interventions across whole pathways and for the Alliance's whole population.

6. Wards Affected and Local Ward Members

6.1. All wards aligned to NHS South Cheshire CCG (Wrenbury; Bunbury; Audlem; Nantwich South and Stapeley; Nantwich North and West; Wybunbury; Shavington; Willaston and Rope; Wistaton; Crewe South; Crewe West; Crewe Central; Crewe St Barnabas; Crewe North; Crewe East; Leighton; Haslington; Sandbach Ettiley Heath and Wheelock; Sandbach elworth; Sandbach Town; Sandbach Heath and East; Middlewich; Brereton Rural; Alsager; Odd Rode).

7. Implications of Recommendation

7.1. Policy Implications

7.1.1. Nil specific

7.2. Legal Implications

7.2.1. Nil specific

7.3. **Financial Implications**

7.3.1. Nil specific.

7.4. **Equality Implications**

7.4.1. Half of all cancers are diagnosed in people aged 70 or over and the highest incidence is observed in people aged 85+. However, different types of cancer tend to be diagnosed in different population groups. Cancer is more common in people living in deprived areas.

7.5. **Rural Community Implications**

7.5.1. Nil specific

7.6. **Human Resources Implications**

7.6.1. As described above

7.7. **Public Health Implications**

7.7.1. As described above

7.8. **Implications for Children and Young People**

7.8.1. Nil specific.

7.9. **Other Implications (Please Specify)**

7.9.1. Nil specific.

8. Risk Management

8.1. Implementation of the national cancer strategy locally is essential both for improving patient outcomes and reducing costs associated with avoidable morbidity, mortality and healthcare costs.

9. Access to Information/Bibliography

9.1. Cancer Research UK (2015). Achieving World Class Cancer Outcomes .A Strategy for England 2015-2020. http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

10. Contact Information

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NHS

Our Cancer Strategy

for South Cheshire and Vale Royal (2016-2020)

Action on Cancer
Working together across Central Cheshire

Improving cancer outcomes in South Cheshire and Vale Royal over the next five years

Our Cancer Strategy

for South Cheshire and Vale Royal (2016-2020)

Our ambition

This strategy sets out our local ambition to radically improve cancer outcomes in South Cheshire and Vale Royal over the next five years. Our aims are that by 2020 we will see:

- **fewer people being diagnosed with preventable cancers**; and
- more people:
  - **surviving for longer** after a diagnosis
  - having a positive experience of care and support;
  - enjoying a **better long-term quality of life.**

We will achieve this by a greater focus on prevention, earlier detection and improved treatment. Critically, this will focus on improving health and wellbeing across the area but also significantly reducing inequalities and variations in outcomes between local areas and between different population groups.

This strategy is underpinned by **three strategic objectives:**

1) Reduce the overall growth in the number of all cancer cases
2) Improve survival of people diagnosed with cancer
3) Improve the quality of life of patients after treatment and at the end of life

These objectives will be achieved through **eight key actions:**

1) Promote, encourage and empower people to have healthier lifestyles
2) Diagnose cancers through screening programmes before signs and symptoms appear
3) Empower patients to present early with cancer signs and symptoms
4) Support primary care to manage patients in accordance with best practice
5) Ensure prompt access to diagnostic tests and referral pathways
6) Provide individualised care and support to cancer patients
7) Reduce risks and improve long term outcomes amongst those diagnosed with cancer
8) Actively monitor progress and performance of the strategic aims

In July 2015, the National Cancer Strategy **'Achieving World Class Cancer Outcomes'** was published. This set out a number of ambitions for outcomes which matter most to patients and society. For example, by 2020:

- a reduction in cancer incidence and number of cancer cases linked to deprivation
- 62% of cancers will be diagnosed at an early stage (stage 1 or 2)
- 75% of people with cancer should survive to at least 1 year following diagnosis
- 57% of people with cancer should survive to at least 10 years following diagnosis
- Continuous improvement in patient experience and improved quality of life following diagnosis

Partners in South Cheshire and Vale Royal will rise to and go **beyond this challenge**. People in South Cheshire and Vale Royal will experience consistently excellent care which promotes prevention at every stage of the pathway.

Overview of local cancer needs

Cancer touches the lives of many people in South Cheshire and Vale Royal. More than 1100 cancers in South Cheshire and more than 600 cancers in Vale Royal are diagnosed every year. In addition, there has been an increase in the number of new cancer cases across both areas. This is due to better treatment and survival from other illnesses such as heart disease and our ageing population (cancer is more common as we get older) as well as the prevalence of preventable risk factors such as poor diet. New cancer diagnosis rates overall are higher than the England average (over 5% higher in South Cheshire and nearly 7% higher in Vale Royal).

The most common new cancers in South Cheshire and Vale Royal are breast, prostate, lung and colorectal (bowel) cancer (Figure 1). Collectively these account for more than half of all new cancer cases.

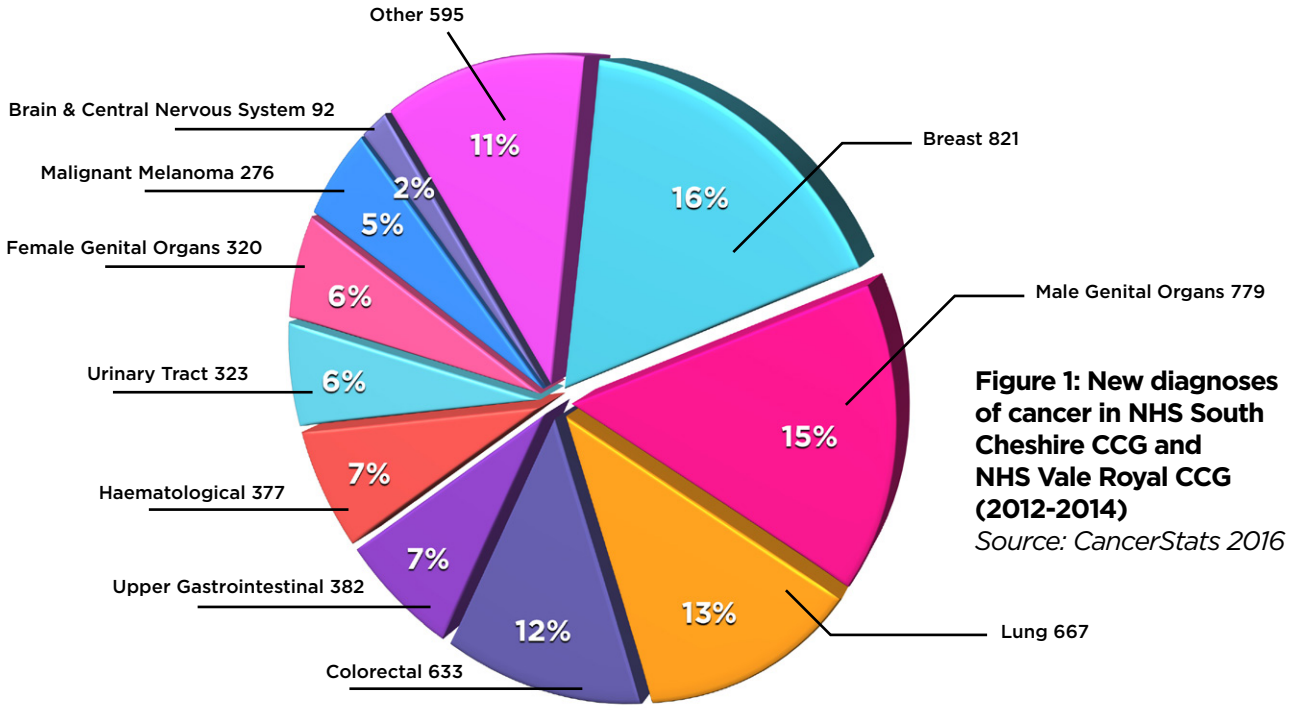


Figure 1: New diagnoses of cancer in NHS South Cheshire CCG and NHS Vale Royal CCG (2012-2014)
Source: CancerStats 2016

A very different pattern is seen for cancer deaths (Figure 2). Lung, upper gastrointestinal (oesophageal, stomach and pancreatic) and colorectal cancer are the most common cause of cancer deaths (collectively responsible for 45% of all cancer deaths), reflecting poorer survival from these cancers.

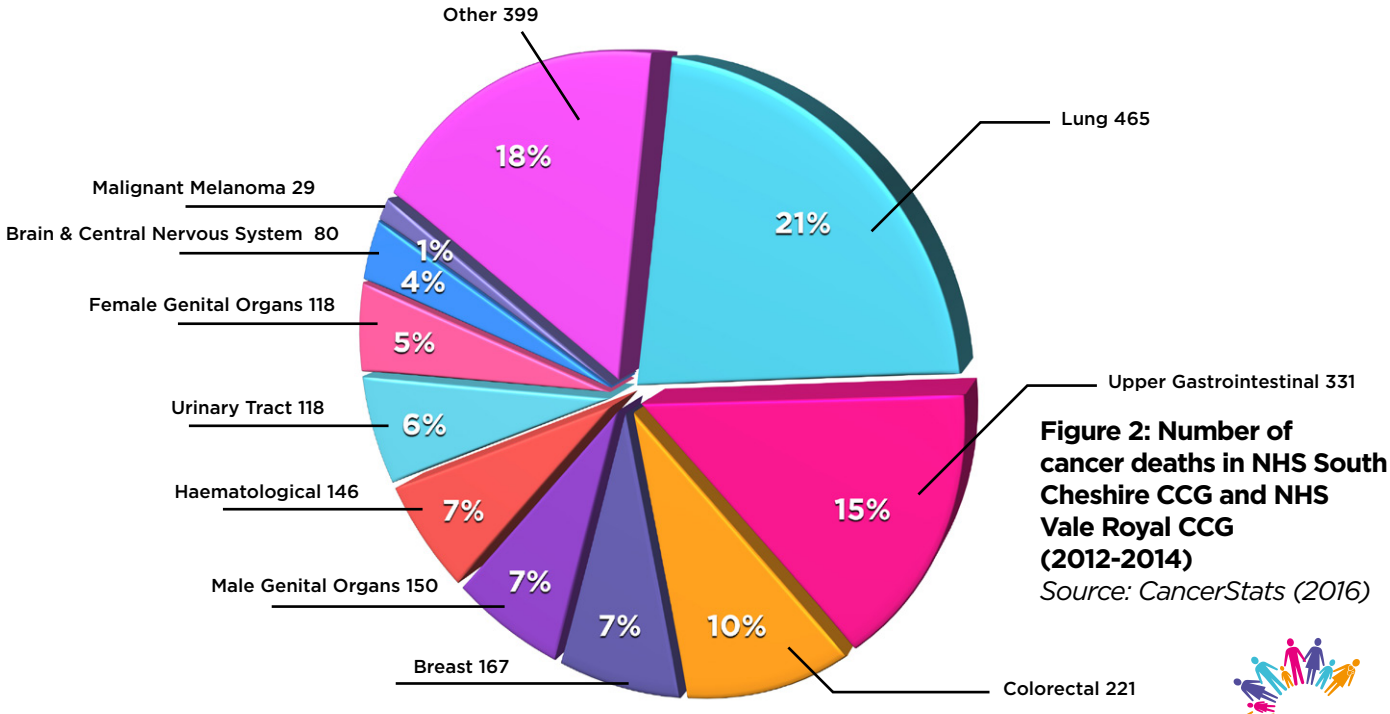


Figure 2: Number of cancer deaths in NHS South Cheshire CCG and NHS Vale Royal CCG (2012-2014)
Source: CancerStats (2016)

Cancer death numbers have increased over a ten year period (by 9% in South Cheshire and 14% in Vale Royal). There were 1416 cancer deaths in South Cheshire and 846 in Vale Royal in 2012-2014. Yet there is much to celebrate. Mortality rates have declined in both areas since 2001-2003 (similar to England) due to improved diagnosis and treatment **(Figure 3)**; by 14% for South Cheshire and 7% for Vale Royal. Mortality rates in South Cheshire are consistent overall with the England average but in Vale Royal, mortality rates are now 8% higher than England average, with mortality rates appearing to have increased here since 2006.

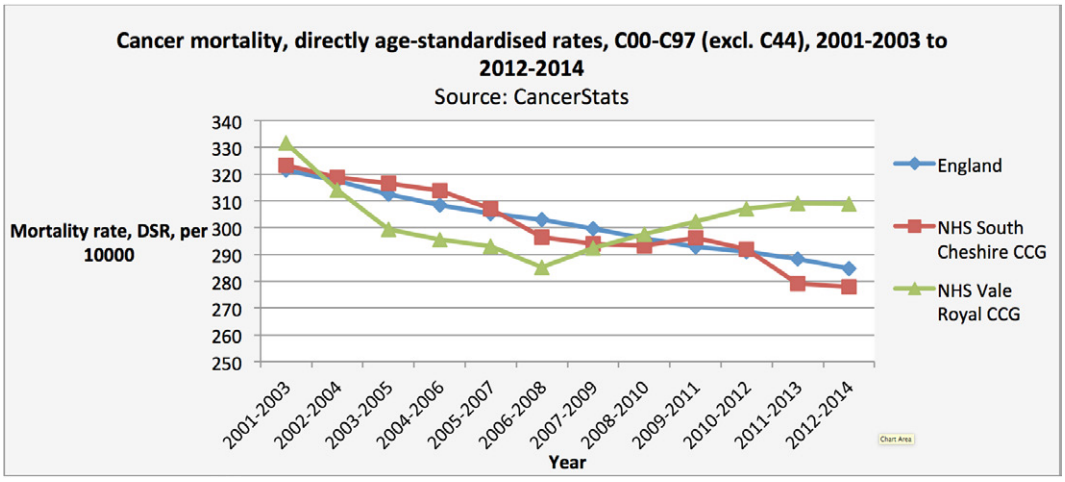


Figure 3: Cancer mortality, directly age-standardised rates, C00-C97 (excl. C44), 2001-2003 to 2012-2014
Source: CancerStats

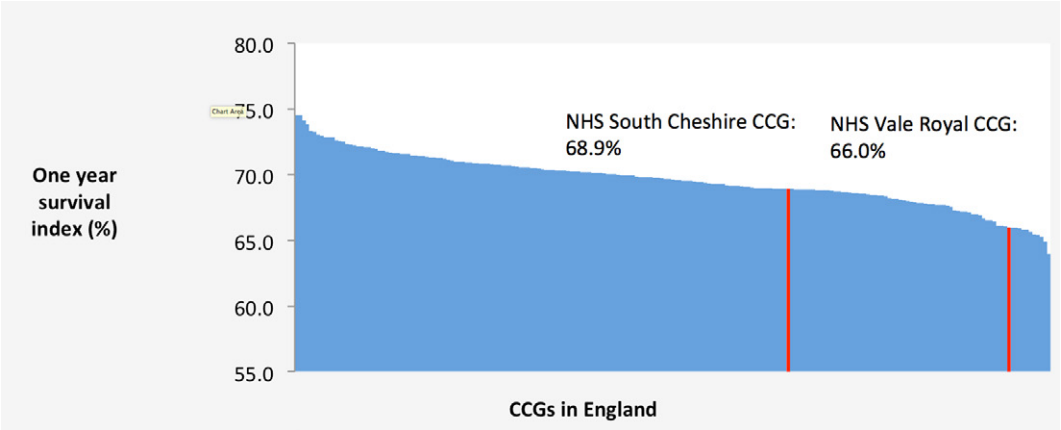


Figure 4: One year survival index (%) for all cancers, diagnoses made in 2013, by CCG

Of further concern is one year survival from cancer locally (Figure 4). Poor one year survival suggests that late diagnosis of cancer is an issue. One year survival in both South Cheshire and Vale Royal is below England average and worse than that seen in similar CCG areas.

This suggests that there are considerable opportunities to improve cancer survival locally through earlier detection and diagnosis of cancers.

Objective 1: Reduce the growth in the number of cancer cases in South Cheshire and Vale Royal

Key action 1: Promote, encourage and empower people to have healthier lifestyles

What are we going to do?

- Develop a local response to local evidence and strategies aimed at reducing risk factors for cancer. In 2016/2017, these include:
  - o The new Tobacco Control Plan
  - o The National Childhood Obesity Strategy
  - o Public Health England's Alcohol Evidence Review
- Support evidence-based social marketing campaigns such as OneYou and Change4Life
- Commission public health services, including NHS Health Checks, Stop Smoking Services and Weight Management Services aimed at supporting people to adopt healthy lifestyles
- Promote uptake of the HPV vaccination programme and respond to any nationally determined changes to the programme
- Support and implement key actions identified in the Health and Wellbeing Strategy of Cheshire West and Chester and Cheshire East Councils.
- Seek opportunities to embed healthy lifestyle advice with appropriate signposting and referral in patient pathways including cancer pathways.

Why?

Rates of new cancer cases are 5% higher in South Cheshire than England average and nearly 7% higher in Vale Royal, indicating that cancer prevention locally has not kept pace with national improvements. Although timescales associated with prevention mean that it will take time to reverse the trend of increasing cancer cases. Nevertheless it is critical that actions are taken now to prevent cancers in the long term.

There is much we can do to reduce the risk of developing cancer; 4/10 cancers are potentially preventable through lifestyle change.
Some cancers (e.g. cervical cancer) are now largely preventable, as are many cases of common cancers. For example, nearly 9 in 10 cases of lung cancer could be prevented through actions such as not smoking. To reduce preventable cancer cases, we will need to:

- promote healthy lifestyles and reduce the prevalence of lifestyle risk factors (which carry wellbeing benefits beyond reducing cancer risk)
- support efforts to reduce exposure to medical, environmental and occupational risk factors

Figure 5: Cancer Incidence, directly age-standardised rates, C00-C97 (excl. C44), 2001-2003 to 2012-2014

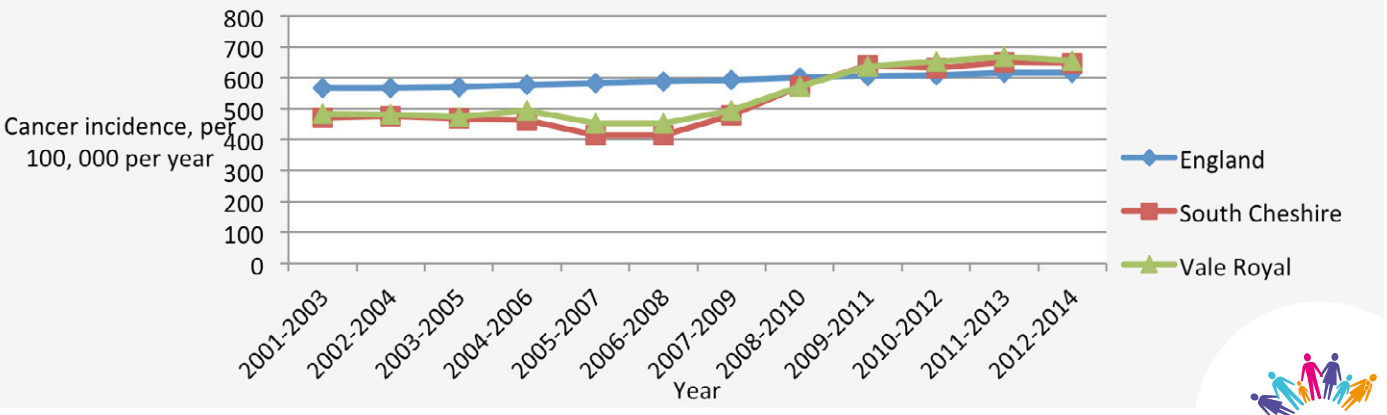
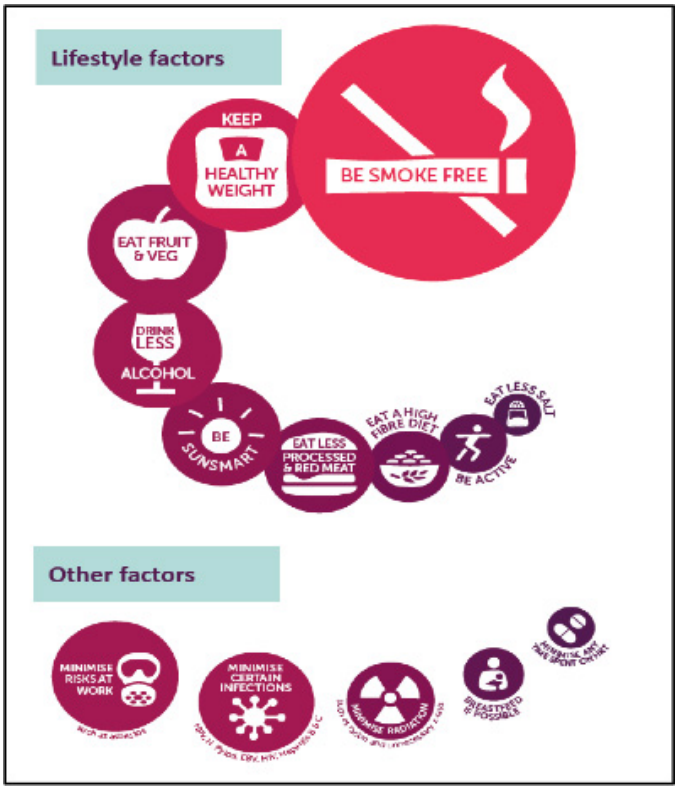


Figure 6: Risk Factors for cancer (Cancer Research UK, 2015)



Smoking is the largest cause of preventable cancers with nearly 1 in 5. It is linked with lung and upper gastrointestinal cancer (two considerable contributors to early deaths locally) as well as a number of others. Tobacco use is also a significant factor in other local health inequalities. Continued smoking amongst those diagnosed with cancer can impact upon success of treatment. Although smoking rates have declined dramatically in recent years, a higher proportion of adults smoke locally than England average (13.9% in South Cheshire; 15.3% in Vale Royal).

Diet is the second largest cause of preventable cancers – linked with 9% of cancers (5% not eating enough fruit and vegetables; 3% eating processed and red meat; 2% lack of dietary fibre; 1% consuming too much salt). Local data indicates that dietary behaviours are on a par with the England average. However, there is evidence of significant local variation. For example, nearly 29% of adults in England consume five portions of fruit and vegetables every day. In wards across South Cheshire and Vale Royal, the proportion of adults consuming five portions of fruit and vegetables per day varied between 20.6% and 34.4%.

Excess weight is linked with 5% of cancers and can affect response to treatment. Being overweight and obesity affects 66% adults in South Cheshire and 64.6% in Vale Royal

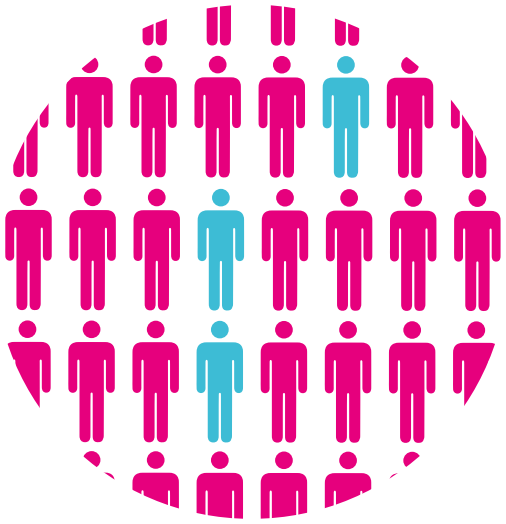
Alcohol is linked with 4% of cancers. 22.3% of adults in South Cheshire and 23.5% in Vale Royal report binge drinking. Hospital alcohol admission rates in some areas are over 44% higher than the England average. New national guidelines on alcohol consumption outline how both men and women should not drink more than 14 units of alcohol per week, recognising the considerable links between alcohol and cancer.

Sun and sunbed exposure (ultraviolet (UV) radiation) is linked with 3% of cancers. Of all malignant melanomas, 86% are caused by UV exposure. In South Cheshire and Vale Royal, rates of new diagnoses of malignant melanoma are significantly higher than the England average.

Other factors associated with the development of preventable cancers include occupational exposures including asbestos (4%); ionising radiation including natural and from medical diagnostics (2%); not breastfeeding (2%); use of hormone replacement therapy (1%); physical inactivity and sedentary lifestyle (1%). One key risk factor is infection such as with human papilloma virus (HPV). HPV is one of the most common sexually transmitted infections. The HPV vaccine is currently offered routinely to females aged 12 to 13 years and the programme's primary aim is to prevent cervical cancer in women.

Importantly, however, some cancers are not currently considered to be preventable at all (e.g. prostate cancer) and a large proportion of many types of cancer are not preventable. Nevertheless there is clearly much we can still do to reduce the risk of developing cancer amongst our local population including those who have previously been diagnosed with a cancer and who are potentially at increased risk of both recurrence and new cancers.

Objective 2: Improve Survival of people diagnosed with cancer in South Cheshire and Vale Royal



Improving survival is dependent on diagnosing cancers earlier. Diagnosing cancers at an earlier stage means better outcomes for patients, both in terms of reduced risk of dying from cancer and also quality of life as well as reduced treatment costs and better patient experience.

The impact of earlier diagnosis is stark[1]. For example, one-year survival for lung cancer increases from under 17% when diagnosed at stage 4 to 83% when diagnosed at stage 1. For breast cancer, one year survival is 63% when diagnosed at stage 4 but is similar to the general population when diagnosed at stage 1. Although stage at diagnosis has a different impact on survival for each different cancer type, those diagnosed at stage 4 generally experience much worse one-year survival.

Around 1 in 2 cancers are currently diagnosed at an early stage (1 or 2) in South Cheshire and Vale Royal[2]. However, we know that there are several opportunities for improvement. For example, South Cheshire and Vale Royal benchmark poorly on late stage diagnosis for bowel cancer, which has comparatively poor one year survival when compared with the rest of England.

Across England around 1 in 5 cancers are diagnosed via an emergency presentation and a similar picture is seen locally[3]. Generally, those who are much younger or older, those who are less affluent and those presenting with rarer cancers are more likely to be diagnosed via emergency presentation. This is problematic as cancers diagnosed as an emergency are often more advanced. When our local areas are compared with other similar areas, it is of note that the proportion of bowel cancers in particular diagnosed via emergency presentation is significantly higher in both South Cheshire and Vale Royal[4]. This is also true for lung cancer in Vale Royal (although early stage diagnosis is significantly better here than the peer group average). A similar picture is observed in South Cheshire although this doesn't reach statistical significance/is not quite as marked.

In order to ensure earliest diagnosis of cancer in South Cheshire and Vale Royal, opportunities must be maximised throughout each stage of the patient pathway.

[1] Office for National Statistics and Public Health England (2016). Cancer survival by stage at diagnosis for England (experimental statistics): Adults diagnosed 2012, 2013 and 2014 and followed up to 2015. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/cancersurvivalbystageatdiagnosisforenglandexperimentalstatistics/adultsdiagnosed20122013and2014andfollowedupto2015

[2] National Cancer Intelligence Network (2016). Cancer Outcomes: Stage at Diagnosis and Emergency Presentations. http://www.ncin.org.uk/cancer_type_and_topic_specific_work/topic_specific_work/cancer_outcome_metrics
* based on data on invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin up to Q4 2013

[3] National Cancer Intelligence Network (2016). Cancer Outcomes: Stage at Diagnosis and Emergency Presentations. http://www.ncin.org.uk/cancer_type_and_topic_specific_work/topic_specific_work/cancer_outcome_metrics
* based on data on invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin up to Q4 2013

[4] NHS England (2016). Commissioning for Value. https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/north-region/#3

Key Action 2: Diagnose cancers through screening programmes before signs and symptoms appear

What are we going to do?

- Promote the uptake of existing and future cancer screening programmes locally and reduce the variation in uptake locally including by working closely with GP practices and pharmacies
- Support the roll out of planned developments in the national cancer screening programme:
  - o FIT into the bowel scope screening programme
  - o Primary HPV testing in the cervical screening programme
- Support the local introduction of any new national cancer screening programmes

Why?

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition[5]. The UK National Screening Committee advises ministers and the NHS about all aspects of screening programmes Cancer screening provides an opportunity to diagnose cancer at an earlier stage before symptoms and signs have developed when treatment may be less complex and outcomes better. The cervical cancer and bowel cancer screening programmes also help to prevent cancer cases. Improving screening uptake is thus a priority and given significant local variation in uptake, there is a considerable opportunity to reduce local variations in outcomes. In the UK, around 5% of cancers are diagnosed via screening[6] and there are currently three cancer screening programmes:

Breast screening is offered every 3 years to women aged 50-70 and women aged over 70 can self-refer to screening. 31% of female breast cancers diagnosed in England in 2013 were diagnosed via screening.

Bowel cancer screening encompasses two programmes. Firstly, a home testing kit for blood in a stool sample for people aged 60-74 (with self-referral for those aged over 75). Nine percent of bowel cancers diagnosed in England in 2013 were diagnosed via screening. A newer test for those aged 55 which involves finding and removing any small bowel growths, called polyps, that could eventually turn into cancer. This is the bowel scope screening test.

Cervical cancer screening checks the health of cells in the cervix. It is offered every 3 years to those aged 25-49 and every 5 years to those aged 50-64. In England in 2013, 31% of cervical cancer (in-situ) were diagnosed via screening.

	% of breast cancers diagnosed via screening (2006-2013)	%of bowel cancers diagnosed via screening (2006-2013)
NHS South Cheshire CCG	32%	6%
NHS Vale Royal CCG	29%	6%
England	29%	7%

[5]NHS Choices (2016).
[6]National Cancer Intelligence Network (2016).
Routes to diagnosis. http://www.ncin.org.uk/publications/routes_to_diagnosis

Key Action 3: Empower patients to present early with cancer signs and symptom

What are we going to do?

Engage and empower out community to recognise early signs and symptoms of cancer including through:

- The Action on Cancer communications campaign
- Recruitment of community cancer champions
- Continued support for and increased promotion of the national Be Clear on Cancer campaigns including in general practice, pharmacies and other public organisations
- Ensuring after diagnosis summaries include signs and symptoms of secondary disease

Why?

It is crucial that people in South Cheshire and Vale Royal are informed about symptoms and signs of cancer. However, awareness is necessary but not sufficient on its own to empower patients to see their doctor as soon as possible. People also need to understand the value of early presentation and feel able to take charge of their health. There have been several national social marketing campaigns run by Public Health England under the Be Clear on Cancer brand. These have aimed to promote awareness and early presentation with symptoms of cancer and have included several specific cancer types as well as those focussed on more general potential cancer signs. These campaigns have delivered promising results.

However, given the enormous opportunities to improve rates of early diagnosis, we have launched our local Action on Cancer initiative which will be particularly focussed on lung, upper gastrointestinal and bowel cancer. Through Action on Cancer we will inform, educate and empower our local population, communities and a range of professionals to be more aware of signs and symptoms, to present earlier to their GP and to participate in the cancer screening programmes where appropriate. We will achieve this through a social marketing campaign targeted at our most at-risk populations which will include face-to-face promotion via a team of representative community champions recruited from within our communities. Crucially, this will build on learning and success from the recent Every Breath You Take campaign which was focussed on earlier diagnosis of lung cancer.

Key Action 4: Support primary care to manage patients in accordance with best practice

What are we going to do?

- Ensure education and training on cancer detection and management is delivered to primary care
- Implement clinical decision / risk assessment tools for use in primary care and in the community
- Embed effective safety netting systems and processes in primary care patients presenting with possible cancers
- Explore options for a vague symptoms pathway locally

Why?

Assuming early presentation with symptoms and signs of cancer takes place, accessing a potential diagnosis of early cancer is dependent upon appropriate investigation and referral within primary care. Ideally, as many people with cancer as possible should be diagnosed via the urgent referral (two week wait) pathway which ensures timely access to tests and specialist care. In South Cheshire and Vale Royal, there are relatively low rates of two week wait (TWW) referrals with an accompanying high rates of conversion into cancer diagnoses suggesting a relatively high threshold of suspicion locally. Furthermore, in England as a whole, there is a high threshold of suspicion which impacts upon referral rates and in turn leads to lower survival rates than in other countries. It is thus pivotal that people get on the right pathway as soon as possible. There is a need to improve processes within general practices to ensure a rapid response for patients with relevant symptoms that could be cancer. Failure to do this can lead to unnecessary and inappropriate healthcare usage (e.g. through repeated appointments and unwarranted tests), significant anxiety for patients and ultimately worse treatment outcomes.

The average GP may only manage a few cases of cancer each year but will provide care for many more people who present with symptoms which may or may not turn out to be cancer. Such care must be appropriate, proportionate and based on the best available evidence regarding cancer risks. Particular scenarios can pose considerable challenges:

- Misleading or vague symptoms or another presentation which the GP suspects may be cancer but doesn't lend itself to clear investigative pathways
- Younger patients and those from BME communities
- Some types of cancer (e.g. ovarian cancer)

It is also important that general practitioners help to protect patients through safety netting mechanisms whereby GPs continue to follow up patients after they have been referred for test ensuring that abnormal results are managed and - in the event of negative tests - continuing symptoms are appropriately investigated. Evidence around best practice is changing all the time and we need to support our local primary care doctors and nurses to stay up-to-date with this through education, training and ongoing engagement and discussion where appropriate courses of action are less clear.

Key Action 5: Ensure prompt access to diagnostic tests and referral pathways

What are we going to do?

- Review and manage diagnostic capacity to support increased use of appropriate diagnostic tests in line with NICE guidance
- Ensure cancer pathways comply with NICE guidance
- Provide sustainable access to cancer nurse specialists to ensure provision of support throughout their pathway
- Review and improve multidisciplinary team (MDT) processes to ensure seamless coordination of patient care
- Offer appropriate genetic testing including:
  - Lynch syndrome for people diagnosed with bowel cancer under the age of 50
  - BRCA1/BRCA2 for women diagnosed with a certain type of ovarian cancer and, if under the age of 50, breast cancer

Why?

The National Institute for Health and Care Excellence (NICE) considers the very best evidence available and publishes detailed guidance on what excellent cancer care looks like. It is crucial that local patients receive care that complies with this guidance. New NICE guidance indicates that where patients present with symptoms with a 3% or higher risk of cancer, they should be referred for further tests. In rolling out the implementation of these guidelines in South Cheshire and Vale Royal, further resource will be needed in terms of diagnostic capacity (e.g. for more CT scans) and the impact of these changes of the health system will need to be closely monitored and responded to.

There are 2 very important elements in ensuring access to excellent cancer care. One of these is access to a Cancer Nurse Specialist (CNS). Cancer Nurse Specialists are experts in a particular area of cancer nursing. They provide information, advice and support to patients; liaise with other healthcare professionals in what can be quite complex cancer pathways to offer coordinated and personalised care and can drive improvements in patient care and outcomes. They also act as key contacts within the multidisciplinary team (MDT). The MDT is 'gold standard' in terms of delivering cancer care, ensuring better access to treatment. However there is a need to ensure that local MDTs are operating as effectively and as efficiently as possible, placing more emphasis on more complex patients and learning lessons from patients who die within weeks of completing treatment.

Although rare, some people have genetic faults which put them at significantly increased risk of cancer. These include:

- **BRCA1 and BRCA2:** mutations that put women at increased risk of breast and ovarian cancer (and in the case of BRCA2 puts men at increased risk of breast cancer and prostate cancer).
- **Heritary non-polyposis colorectal cancer (HNPCC) mutations:** Lynch Syndrome is associated with 5% of colorectal cancer and also increases the risk of other cancers.

Offering genetic testing at the point of diagnosis (where evidence supports this) ensures that patients get the most appropriate treatment and that family members at high risk for cancer can reduce their risk through more frequent screening, active surveillance, chemo-prevention and surgery.

Cancer Nurse Specialists are experts in a particular area of cancer nursing. They provide information, advice and support to patients

Objective 3: Improve the quality of life of patients after treatment and at the end of life

Key Action 6: Provide individualised care and support to cancer patients

What are we going do?

- Ensure all patients with cancer receive an holistic assessment of their needs
- Ensure all patients with cancer receive a written individualised care and support plan
- Maximise the opportunities associated with the cancer care review in primary care
- Commission high quality integrated palliative and end of life services
- Support and complement the work of the End of Life Partnership

Why?

As highlighted, cancer affects many residents of South Cheshire and Vale Royal, all with their own specific needs. It is therefore essential that care received is personalised and tailored to ensure that experience of cancer care is as positive as possible and that best outcomes for patients are achieved.

The Cancer Care Review is a requirement set out in the Quality and Outcomes Framework. Patients should receive a review in primary care within 6 months of diagnosis to discuss ongoing needs and promote appropriate care and follow-up. Similarly, an holistic assessment of needs from diagnosis onwards, encompassing physical, financial, psychosocial, and information and support needs as well as consideration of co-morbidities, can improve patient experience. This assessment should be used to develop a written individualised care and support plan which is shared with GPs and owned by patients themselves.

In addition, a number of pilots are being commissioned nationally (including comprehensive care pathway for older adults, assessment of holistic needs at point of diagnosis) to sit alongside a programme guideline on living with and beyond cancer. Locally, we will be responsive to national developments in this area, ensuring that best practice is implemented in Central Cheshire.

Much work is already underway in Cheshire to improve the experience of patients at the end of life through the commissioning of high quality services and the End of Life Partnership. It is of critical importance that we continue to support this work to guarantee optimum patient experience.

The End of Life Partnership (http://eolp.co.uk/) aims to transform end of life experience and care and was formed from Cheshire Hospices Education, End of Life Care Service Model and Cheshire Living Well Dying Well Partnership working alongside a number of partners including St Luke's Cheshire Hospice, Macmillan, Carers Trust, University of Chester, commissioners and NHS providers.

Current work includes:

- **Service development:** Providing effective guidance, coaching and support to the workforce so that they can deliver high quality end of life care
- **Public health and wellbeing:** Changing knowledge, attitude and behaviour towards life, age, death and loss
- **Education and practice development:** leading, educating and facilitating excellence and best practice in palliative and end of life care
- **Research, evaluation and technology:** Supporting and building an evidence base around end of life care and developing and delivering all IT requirements.

Key Action 7: Reduce risks and improve long term outcomes amongst those diagnosed with cancer

What are we going do?

- Ensure that patients with cancer receive healthy lifestyle advice and where appropriate signposting and referral to health and wellbeing services
- Ensure that all patients at the end of their cancer treatment are risk stratified and have clear and appropriate follow-up plans in place
- Ensure all patients are aware of short and long-term side effects of treatment and key signs of recurrence and secondary cancers as well as advice as to how these should be managed (including key contacts for advice and care)

Why?

Survival from cancer has never been better. There are consequently nearly 4500 people on primary care cancer registers in South Cheshire and nearly 2500 people in Vale Royal[9]. It is estimated that by 2020, there will be over 6400 people in South Cheshire and nearly 4000 in Vale Royal who will be living up to 20 years after a cancer diagnosis. This is great news.

However, whilst many people make a full recovery from cancer, 1 in 4 people will go on to suffer ill health or disability following treatment. In addition, many people diagnosed with cancer will experience wider impacts from their diagnosis and treatment including psychosocial and financial impacts; co-morbidities are common; cancer recurrence is a known risk and risk factors for cancer are also associated with other medical conditions. There are thus considerable opportunities to improve both short-term and long-term quality of life following treatment. It is imperative therefore that we encourage behaviours amongst patients after treatment which are more likely to prevent recurrence and late presentations with recurrent or secondary cancers.

A Recovery Package is a package of intervention known to improve outcomes. It includes (in addition to the Cancer Care Review and the holistic needs assessment):

- Information on short-term and long-term side-effects of treatment and how best to manage these
- Potential markers of recurrence/secondary cancers and information on what to do with these
- Key contact point for rapid re-entry if recurrence markers or serious side effects become apparent
- A treatment summary completed at the end of every phase of acute treatment, sent to the patient and GP.
- Access to a patient education and support event (e.g. a Health and Wellbeing Clinic) to prepare for the transition to supported self-management, including advice on lifestyle and physical activity.
- Signposting to rehabilitation, work and financial support services

Risk stratified follow-up pathways have been shown to improve quality and offer cost saving benefits. They consist of needs assessment, self-management support, remote monitoring and re-entry pathways. Such breast cancer pathways have been designed and can be locally tailored, Other pathways are in development nationally and will be rolled out before 2020.

[9]Health and Social Care Information Centre (2015). Quality and Outcomes Framework (2014/2015). http://www.hscic.gov.uk/catalogue/PUB18887

Why?

We're working towards...

Ensuring we achieve local cancer outcomes

Key Action 8: Actively monitor progress and performance

What are we going to do?

- Develop a Cancer dashboard that brings together information on cancer outcomes, performance, quality and patient experience
- Monitor our progress through the South Cheshire and Vale Royal Cancer Commissioning Board using the Cancer Dashboard
- Develop meaningful GP practice profiles that provide an evidence base for improvement plans and evaluation of progress at practice level
- Use audit and benchmarking data and local intelligence to identify and manage areas for improvement

- The national cancer strategy for 2015-2020 **'Achieving World Class Cancer Outcomes'** sets out ambitious national targets to be achieved by the end of March 2020:
- A visible reduction in age-standardised cancer incidence rates and a reduction in the number of cases linked to deprivation
- Improved screening uptake with 75% uptake for bowel FIT screening
- 50% of patients referred by a GP with symptoms receive a definitive diagnosis or cancer excluded within 2 weeks and 95% within 4 week
- Reduction in emergency presentations
- 62% of cancers diagnosed early at stage 1 or 2 (and an increase in the proportion of cancers staged)
- 96% of patients meeting 31 day and 85% meeting 62 day cancer waiting time targets
- 95% of patients with patient-agreed written after-treatment plan
- 57% of patients surviving cancer for ten years or more
- One year survival for all cancers 75% or more with improved survival amongst older people
- Reduction in under 75 mortality for cancer
- Continuous improvement in patient experience with a reduction in variation (as evidenced by the Cancer Patient Experience Survey)
- Continuous improvement in quality of life (through a metric of quality of life in development)
- Increase in the proportion of people who die with a personalised end of life care plan

Achieving this locally will not be easy and will require proactive monitoring using the best available data and intelligence in order to ensure that we are on track and to enable us to respond to emerging issues and needs. To this end, we will use both a commissioner and provider local dashboard of cancer metrics as well as local profiles for general practice in order to provide timely feedback on progress. In addition, we will make use of routinely available data such as Public Health England's Fingertips Cancer Profiles and ensure that programmes and actions are informed by needs identified in the two local Joint Strategic Needs Assessments and local and national clinical audits. Progress will be closely monitored and overseen by the Cancer Commissioning Board.

appendix

Action on Cancer
Working together across Central Cheshire

NHS South Cheshire Clinical Commissioning Group (SCCCG)

ALL CANCER

Emergency Presentation

98 in 100,000 people received emergency diagnoses (2014/2015).
This is **consistent with** the England average (90 in 100,000)

Stage at Diagnosis

50% of cancers are diagnosed early (Rolling 1 year average at Q1 2014)
England average is 49%

Diagnosis

1116 people diagnosed (2014)

629 new cases per 100,000 people.
England average is 608 per 100,000.

GP Referral

2535 in 100000 people were referred to hospital by their GP for cancer investigations (Two week wait) (2014/2015)
This is **lower** than England average
10.4% of these people were found to have cancer
This is **higher** than the England average

Treatment

90.1% positive overall experience of care (2014)
This is consistent with England average (89%)

100% of patients treated within 31 days (2015/2016) (Target 96%

89.7% of patients start treatment within 62 days of referral (2015/2016) (Target 85%)

Deaths

284 in 100,000 died of cancer in 2014
England average is 281 per 100,000

491 people died from cancer in 2014.

Survival

1-year survival: **68.9%** (2014)
Worse than England average (70.2%)

England **5-year** survival: **49.6%** (2009)

ALL CANCERS

NHS Vale Royal Clinical Commissioning Group (VRCCG)

Emergency Admission

85 in 100,000 people received emergency diagnoses (2014/2015).
This is **consistent with** the England average (90 in 100,000)

Stage at Diagnosis

49% of cancers are diagnosed early (Rolling 1 year average at Q1 2014)
England average is 49%

Diagnosis

611 people diagnosed in 2013

621 new cases per 100,000 people
England average is 608 per 100,000).

GP Referral

2296 in 100000 people were referred to hospital by their GP for cancer investigations (Two week wait) (2014/2015)
This is **lower** than England average

10.4% of these people were found to have cancer
This is **higher** than the England average

Treatment

91.9% positive overall experience of care (2014)
This is consistent with England average (89%)

100% of patients treated within 31 days (2015/2016) (Target 96%)

92.9% of patients treated within 62 days of referral (Feb 2016) (Target 85%)

Survival

1-year survival: **66.0%** (2014)
Worse than England average (70.2%)

England **5-year** survival: **49.6%** (2009)

Deaths

301 in 100,000 died of cancer in 2014
England average is 281 per 100,000

282 people died from cancer in 2014.

LUNG CANCER

NHS South Cheshire Clinical Commissioning Group (SCCCG)

Emergency Admission

27 in 100,000 people received emergency diagnoses (2006-2013).
England average is 28 in 100,000

Stage at Diagnosis

24.1% of lung cancers are diagnosed early (2013)
England average is 20.3%.

Diagnosis

153 people diagnosed (2014)

87 new cases per 100,000 people

England average is 78 per100,000.

GP Referral

116 in 100000 people were referred to hospital by their GP for cancer investigations (Two week wait) (2014/2015)

This is **consistent with** England average

Survival

1-year survival: **30.5%** (2014)
Worse than England average (35.4%)

England **5-year** survival: **9.8%** (2009)

Deaths

60 in 100,000 died of lung cancer in 2014
England average is 61 per 100,000

104 people died from lung cancer in 2014.

LUNG CANCER

NHS Vale Royal Clinical Commissioning Group (VRCCCG)

Emergency Admission

33 in 100,000 people received emergency diagnoses (2006-2013).
England average is 28 in 100,000

Stage at Diagnosis

35.1% of lung cancers are diagnosed early (2013)
England average is 20.3%.

Diagnosis

83 people diagnosed (2014)

86 new cases per 100,000 people

England average is 78 per100,000.

GP Referral

104 in 100000 people were referred to hospital by their GP for cancer investigations (Two week wait) (2014/2015)

This **is consistent with** England average

Survival

1-year survival: **32.2%** (2014)
Consistent with England average (35.4%)

England **5-year** survival: **9.8%** (2009)

Deaths

71 in 100,000 died of lung cancer in 2014
England average is 61 per 100,000

69 people died from lung cancer in 2014.

BOWEL CANCER

NHS South Cheshire Clinical Commissioning Group (SCCCG)

Emergency Admission

20 in 100,000 people received emergency diagnoses (2006-2013).
England average is 18 in 100,000

Bowel Screening

58.9% of people eligible screened for bowel cancer in last 2.5 years (2014/2015)
This is **higher** than the England average (57.9%)

6% of cancers diagnosed by screening (2006-2013)

Diagnosis

132 people diagnosed (2014)

74 new cases per 100,000

England average is 70 per 100,000.

Stage at Diagnosis

29.8% of bowel cancers are diagnosed early (2013).
England average is 36.8%

GP Referral

448 in 100000 people were referred to hospital by their GP for cancer investigations (Two week wait) (2014/2015)

This is **consistent with** England average

Survival

1-year survival: **71.3%** (2014)
This is **worse than** England average (77.7%)

England **5-year** survival: **57.0%** (2009)

Deaths

25 in 100,000 died of bowel cancer in 2014

England average is 27 per 100,000

46 people died from bowel cancer in 2013.

BOWEL CANCER

NHS Vale Royal Clinical Commissioning Group (VRCCCG)

Emergency Admission

21 in 100,000 people were diagnosed as an emergency(2006-2013).
England average is 18 in 100,000

Bowel Screening

57.3% of people eligible screened for bowel cancer in the last 2.5 years (2014/2015)
This is **consistent with** the England average (57.9%)

6% of cancers diagnosed by screening (2006-2013)

Diagnosis

72 people diagnosed (2014)
.
74 new cases per 100,000

England average is 70 per 100,000.
.

Stage at Diagnosis

30.8% of bowel cancers are diagnosed early (2013).
England average is 36.8%

GP Referral

347 in 100000 people were referred to hospital by their GP for cancer investigations (Two week wait) (2014/2015)

This is **lower than** England average

Survival

1-year survival: **69.6%** (2014)
This is **worse than** England average (77.7%)

England **5-year** survival: **57.0%** (2009)

Deaths

25 in 100,000 died of bowel cancer in 2014

England average is 27 per 100,000

23 people died from bowel cancer in 2013.

BREAST CANCER

NHS South Cheshire Clinical Commissioning Group (SCCCG)

Emergency Admission

7 in 100,000 people received emergency diagnoses(2006-2013)).
England average is 7 in 100,000

Breast Screening

76.4% of women aged 50-70 screened for breast cancer within the last 3 years (2014/2015)
This is **higher** than the England average (72.2%)

32% of cancers diagnosed by screening (2006-2013)

Diagnosis

130 women diagnosed (2014)

137 new cases per 100,000 women.

England average is 173 per 100, 000.

.

Stage at Diagnosis

80.7% of breast cancers are diagnosed early (2013).
England average is 71.0%

GP Referral

465 in 100000 people were referred to hospital by their GP for cancer investigations (Two week wait) (2014/2015)

This is **consistent with** England average

Survival

1-year survival: **95.5%** (2014)
Consistent with England average (96.7%)

England **5-year** survival: **85.9%** (2009)

Deaths

40 in 100,000 women died of breast cancer in 2014

England average is 35 per 100,000

39 women died from breast cancer in 2014

BREAST CANCER

NHS Vale Royal Clinical Commissioning Group (VRCCCG)

Emergency Admission

8 in 100,000 people received emergency diagnoses (2006-2013).
England average is 7 in 100,000

Breast Screening

72.9% of women aged 50-70 screened for breast cancer within the last 3 years (2014/2015)
This is **Consistent with** the England average (72.2%)

29% of cancers diagnosed by screening (2006-2013)

Diagnosis

112 women diagnosed (2014)

206 new cases per 100,000 women

England average is 173 per 100, 000.

.

Stage at Diagnosis

72.0% of breast cancers are diagnosed early (2013).
England average is 71.0%

GP Referral

441 in 100000 people were referred to hospital by their GP for cancer investigations (Two week wait) (2014/2015)

This is **consistent with** England average

Survival

1-year survival: **95.6%** (2014)
This is **consistent with** England average (96.7%)

England **5-year** survival: **85.9%** (2009)

Deaths

55 in 100,000 women died of breast cancer in 2014

England average is 35 per 100,000

29 women died from breast cancer in 2014.

Action on Cancer

Working together across Central Cheshire

Thank you to all our partners for funding, developing, delivering and supporting the campaign.

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Action on Cancer
in Central Cheshire is a collaboration between:
NHS South Cheshire Clinical Commissioning Group, NHS Vale Royal Clinical Commissioning Group, Mid Cheshire Hospital Foundation Trust, Cheshire East Council, Cheshire West & Chester Council, Macmillan Cancer Support and Cancer Research UK.

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Briefing Note for Health and Wellbeing Board

Summary of Health Protection Forum Discussions and Actions 2016

(Edited details from meeting notes)

April 2016

- Terms of Reference.
  - Bring back to the Forum on an annual basis to check they remain fit for purpose
- Prevention and control of communicable diseases
  - A programme for Latent TB Infection testing (to detect TB prior to it reaching a clinical stage) is to be developed for East Timorese migrants in Crewe, as this group is at increased risk of developing tuberculosis
  - Continue to monitor implementation of the ICNet system upgrade, a surveillance programme used by infection prevention teams to input data and monitor activity
- Vaccination against infectious diseases
  - The childhood Immunisation JSNA section highlighted particular age groups and areas where immunisation rates need to be increased. The JSNA was sent to CCG's and General Practices to improve awareness about immunisation
- Environmental hazards including air quality, contaminated land, and noise
  - The HPF took the decision to set up an Air Quality Steering Group

July 2016

- Prevention and control of communicable diseases
  - The DPH to take action to promote flu vaccination, including for front line staff and carers. Information to be distributed via various routes including Adult Social Care, libraries, children's centres and pharmacies
  - A Care Home Hygiene Awards pilot scheme has enabled staff from a number of homes to complete infection control training. A report is being written and the scheme will then be extended
  - The Clinical Lead for Pathology gave a presentation on antimicrobial resistance and how the reduction in use of antibiotics in both the community and hospital settings has had a positive impact. The information will be shared with GPs for use at a CPD session
- Emergency planning and response including extreme weather events
  - An improvement plan relating to the NICE guidance is being developed to support those identified with needs, prior to the referral service being reviewed and then relaunched

November 2016

- Prevention and control of communicable diseases
  - Public Health England have updated their Care Home Influenza Outbreak Response pack, and information about prescribing of anti-virals
- Vaccination against infectious diseases/ National screening programmes
  - Uptake of nasal flu vaccine in 2, 3 and 4 year olds to be added to indicators framework
  - An Immunisation Steering Group to be set up (draft Terms of Reference agreed by the Health Protection Forum)
  - The draft cervical cancer control JSNA was brought to the meeting. It was noted that HPV vaccination uptake had fallen, and there had been a rise in the incidence of invasive cervical cancer in South Cheshire CCG
- Emergency planning and response
  - A presentation was given covering the types of emergencies that the team respond to, and ongoing planning including learning from local and national incidents

Helen John
Senior Health Protection Manager December 2016

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