Champs Public Health Collaborative

Working together to improve health and wellbeing in Cheshire and Merseyside

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The Case for Change

Evidence based interventions for public health and the health and social care system across Cheshire and Warrington October 2016

Public Health Institute, Faculty of Education, Health and Community, Liverpool John Moores University, Henry Cotton Campus, 15-21 Webster Street, Liverpool, L3 2ET | 0151 231 4452 | l.jones1@ljmu.ac.uk | www.cph.org.uk | ISBN: 978-1-910725-67-2 (web)

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1 Introduction

People in Cheshire & Warrington are living longer than ever before. However, while measures suggest that many local people have similar or higher health and wellbeing outcomes than their national counterparts, there are significant internal inequalities and pockets of poor health across the Cheshire and Warrington sub-region. Much of this burden is avoidable and driven by factors that lie outside the traditional health and care system; related to areas such as educational attainment, housing conditions and the quality of employment. In order to ensure that all people and communities in the Cheshire and Warrington sub-region have equal opportunities to be healthy, transformative action is required to tackle these social determinants of health.

As the natural leaders for public health in their areas, local authorities can push forward an agenda to make improving public health 'everyone's business' (1, 2). Collectively gaining an understanding of 'what works' to address public health challenges and then implementing new models rapidly and at scale is key to ensuring the future sustainability of the NHS and adult social care (1).

This report is intended as a guide to direct collective and collaborative local action to address public health challenges in the Cheshire West & Chester, Cheshire East and Warrington Sub-region, improve health and wellbeing and reduce health inequalities. It focuses on the key actions for 'what works' and should be implemented rapidly and at scale. The report aims to create a clear narrative that can be used by any agency working across the Cheshire and Warrington Sub-region, not just in the health and care system, to improve health and wellbeing and reduce health inequalities.

2 Overview of health and wellbeing

This section begins by describing the demographic profile of the residents of Cheshire and Warrington in order to identify key challenges to the state of health and key health priorities for children and young people, adults and older adults.

Three priority areas are considered in detail:

- Early Years and the 'Best Start in Life';
- Worklessness and Workplace Health; and
- Mental Health.

Although the focus has been given to these issues to reflect some of Cheshire and Warrington's own priorities, it is important to recognise that these are not the only health and wellbeing issues for Cheshire and Warrington and that data from national and local profiles and indicators is used to identify other important priorities.

2.1 Demographic challenges

Population projections provide an indication of future population size and age structure based on assumptions regarding future levels of fertility, migration and mortality; as such they do not take into account government policy proposals (such as housing developments or HS2 high speed rail) that may be expected to have an impact on population trends. The population of the Cheshire and Warrington sub-region is projected to increase by 36,900 people over the next decade, rising from 913,000 people in 2014 to 950,000 people by mid-2024 (3). Although smaller in population size than the other two local authorities, the population of Warrington is predicted to increase the most in the next decade by 6.5%. Figure 1 gives a breakdown of population changes by 5 year age bands. In line with national trends, Warrington's population of children and young people (0 to 24 years) and those of a working age (16 to 64 years) are predicted to increase overall over the next decade. In contrast, Cheshire East and Cheshire West & Chester are predicted to see an overall decline in both these age groups. In the North West, numbers in these population groups will remain relatively stable. The population of Cheshire and Warrington is slightly older than the national average at 41.8 years (39.7 years nationally) and there will be substantial growth in the number of elderly people across the sub-region over the next decade (**Figures 1 and 2**). The number of people aged 65 and over in the sub-region is projected to increase by around 21% over the next decade (by 38,400 people between 2014 and mid-2024) (4) and the increase is particularly marked in those aged over 90 years, where a 47% increase is projected (equivalent to 4,100 more people). The pace of population ageing is expected to increase in the coming decades.

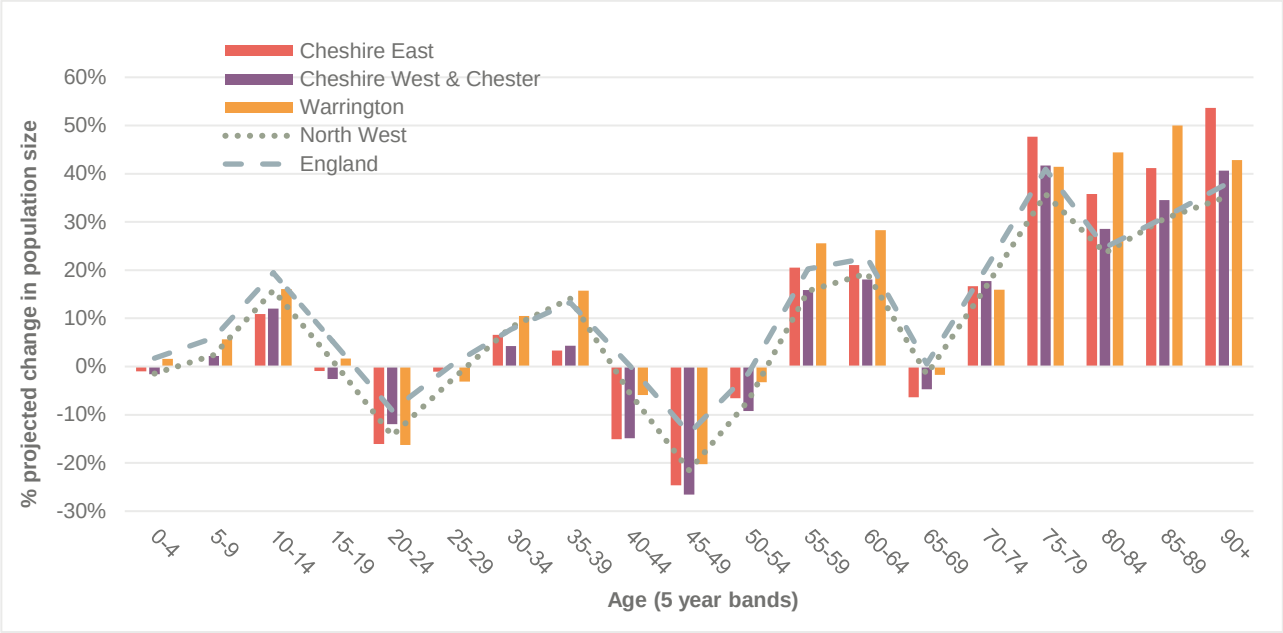

Figure 1: Projected population of Cheshire & Warrington sub-region, 2014 to mid-2024.
Source: ONS 2014-based Population Projections, 2016.

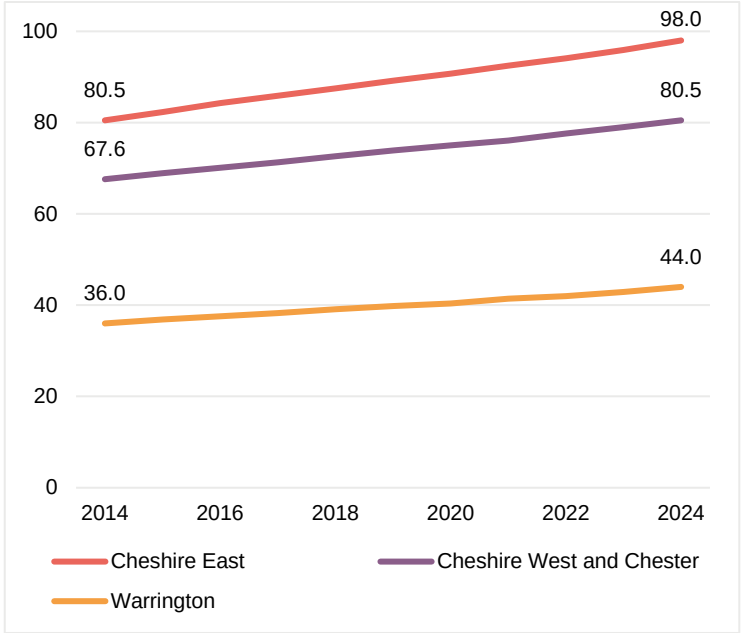

Figure 2: Population aged 65 years and over, projected to 2025 in Cheshire & Warrington (thousands).
Source: ONS 2014-based Population Projections, 2016.

Life expectancy & healthy life expectancy: Compared to the national average, life expectancy in Cheshire East is longer, similar in Cheshire West & Chester and shorter in Warrington. Life expectancy across Cheshire and Warrington is higher than the North West average, with the exception of females in Warrington, where it is slightly lower (**Figure 3**).

Healthy life expectancy is a measure which describes not only the longevity of life but whether those additional years are healthy. On average, people in Cheshire and Warrington are spending around a fifth of their life in ill-health (although only around 17% amongst males in Cheshire East). Compared to the national average, men and women in Warrington spend a greater proportion of their life living with disability or poor health, although levels are better than the North West average (**Figure 4**).

Long term trends show that overall life expectancy is increasing at a faster rate than healthy life expectancy, meaning that more residents of Cheshire and Warrington are living into old age with multiple long term conditions, disability and care needs. Without real improvements in healthy life expectancy, the number of residents living with long term conditions and disabilities is likely to increase significantly as the size of the older population grows.

Deprivation: Deprivation is significantly associated with poor health outcomes from childhood through adult life to old age. People living in more deprived communities experience poorer health and require more complex care from a younger age. In Cheshire and Warrington, deprivation levels are low, with significantly lower proportions of people living in the 20% most deprived areas in England, compared to the national average of 20.2% and the North West average of 31.9% (2014). However, each local authority contains pockets of deprivation. Cheshire East has deprived areas mainly in Crewe, while Warrington has deprived areas around the town centre, and Cheshire West & Chester has high levels of deprivation in Ellesmere Port and in Blacon next to the Welsh border[i].

Life expectancy varies substantially according to deprivation. Although levels of deprivation are lower than the national average, there are still health inequalities within the Cheshire and Warrington local authorities. Male life expectancy is between 10 and 12 years greater for those in the least deprived areas compared with the most deprived and female life expectancy is between 7 and 8 years greater. This difference varies by local authority with the greatest difference in life expectancy seen in Warrington for males and Cheshire West & Chester for females (**Figure 5**).

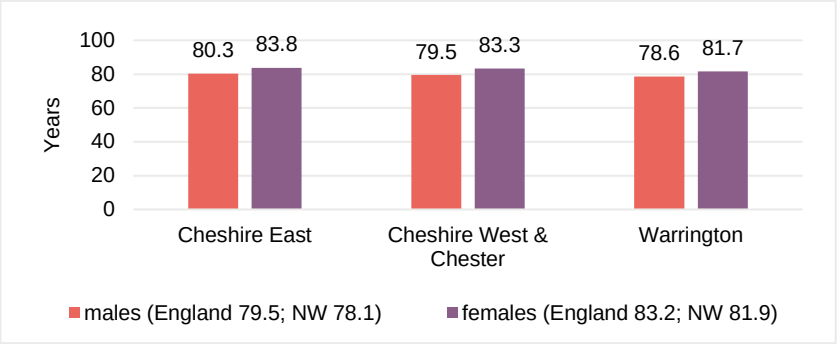

Figure 3: Life expectancy in Cheshire & Warrington, 2012-14. Source: PHE Fingertips.

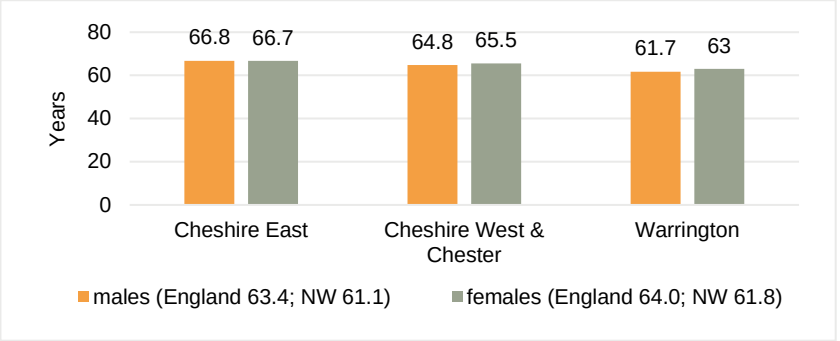

Figure 4: Healthy life expectancy in Cheshire & Warrington, 2012-14. Source: PHE Fingertips.

Figure 5: Slope index of inequality in life expectancy at birth based on local deprivation deciles, 2012-14. Source: PHE Outcomes Framework.

[i] *see IMD 2015 maps from 'PHE local health':* http://www.localhealth.org.uk/#v=map7;i=t1.imd_2015_score;z=316716,412351,117822,97699;sid=47;sly=ltla_2013_DR;l=en

2.2 Healthy children and young people

Children and young people represent 28.1% of the total Cheshire and Warrington population (0 to 24yrs) which is lower than the England average of 30.4%and the North West average of 30.6% (2014). Additionally the proportion of children belong to a minority ethnic group is lower than the national average of 28.9% and the North West average of 20.1% in all three local authority areas; around 10% in Warrington and Cheshire East, and 7.3% in Cheshire West & Chester (2015).

Health and risk factors

Children and young people in Cheshire and Warrington face a good start in life overall, with significantly lower levels of deprivation and child poverty than the national average. However, there are pockets of stark need within each local authority, and in Warrington, levels of lone parent families (at a greater risk of poverty than couple families) are higher in than the national average (although lower than the North West average).

Pre-birth and early years: The first 1,000 days from conception and the early years are essential to ensuring children are healthy, ready to learn, grow and have good life chances. For Cheshire and Warrington, there is a mixed picture for babies and children. Breastfeeding rates are lower than the national average in Cheshire West & Chester and Warrington, although higher than the North West average. The number of mothers smoking at time of delivery is higher than the national average in Cheshire East and has been for some years. Local authority areas in Cheshire and Warrington have a higher rate of hospital admissions for unintentional and deliberate injuries than the national average, significantly so in all areas among children aged 0 to 4 years. Compared to national figures, all local authority areas in Cheshire and Warrington have a significantly higher vaccination uptake for MMR and Dta/IPV/HIB and significantly fewer babies being born with a low birth weight (fewer but not significantly so in Warrington).

Primary school: Primary school is a significant milestone for children and presents a key opportunity for tackling health and social inequalities faced by some children in Cheshire and Warrington. Levels of school readiness amongst children aged 5 and child obesity are either higher or similar to the national average in the local authority areas of Cheshire and Warrington. However, in Warrington, almost one third of children aged 5 has decayed, filled or missing teeth (31.6%), significantly higher than the national average of 27.9%, although lower than the North West average of 34.8%..

Children to young people: Progression to secondary school represents new opportunities for many children and young people. It is essential that children are supported with positive environments and opportunities to grow in to confident and healthy young people. Local authority areas in Cheshire and Warrington have higher or similar levels of GCSE attainment, levels of physical activity and youth crime compared to the national average. Additionally, the Cheshire and Warrington local authority areas have the three lowest levels in the North West of young people not in employment, education or training (NEET) in 2014. In Cheshire East and Warrington, compared to the national average, there are significantly lower rates of chlamydia detection and higher levels of hospital admissions related to injuries, alcohol and self harm amongst young people. In Warrington, there are also more admissions for substance misuse, twice the national average. Warrington has significantly higher proportions of young carers compared to the national average and in Cheshire East, there are significantly more young people reporting being drunk during the last four weeks.

2.3 Healthy adulthood

Health drivers in Cheshire and Warrington

The Marmot Review in 2010 (5) led to a focus on the wider determinants of health across government and local authority areas. Access to, and the quality of healthcare received, has a relatively limited impact on our health, with environment, socio-economic circumstances, behaviours and genetics being the major drivers. The 'fuzzy pie chart' shows the range of values that have been suggested for the extent to which these drivers contribute to an individual's health and their interaction (**Figure 6** (6)). Preventive action can be taken to make a difference for many of these drivers. Access to healthcare can also be an important issue for some populations, for example, people with learning disabilities, as found in a recent health needs assessment conducted in Cheshire and Merseyside (7, 8).

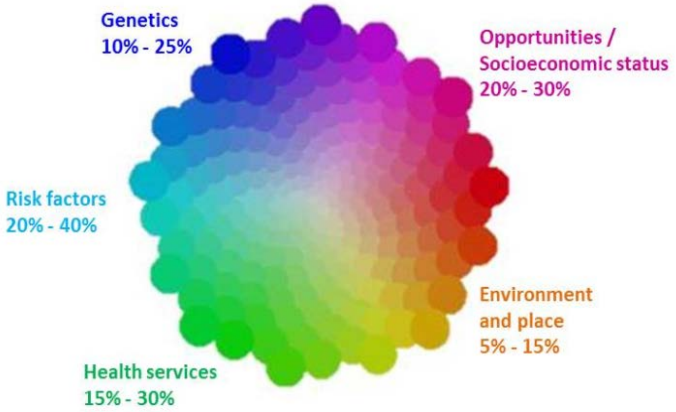

Figure 6: What determines health? Source: [6]

Health and risk factors

The way we live our lives has a major impact on our health. The Global Burden of Diseases study (9) demonstrates the impact of poor diet, obesity, lack of exercise, smoking, high blood pressure and too much alcohol on our health. Dietary risks, tobacco and high blood pressure together account for a third of the burden of disease in the UK, underlining the importance of prevention in improving health and wellbeing. Unhealthy diet and physical inactivity are major risk factors for overweight and obesity as well as many chronic health conditions including cardiovascular disease (CVD), diabetes, high blood pressure and some cancers.

Around two thirds of adults in Cheshire East and Cheshire West & Chester are classified as overweight or obese (similar to the national and North West averages), rising to nearly 70% in Warrington (significantly higher than the national average). Although comparing well to the national average on the whole, there are pockets within Cheshire West & Chester where obesity levels are significantly higher. This is illustrated in **Figure 7**, where it can be seen, for example, that obesity levels are highest in mid-east Cheshire West & Chester (Winsford Wharton ward, 28.1%), the north (Ellesmere Port Town ward, 29.3%) and in Blacon ward (27.9%). Obesity levels in Warrington are highest in Latchford East ward (28.2%), and in Cheshire East are highest in Crewe East ward (25.8%) (although not significantly higher than the national average) (10). (Note: this data is taken from a survey from 2006-08).

Rates of physical inactivity are similar to the national average of 28.7% in Cheshire and Warrington. , and better than the North West average of 32%.Nationally, just over half of all adults are meeting the recommended 5-a-day target for fruit and vegetable consumption (52.3%). Levels across Cheshire and Warrington are similar to the national average and higher than the North West average of 48.1% (11). Within these local authorities, patterns are similar to obesity levels, with wards around central Warrington, Ellesmere Port, Blacon, Winsford and Crewe having low levels of healthy eating (**Figure 8**) (10).

Smoking prevalence is significantly lower than the national average of 18% in Cheshire East (12.6%) and Warrington (15.5%) and similar to the national average in Cheshire West and Chester (20.1%). The North West average is 19.9%.

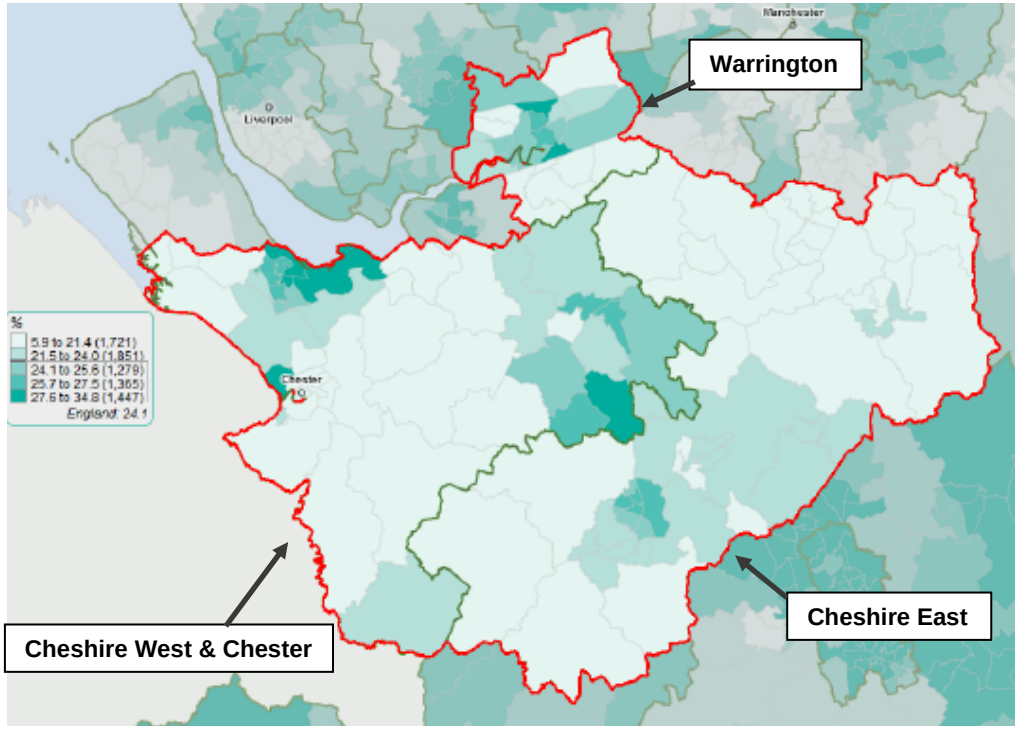

Figure 7: Obesity in Warrington, Cheshire West & Chester, and Cheshire East, by ward (2013 boundaries)

Percentage of the population aged 16+ with a BMI of 30+, modelled estimate, 2006-2008 - source: Public Health England 'Local Health', NHS IC © Copyright. ©PHE - © Crown copyright and database rights 2014, Ordnance Survey 100016969 – ONS © Crown Copyright 2014

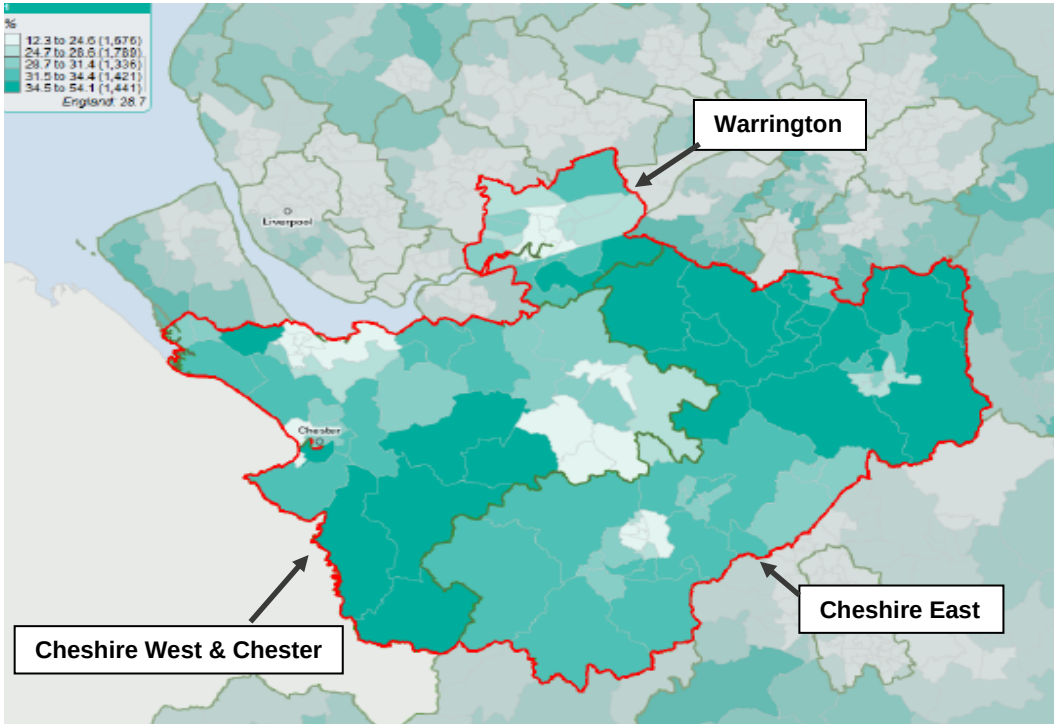

Figure 8: Healthy eating levels in Cheshire and Warrington by ward.

Estimated percentage of the population aged 16+ that eat healthily. Note -uses modelled data – slightly older and different definition to indicator in main text, but available for small areas. Source: Public Health England 'Local Health', NHS IC © Copyright. ©PHE - © Crown copyright and database rights 2014, Ordnance Survey 100016969 – ONS © Crown Copyright 2014.

Disease and poor health

Adults in Cheshire and Warrington spend around a fifth of their life in poor health. Cheshire West & Chester and Cheshire East generally compare well or are similar to the national average for most public health indicators while Warrington has more of a mixed picture. The rate of mortality from causes considered preventable is significantly above the national average in Warrington (200.9 per 100,000 persons); significantly below the national in average in Cheshire East (167.2 per 100,000 persons); and similar in Cheshire West & Chester (187.3 per 100,000 persons). All are lower than the North West average of 223.6. Rates of mortality from preventable causes are consistently higher among males (11).

Nationally, treatment for long term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure. Long term conditions are more prevalent in older people and in more deprived groups (12).

The prevalence of people diagnosed with long term conditions recorded by GPs in Cheshire and Warrington is shown in **Figure 9** for each local authority compared to England and the North West:

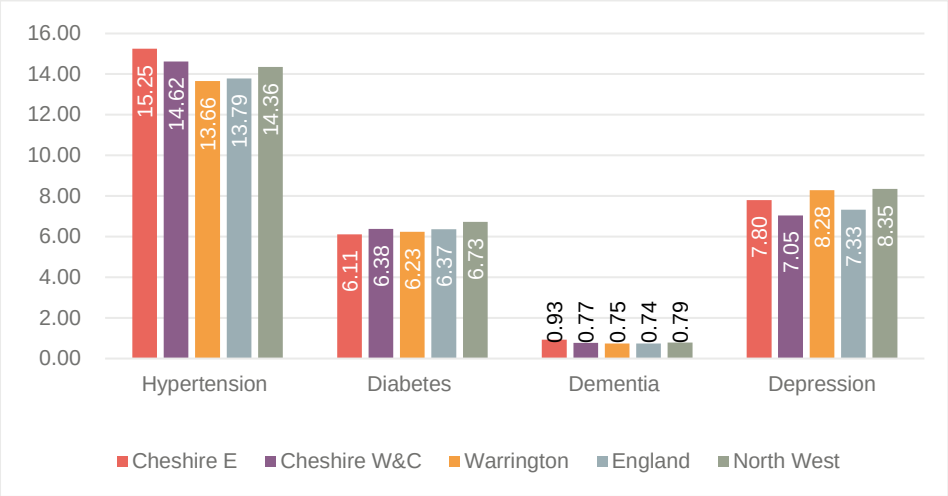

Figure 9: Percentage prevalence of selected long term conditions in Cheshire & Warrington, compared to England and the North West. Source: 2014/15 GP QOF data.

- Levels of reported hypertension are significantly higher than the national and North Westaverages in Cheshire East and Cheshire West & Chester (13).
- Levels of diabetes are significantly lower than national and North West averages in Cheshire East and in Warrington (13).
- Levels of dementia are higher than national and North West averages in Cheshire East.
- Levels of depression are higher than the national average in Warrington.

(14)

For several years Cheshire West & Chester and Cheshire East have experienced higher levels of malignant skin cancer and serious road traffic injuries than the national average. These indicators are generally higher in more affluent areas. Serious car crashes might be more common in rural areas where road speeds are higher than in urban areas.

2.4 Healthy ageing

A growing elderly population

The growing elderly population in Cheshire and Warrington (**Figure 2**) emphasises the need to ensure good health and wellbeing for older adults (15). The likelihood of older people in Cheshire and Warrington spending their later years with good health and wellbeing will vary across the area. This variation is dependent not only on older people's physical and mental health but on a range of wider social and environmental determinants.

Health and risk factors

Numerous factors affect older adults physical and mental health including: social isolation and loneliness, participation within families and the wider community, poverty, personal safety and being a victim of crime, poor quality housing and poorly maintained physical environments (16). Among older people in all three local authorities in Cheshire and Warrington, income deprivation is lower than the national and North West average. .Health related quality of life for older people is significantly higher than the national average in Cheshire East and similar in Cheshire West & Chester and Warrington. Levels in all three authorities are higher than the North West average (11, 17).

The effects of winter cold provide a key example of how wider social determinants impact upon older people's physical health. Ill health and death rates increase among older people in cold weather and cold homes due to poor heating and insulation cost the NHS more than £1.36 billion every year (18). The rate of **excess winter deaths** can vary quite dramatically from year to year. The three year excess winter death index for 2011/12 to 2013/14 in all three local authorities was similar to the national and North West average. For those aged over 85, the three year index was also similar to the national and North West averages. However, for men aged over 85, there were significantly higher levels of excess winter deaths in Cheshire East (35.0) and Cheshire West & Chester (36.3) compared to the national average of 21.8. Levels here were also higher than the North West average of 23.2. These were the only two local authorities in the whole of the North West where levels were significantly higher than the national average (11).

Older people are the most frequent and costly users of both health and social care. Use is highest among those with complex multiple needs, long term conditions and functional, sensory or cognitive impairments. Nationally, dementia accounts for more health care expenditure than heart disease and cancer combined (11). Fewer people in Cheshire East and Cheshire West & Chester received an NHS health check when compared to the national and North West average. Cheshire West & Chester and Warrington are also lower than the national average for access to non-cancer screening programmes such as diabetic retinopathy.

Cheshire East and Warrington are higher than the national average for injuries due to falls in people aged 65+ years with all Cheshire and Warrington areas higher than the national average for falls in aged 80+ years. Compared to the North West average, Warrington (aged 65+ and 80+) and Cheshire East (80+) had higher levels of falls. With a projected increase in older people and the dramatic rise particularly in people aged 85+ this makes this population group vulnerable to social and rural isolation with other factors such as cognitive and visual impairment.

3 Key actions to improve health and wellbeing and reduce health inequalities

This section reviews the evidence base for effective and cost-effective large scale interventions and provides summary recommendations on which interventions should be delivered and by which agencies. The overarching aim is to identify evidence on approaches that combine collective and collaborative local action to address public health challenges in the Cheshire West & Chester, Cheshire East and Warrington Sub-region across three priority areas:

- Early years and the 'best start in life';
- Worklessness and workplace health;
- Common mental health problems (including preserving mental health and wellbeing).

These topic areas have been identified as some of the key public health challenges in the Cheshire West & Chester, Cheshire East and Warrington Sub-region. However, we recognise that there are a range of additional areas that could be considered moving forward.

This report draws on 'preappraised' evidence, i.e. evidence that has already been through an appraisal process. Our search for evidence was undertaken through the National Institute for Health and Care Excellence *Evidence search* which provides access to selected and authoritative evidence in health, social care and public health. We have targeted our searches at the top of the hierarchy of preappraised evidence focusing on *summaries* that integrate evidence-based information about specific health issues in the form of NICE-accredited national recommendations and guidelines. These *summaries* incorporate the highest quality and most synthesised sources of typically international evidence, with actions adapted to the national context. Alongside this we draw on evidence from the Department of Health, NHS England, Public Health England, the Local Government Association, the King's Fund, and the World Health Organization.

3.1 Early years and the 'best start in life'

Why focus on giving children the best start in life?

The importance of giving every child the best start in life and the need to reduce health inequalities throughout life has been highlighted by Professor Sir Michael Marmot and the Chief Medical Officer (19). Children and young people (aged 0 to 24 years) represent over a quarter of the total Cheshire and Warrington population (11), and although this is lower than the England and North West averages, a healthy future society is dependent on all children getting the best start in life. Experiences in the early years frame a child's development and ability to learn, which in turn impacts on their future development and life chances in terms of health and wellbeing (20), but also in terms of their educational attainment, and their future ability to make an economic contribution to society. Generally, children and young people in Cheshire and Warrington face a good start in life with significantly lower levels of deprivation and child poverty compared to the national average. However, there are pockets of need within the sub-region, and some markers of wellbeing suggest children may face greater challenges in life, including being borne into lone parent families, significantly fewer babies being breastfed and significantly higher rates of hospital admissions for both babies and for childhood injuries. These challenges are largely preventable and early detection and timely intervention can significantly reduce and prevent their potential lasting effects.

What can be done?

Support maternal (perinatal) wellbeing

Maternal depression and anxiety are as least as common during pregnancy as they are in the year after childbirth (21) and a significant minority (15 to 20%) of women suffer from depression or anxiety during pregnancy or in the first year after childbirth (22). Estimates suggest that the long-term cost to society of a single case of perinatal depression is around £74,000 (see **Box 1**) (23). Rates of perinatal depression are higher amongst women experiencing disadvantages such as poverty or social exclusion (24), as well as poor housing and domestic violence (25). The risk of depression is also twice as high amongst teenage mothers (26).

Support for maternal (perinatal) mental wellbeing is important. Midwives, GPs, nurses and health visitors (representing universal services) are a crucial part of local care pathways, as they have regular contact with nearly all families during pregnancy and after childbirth. Professionals delivering universal services therefore need to be competent in detecting, discussing and dealing with mental health problems (27, 28). Appropriate care of women and their babies during childbirth is also important - home births and freestanding midwifery units should be available to all women (in their local area or in a neighbouring area) as appropriate, alongside hospital based midwifery or obstetric units (labour wards) (29).

Box 1. The costs of mental health problems during pregnancy and after childbirth

- Depression, anxiety and psychosis during pregnancy and in the first year after childbirth carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK.
- This is equivalent to a cost of just under £10,000 for every single birth in the country.
- Of these costs, 72% relates to adverse impacts on the child and 28% to the mother.
- The cost to the public sector of perinatal mental health problems is 5 times the cost of improving services.

Source: Bauer et al. 2014 [22]

Expert early identification and management of perinatal mental health problems via more screening and assessment should prevent more women from reaching the point where they need inpatient care (22, 27). Health visitors and midwives are well placed to identify mothers and fathers experiencing mental health problems and enable their access to support. Improved training and support will enable health visitors and midwives to spot the early signs of maternal mental health problems and to work together

to meet the physical health, mental health and wellbeing needs of parents, babies and families (30). The Maternal Mental Health Alliance, which includes the Royal College of Midwives and the NSPCC, recommends that every maternity service has Specialist Mental Health Midwives and Health Education England has a mandate commitment to ensure that trained specialist mental health staff are available to support mothers in every birthing unit by 2017.

Established regional clinical networks for perinatal mental health services can assist with meeting local need for perinatal mental health services and the provision of integrated care. NICE guidance (27) highlights the importance of co-ordinated care, and recommends that an integrated care plan should be developed for women who have known mental health problems, covering pregnancy and the postnatal period, that sets out care and treatment as well as the roles of all healthcare professionals involved. Whilst the majority of new mothers with mental health problems can be effectively managed within an extended primary care team, a minority will require specialist care (30). Having commissioning arrangements in place can ensure that these women have access to specialist perinatal mental health services (27). According to Department of Health guidelines (30) support should be provided by specialist community perinatal mental health teams and if necessary, via admission to specialist mother and baby units. Where mothers are identified as needing support, services should not only support recovery from depression, but should also look to help mothers to care for their babies.

The Centre for Mental Health (22) has highlighted **identification and treatment of anxiety and depression for women during pregnancy and after childbirth** as one of nine priority areas for investment. For women who require help, evidence supports the provision of psychological therapy (22, 31, 32). The recent Five Year Forward View mental health strategy has recommended improving the identification of perinatal depression and anxiety and providing psychological therapy to all who would benefit (22, 31, 32). While the full costs of implementation nationally would be in the region of £53 million a year, reductions in health service use are expected to more than cover this cost over time; with predictions suggesting that around two-thirds of costs could be recovered within five years. In addition to psychological therapies, there is a need to ensure access to the right range of specialist community or inpatient care, so that comprehensive, high-quality services are in place (31).

Coordinate promotion and support for breast feeding

UK breastfeeding rates are among the lowest in Europe (33), and the number of mothers who initiate breastfeeding, and the proportion still breastfeeding at 6-8 weeks, is lower overall in Cheshire and Warrington than the national average (**Figure 10**) (11). However, breastfeeding initiation levels are higher than the North West average in all three authorities (North West figures on prevalence at 6-8 weeks are not available). Babies who are breastfed are less likely to develop many short and long-term illnesses throughout the life course, while mothers who breastfeed for longest have reduced risks of breast and ovarian cancers (34). Breastfeeding also supports maternal and infant well-being and mother and infant attachment (35).

A broad range of experts agree that the 'breastfeeding crisis' in the UK reflects a lack of support and protection for mothers who choose to breastfeed[ii]. Evidence shows that a **multifaceted approach or a coordinated programme of interventions across different settings** is needed to increase breastfeeding rates (34). NICE recommends that a structured programme that encourages breastfeeding is implemented, using the **UNICEF UK Baby Friendly Initiative** (BFI) as a minimum standard. Programmes should be subject to external evaluation and include support from peers and health

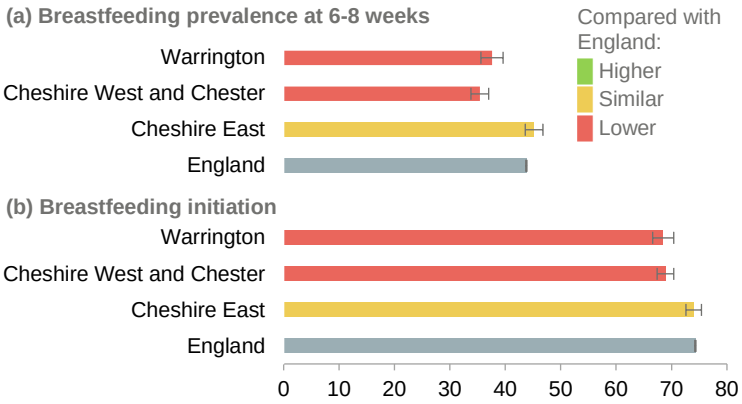

Figure10: Breastfeeding prevalence (a) and initiation (b) across the Cheshire and Warrington local authorities compared to the England average. 2014/15. Source: PHE Fingertips.

[ii] https://ukbreastfeedingtrends.files.wordpress.com/2016/02/open-letter-uk-response-to-lancet-updated7.pdf

professionals combined with robust restrictions on formula advertising. The National Social Marketing Centre provide a tool that can be used to plan and evaluate social marketing and other interventions aimed at improving breastfeeding rates[iii] (36).

NICE guidance recommends that midwives and health visitors ensure that pregnant women and their partners are offered **breastfeeding information, education and support** on an individual or group basis (34). As well as supporting individual mothers, Health Visitors can lead the implementation and delivery of evidence-based public health programmes in their locality (37, 38). They can ensure a whole system approach to promoting breastfeeding by implementing BFI standards and supporting other settings such as Children's Centres to become Baby Friendly. Health visitors in particular are thought to be well positioned to support mothers with breastfeeding because of their continued and active engagement with mothers after childbirth. They provide advice on breastfeeding and medication and have a key role in developing or signposting mothers to breastfeeding peer support programmes, as well as promoting the benefits of heath visiting with fathers. Specifically training health visitors in breastfeeding support can also improve breastfeeding rates (28).

NICE guidance further recommends the provision of **local, easily accessible breastfeeding peer support programmes** and to ensure that peer supporters are part of a multidisciplinary team (34) (see Box 2 (39)). In support of the BFI and NICE guidance, the Breast Feeding Network[iv] highlights that properly commissioned and adequately funded breastfeeding peer support services are effective and relatively low cost for the benefits they can achieve.

Box 2. East Cheshire (Crewe) 'Cherubs' breastfeeding support

'Cherubs' (Cheshire's Really Useful Breastfeeding Support) was the response to low breastfeeding rates in the East Cheshire area. The programme is designed to enable breastfeeding mothers to come together in a supportive environment and gain support from each other as well as to receive professional expertise and advice. Health visitors in the area have worked alongside other local agencies, such as local children's centres to promote the service. The programme has increased from two breastfeeding support workers in 2010 to five support workers and 14 groups across Cheshire East, with more specialist support in those areas of high deprivation.

Source: Department of Health [38]

All partner organisations, local authorities and third sector organisations involved in improving breast feeding rates should **comply fully with the WHO Code on the marketing of breast milk substitutes**[v]. The code is intended to protect all infants from inappropriate marketing of infant formula by regulating marketing, limiting the provision of product information to health professionals to a scientific and factual basis only, and by prohibiting the promotion of products in all healthcare facilities.

Support early identification of need and provide appropriate support

The stage of development reached at age 2 to 2½ years is crucial for predicting further speech and language development, as well as social, emotional and cognitive development (28, 40). Therefore experts recommend that **appropriate monitoring of progress and appropriate interventions** are put in place at this stage of development. Health visitors are ideally placed to identify children in families with additional needs and problems and to support families and carers in promoting school readiness of all children (41). Integrating the Early Years Foundation Stage Progress Check at age 2 to 3 years and the Healthy Child Programme health and development review at age 2 to 2½ years has been shown to help meet families and children's needs more effectively by identifying problems earlier and reducing conflicting advice (41). Integration, especially at joint meetings, has been shown in pilot projects to add clear value, enable a greater range of advice to be pooled in a holistic way, and to provide

[iii] http://www.thensmc.com/resources/vfm/breastfeeding
[iv] https://www.breastfeedingnetwork.org.uk/commissioning-peer-support/
[v] http://www.who.int/nutrition/publications/code_english.pdf

greater flexibility in the provision of ongoing support (42). Integration also fits well with the Government's current drive to use early years resources more efficiently and to expand the role of early years professionals in safeguarding (42).

Manage minor illness and prevent unintentional injury

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable (43). In 2015, 27.9% of 5 year olds in England had decayed, missing or filled teeth; the proportion in Cheshire East and Cheshire West and Chester was below this national average, but higher in Warrington (44). **Health visitors lead and support delivery of preventive programmes** for infants and children, including providing advice on oral health, and can play a vital role in tackling inequalities in oral health. Health visitors can also play an important role in educating families on home safety and promoting immunisation (41); and they have a further role in building parental confidence and knowledge on self-management of common childhood illnesses (28). Further, evidence shows that **parent education and training programmes** are effective in reducing unintentional injury in children and young people (45).

Accidental injuries among children are the main cause of death among children post-infancy, and the leading cause of preventable A&E attendances and hospital admissions. Unintentional injuries are a major health inequality - the emergency hospital admission rate for unintentional injuries among the under-fives is 45% higher for children from the most deprived areas, and this gap is widening (46). Injury prevention can be low cost but have a significant impact on health and wellbeing (46). Coordinated action by local authority departments, local NHS organisations and other local agencies, including voluntary sector organisations and the Fire and Rescue services (see **Box 3** (47)) to prevent unintentional injuries can be more effective when supported by a lead person in the local area (48). **Support and training** is needed to enable the whole children's workforce to strengthen its central role in preventing unintentional injury (46). Health visitors lead and support delivery of the **Healthy Child Programme** (HCP), a key component of which is injury prevention (49) and Children's Centres can also play a vital role in in early intervention and helping achieve improved health outcomes for children (49, 50).

Directors of Public Health and other health professionals with responsibility for preventing or treating injuries are ideally placed to lead on and take responsibility for the health sector's involvement in injury prevention and risk reduction (51). **Coordinated working between health professionals** is encouraged and wider partnerships should be sought. For example, partnerships with local highways authorities can promote changes to the road environment – this might include changes to create 20mph zones, or other speed reduction features as part of a broad strategy to prevent injuries and the risk of injuries.

Box 3. Home safety assessments, Cheshire Fire and Rescue Service

Cheshire Fire and Rescue Service provide free home safety visits for people who are aged over 65 and for those considered to be at a particular risk referred by partner agencies. A case study published in the Journal of Public Health [46], showed that the region had seen marked drops in accidental dwelling fires (ADFs) and injuries arising from ADFs coinciding with the introduction of the home safety assessments conducted by Cheshire Fire and Rescue Service.

Provide additional support for vulnerable families and families with complex needs

NICE guidance (52) highlights the need to ensure that women with complex social factors (including women aged under 20, women misusing substances, recent migrants and women experiencing domestic abuse) who become pregnant receive co-ordinated antenatal care. **Local antenatal services should work with local agencies, including social care and third-sector agencies, to coordinate this care**, for example by jointly developing care plans across agencies, signposting to other agencies, or by co-locating services.

Early intervention to support better health and wellbeing provides opportunities to break the cycle of poor outcomes for the future among vulnerable families and families with complex needs (53). Health visitors can be instrumental in safeguarding children from harm within the home (such as from maltreatment and neglect; NICE (54) provide specific guidance on when to suspect maltreatment in under 18s), allowing early identification and intervention for those at risk (28). Health visitors can also play a vital part in supporting vulnerable families and families with complex needs, and in supporting parental mental health.

Local health systems should be developed to deliver integrated services that effectively meet families' needs; for example, working as part of a multi-agency team, seconding health professionals intro troubled families services and referring into existing health initiatives, and sharing information (53). NICE (55) have also produced guidance on the health of looked after children, recommending that partnership and multi-agency working should be at the heart of the planning process, and that children and young people are fully engaged in the design and delivery of services. A recent joint report by the Children's Services Development Group and the Local Government Information Unit recommended that commissioners must not commission solely on the basis of short-term cost but should look at the whole-life costs for a looked after child, including their eventual transition into independence, employment or training (56).

Summary of interventions for Best Start

Evidence based intervention	Action by who/level	Impact
Support maternal (perinatal) wellbeing		
Professionals delivering universal services for women and their babies are competent in detecting, discussing and dealing with mental health problems	Health visitors, GPs, midwives	To improve early identification and provision of support
Co-ordinated and integrated perinatal mental health services, including specialist care, that meets local need.	Commissioners, NHS	To improve outcomes for mothers and their babies
Action to coordinate promotion and support for breast feeding		
Implement structured, multifaceted programmes – using the UNICEF UK Baby Friendly Initiative (BFI) as a minimum standard.	Commissioners, NHS, Local authorities	To improve breastfeeding rates
Provide midwives and health visitors with specific training on breastfeeding information, advice and support.		
Ensure all relevant partner organisations, local authorities and third sector organisations comply with the WHO Code on the marketing of breast milk substitutes.		
Actions to support early identification of need and the provision of appropriate support		
Health visitors lead and support preventive programmes for infants and children, and can provide advice on oral health.	Health visitors	To reduce rates of tooth decay
Improve training for health visitors and midwives, to enable them to identify early signs of maternal mental health problems.	NHS	To identify mental health issues early and signpost to other services as appropriate
Children's Centres can play a vital role in early intervention.	Commissioners	To improve health outcomes
Actions to manage minor illness and families with complex needs		
Ensure that the role of a senior public health position includes leading on injury prevention and risk prevention.	Commissioners	To reduce the number of accidental injuries
Actions to support vulnerable families and families with complex needs		
Record the number of women with complex social needs. Work with other agencies, including social care and third sector agencies, to coordinate antenatal care.	Commissioners	To improve care of women with complex needs
Set up local health systems to develop and deliver integrated services, such as working as part of a multi-agency team, seconding health professionals into the Troubled Families service, sharing information.	Commissioners	To deliver coordinated and effective care

3.2 Worklessness and workplace health

Why focus on worklessness and workplace health?

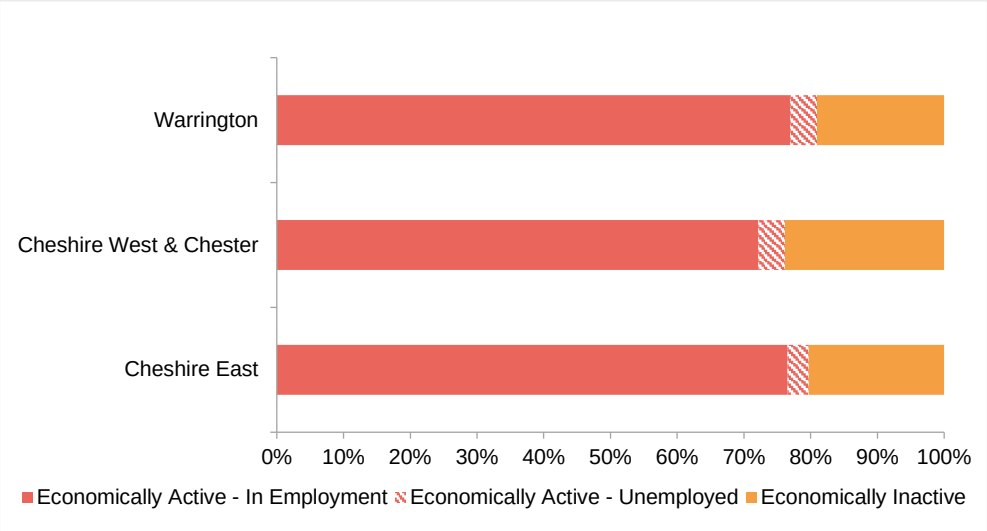

Figure11: Economic activity and inactivity rates, November 2015. Source: NOMIS, 2015.

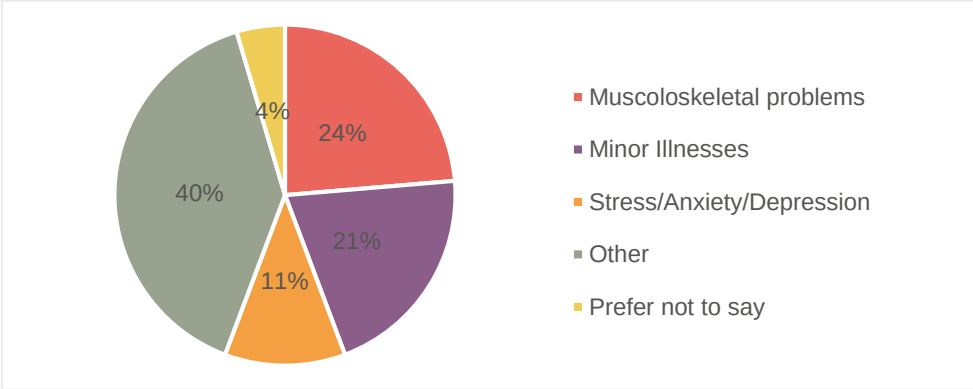

Figure12: Millions of days lost by reason for absence in 2013. Source: ONS, 2014

Work is a key determinant of health. Employment helps to connect people to society but poor health, chronic diseases and lifestyle factors reduce the chances of gaining or maintaining a job and are associated with being out of work. There are many connections between work and health - work can promote good physical and mental health, work can have adverse effects on health, poor health can reduce the chances of gaining or maintaining a job, and being out of work can damage health (57). Being out of work is associated with an increased risk of poor health across all socio-economic groups. According to evidence collated by Public Health England (58) this includes higher risks of limiting illness, cardiovascular disease, poor mental health, suicide and health damaging behaviours such as smoking.

Figure 11 shows economic activity among the working age (16 to 64 years) population in the three local authority areas. Cheshire West and Chester records the highest proportion of people who are economically inactive (24.0%). Within this category, Cheshire West and Chester also records the highest proportion of people with long-term sickness. In the North West, 11% of the working age (16-64) population are claiming the main out-of-work benefits (including Jobseekers, Employment and Support Allowance and incapacity benefits, lone parents, and others on income related benefits). The proportion claiming these benefits is lower in all three of the Cheshire local authority areas than the North West average; 6.0% in Cheshire East, 7.5% in Cheshire West and Chester, and 7.4% in Warrington. In 2013, 131 million days were lost due to sickness absence in the UK (59). Recurrent sickness absence costs employers around £11 billion per year and can have a significant and negative health impact on employees, notably as it increases the risk of work disability in the future (60). As shown in **Figure 12**, the greatest number of working days are lost due to musculoskeletal problems. Mental health problems also contribute to a significant number of working days of lost.

Absent from these figures is the number of people experiencing in-work poverty, which has risen sharply over the past decade. Almost two-thirds of children living in poverty in the UK are from working families (61). Poverty increases people's risk of mental illness and negatively affects how people see themselves, with those experiencing poverty showing significantly lower levels of confidence in their ability to succeed (62, 63).

What can be done?

Creating fair employment conditions and decent work for all is one of the Marmot Review's key recommendations for tackling health inequalities (57). For those 'in work' actions are needed to recognise and address the impact of psychosocial working conditions on health and wellbeing, and for those 'out of work' effective labour market policies are required to support people to enter work (57). A Public Health England report highlighted that those in more disadvantaged socioeconomic positions are more likely to be unemployed, and are therefore at greater risk of poor health (58). Lower paid workers with fewer skills or qualifications are more likely to experience poor psychosocial working conditions and worse health. The review argues that local authorities have a role to play in promoting personalised, tailored support for people with disabilities and long term conditions into work or training. Continuing trends towards higher skilled jobs mean that by 2022, employers will demand more highly qualified people (64). Not meeting the challenges of the skills gap is predicted to lead to a surplus of low skilled workers, with risks to economic growth. Employment and skills are key for a healthy local economy and this reinforces the need for action so that people with known disadvantages in the labour market can be helped to improve their employability and find work in the face of fast-changing employer requirements.

Support the transition into employment

Active labour market programmes aim to support people to enter work by enhancing skills and knowledge, typically through job search assistance and training programmes. Programmes may also provide personal development aspects such as support, education, and skills. Evidence shows that participation in such programmes, specifically government training programmes, can have positive effect on wellbeing and psychological health compared with remaining out of work (65). Alongside government schemes, in the third sector, housing associations have been identified as working at a local level to address unemployment (see **Box 4**) (66).

Box 4. Housing associations helping residents into work or training

A joint Centre for Economic and Social Inclusion and HACT report [65] identified that housing providers across the country were involved in a range of activities to help their residents into work or training. The majority of organisations they contacted were offering help, advice, services or work opportunities to residents to increase their chances of finding or staying in work. The report recommended that housing providers work collectively to develop a framework that benchmarks worklessness among residents, in order to target opportunities and interventions and link up with mainstream provision.

In Warrington, for example, Golden Gates Housing Trust have a dedicated employment team to support local people to develop their skills and access employment or volunteering opportunities. They offer jobs clubs, pre-employment training, employment and volunteering opportunities, advice on getting job ready and a range of other employment support services.

https://www.gght.org.uk/our-services/employment-volunteering/Pages/Home.aspx

Incentives for people seeking work such as contributions to travel costs and tax credits may improve employment rates and can help the transition into employment (67), especially for people who have been out of work for an extended period of time, as well as increasing awareness of available incentives to improve uptake. In order to help those furthest from the labour market, the incentives offered should not be too low or short-lasting, particularly as income from other benefit claims may be lost due to employment (67).

Local authorities can work with local employers to **encourage, enforce and incentivise good quality work** (58). For example, by using the contractual levers of procurement, local authorities can encourage improvement in employee health and working conditions. Use of the Public Services (Social Value) Act 2012 may assist this action through procurement as adopting good working practices and providing employment opportunities for local disadvantaged people can be argued as bringing social value and improving wellbeing (58). Local authorities can also work with employers to **increase payment of the living wage and introduce a higher minimum wage** to improve quality of life, happiness and productivity in work and to help to tackle in-work poverty (61, 68).

Increase opportunities for employment and retention for people with a long-term limiting illness or disability

Local authorities can use their position of leadership combined with their localised knowledge to **forge partnerships, map provision, identify local needs and gaps and to build referral networks** and to offer help and advice to employees (69, 70).

Under the Equality Act 2010, employers must make reasonable adjustments to facilitate access to, return to and retention of work for disabled employees. Adjustments may include shorter working hours, different shift patterns, or transferring someone from a physical to a sedentary post. Evidence shows that such **workplace adjustments** are effective for enabling return to work and in reducing the length of sickness absence (71). Opportunities for employment may be achieved through the use of **financial incentives for employers** such as wage subsidies (72). Access to personal advisors or case management schemes may increase the speed and likelihood of return to work, alongside building relationships and trust with staff. Evidence shows that **supported employment schemes** are beneficial for people with severe mental health problems (73)**. Individual placement and support (IPS)** is a particular model of employment support with an established evidence base from studies conducted in the US. Evidence collated by the National Development Team for Inclusion (NDTi) suggests that IPS is an effective solution for supporting people with mental ill health into paid jobs, however, there are gaps in the evidence giving rise to concerns about the true value for money of supported employment models, including IPS (74).

Improve the quality of work and workplace health and wellbeing

NICE guidance (75, 76) recommends that organisations make **health and wellbeing a core priority for the top management of the organisation**. Employers should encourage a consistent, positive approach to all employees' health and wellbeing. Organisations can introduce workplace policies that promote and protect employee mental wellbeing and support a culture of healthy eating and physical activity (70). They can use available frameworks to benchmark performance, for example, independent, evidence based standards provided by the Workplace Wellbeing Charter. Organisations can provide a range of options to help people get back to work (70). Best practices include early contact, concerted action and collaboration, adjustment of job demands and gradual progressive return to work (72).

Fit Notes were introduced following Dame Black's report, 'Working for a Healthier Tomorrow' (77), which recognised that sick notes were a barrier to patients returning to work (78). It is recommended that fit notes are issued as early as possible following sickness absence. The report also prompted the introduction of a new national (UK) health and work assessment and advisory service, 'Fit for Work'. This **early intervention service** is intended to provide occupational health assessments and general health and work advice to employees, employers and GPs in order to help individuals stay in or return to work.

Workplace interventions that are implemented as early as possible are known to be significantly more effective and cost-effective (79). Investing in employee health can reduce staff turnover, increase productivity and enhance overall performance of employees (80). As the first point of contact when individuals are not well, line managers are important in the return-to-work process (76), for example by taking responsibility for employees' day to day management and ensuring that work adjustments are appropriately addressed (60). Line managers should be given adequate time, training and resources to ensure they balance the aims of the organisation with concern for the health and wellbeing of employees (76). Line managers are ideally placed to promote employee engagement and communication, recognise and praise good performance, and be proactive in addressing concerns early, identifying sources of internal and external support. Employers should encourage and help employees, including older employees, and those who have few qualifications, or who may have received education and training some years ago, to make the most of learning and development opportunities, including giving them time off for training (76).

NICE recently updated previous guidance to include evidence relating specifically to older employees (76). Recommendations included treating each employee as an individual and avoiding stereotypical assumptions often associated with older employees. Employers should consider helping employees to access screening and other health services to which they are entitled - this could include providing information about services such as cervical screening and eye tests and allowing time off to attend appointments (76).

Summary of interventions for worklessness and workplace health

Evidence based intervention	Action by who/ level	Impact
Supporting people into employment		
Offer job search assistance programmes, training programmes and supported employment opportunities. Include: • personalised tailored support for those with disabilities or long term conditions • incentives for individuals, such as travel costs or tax credits • incentives for employers, such as wage subsidies • reasonable adjustments where necessary, such as shorter working hours	Local authorities working with employers.	Reductions in worklessness and in inequalities relating to employment opportunities.
Use procurement to encourage local employment opportunities, targeting work for disadvantaged groups.		Reductions in inequalities relating to employment opportunities
Use the 2016 work programme to address the skills gap		Increased job opportunities for the local population.
Improving workplace health and wellbeing		
Make health and wellbeing a core priority, especially amongst lower paid workers.	Employers.	Improvements in health and wellbeing of workforce. Reductions in inequalities in health and wellbeing. Reductions in absence rates.
Introduce policies that promote health and mental wellbeing, such as: • adjusting job demands • phased returns to work • use of 'fit notes' • use 'fit for work' service to help individuals stay in or return to work • introduce a living wage	Employers/line managers.	
Introduce policies that encourage healthy eating, physical activity and access to screening services.	Employers/line managers.	
Introduce training for line managers in how to support the health and wellbeing of employees.	Employers/line managers.	
Encourage employees, especially older workers, into learning and development opportunities.	Employers/line managers.	
Use procurement to encourage improvements in employee health and working conditions.	Local authorities working with employers.	

3.3 Mental health and wellbeing

'Mental health' and 'mental wellbeing' are terms that have been used interchangeably. However, mental wellbeing is related to, but not the same as, the absence of mental ill health. It has been defined as the ability to cope with life's problems and make the most of life's opportunities (81). People with a mental illness may have an absence of mental health, but it is possible to have both mental ill health and still have moderate or even flourishing levels of mental health and wellbeing. On the other hand, it is possible to be free from mental illness, but with low levels of mental health and wellbeing (82, 83).

An emphasis on measures to ensure the population maximises its mental health and wellbeing, rather than focusing only on treating or preventing mental illness, will have the overall effect of reducing levels of mental illness amongst the population (82, 83). This section of the report considers mental health and wellbeing and summarises the available evidence on interventions that can lead to enhanced wellbeing. The subsequent section summarises the interventions available to deal with minimising and managing the effects of mental illness.

Why focus on mental wellbeing?

Mental wellbeing is defined in **Box 5**. Protective factors seen as key to maintaining wellbeing include self-esteem, confidence, resilience, social networks and sense of control (83, 84). Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation (81). Levels of mental health and wellbeing appear to be generally good across the sub-region. The North West Mental Wellbeing survey (last carried out in 2012/13) found that each local authority in Cheshire and Warrington scored higher than the North West average on the Warwick-Edinburgh Mental Wellbeing Scale (85). However, it remains important to start early, focusing on the social and emotional wellbeing of children and young people to create the foundations for healthy behaviours and educational attainment. This will also help to prevent behavioural problems (including substance misuse) and mental health problems (86, 87).

Box 5: Definitions

Mental wellbeing consists of the following:

- *Emotional wellbeing*: happiness, confidence and not feeling depressed
- *Psychological wellbeing*: a feeling of autonomy and control over one's life, problem-solving skills, resilience, attentiveness and a sense of involvement with others
- *Social wellbeing*: the ability to have good relationships with others and to avoid disruptive behaviour, delinquency, violence or bullying.

NICE 2009: Social and emotional wellbeing in secondary education.

Loneliness is a psychological state. It is a subjective, negative feeling associated with lack or loss of companionship. If you feel lonely, you are lonely. **Social isolation** is a sociological category relating to imposed isolation from normal social networks. This can lead to loneliness and can be caused by loss of mobility or deteriorating health It is possible to be lonely whilst not isolated, for example amongst those caring for a dependent spouse with little help

Cattan et al, 2005; Windle et al, 2011 ; Bolton, 2012

Poor mental wellbeing is strongly associated with a number of social determinants, including deprivation and social isolation (81). Factors such as poor quality housing, unemployment and deprivation can also contribute to mental ill health. Living in more deprived communities is strongly associated with lower levels of mental wellbeing (83). Loneliness and social isolation (see **Box 5**) are important factors and can lead to increased use of health and social care services, especially amongst older adults (88, 89). Lack of social contact can be just as harmful to health as smoking and alcohol consumption, more harmful than not exercising and twice as harmful as obesity (90). Research

shows a 50% increased likelihood of survival for those with stronger social connections (90). Around 10-13 % of older people report feeling lonely often or always (91). Severe loneliness (feeling lonely all or most of the time) occurs in around 9% of those aged over 55 (92).

Economic and demographic challenges have the potential to increase poor mental wellbeing and social isolation amongst various population groups, including lone parents and the over 50s age group. For example, detachment from the labour market in mid-life may reduce levels of social participation in later life due to limited friendship networks and lack of financial resources. An increasing burden from social isolation and loneliness is expected through the projected growth of the elderly population in Cheshire and Warrington (see **Section 1.1**) and the projected growth in single-person households aged 65 and over.

It is known that socioeconomic factors such as poor educational attainment and social disadvantage are related to suicidal behaviour. Unemployment is also a known risk factor, as is low household income. Being divorced or separated can be associated with suicidal thoughts and attempts (83, 93). Suicide rates across Cheshire and Warrington are similar to the England average of 10.3 per 100,000 (2012/14) (11). Between 2013 and 2014, the male suicide rate decreased in England (by less than 1%) and the female suicide rate increased by 14%.

What can be done?

Address wider socioeconomic and environmental inequalities and develop community assets

The key to improving mental wellbeing is to address wider socioeconomic and environmental inequalities (94). **Asset approaches** provide some of the tools to tackle inequalities in health and wellbeing (95). Such approaches recognise and build on assets such as capacity, skills, knowledge, connections and potential in a community (see **Box 6**).

Start early to promote mental wellbeing: Offering better support to new mothers is important, to minimise the risks and impacts of depression and anxiety during pregnancy and after childbirth (30) (see **Section 3.1 'Best Start in Life'**). For those aged under 5, NICE guidelines set out how the social and emotional wellbeing of vulnerable children can be supported through home visiting, childcare and early education (86). In schools, NICE have recommended actions to promote educational attainment and reduce bullying and risk-taking behaviour among pupils, in order to achieve social and emotional wellbeing (87). These universal approaches to improving social and emotional wellbeing in primary and secondary education, in addition to targeted approaches for those showing signs of anxiety or emotional distress, are detailed in specific NICE guidance and pathways (96, 97).

Access to green space: There is increasing evidence for the links between access to pleasant, safe outdoor spaces and green spaces and mental health wellbeing (98-101). Green infrastructure[vi] is

Box 6. Community assets for mental health and wellbeing

An asset is any of 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 ('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 wellbeing

Improvement and Development Agency (2010) [94].

[vi] *Green Infrastructure* is defined as the life support system of an urban area – the network of natural environmental components and green and blue spaces that lies within and around the area, providing multiple social, economic and environmental benefits 102. Liverpool City Council. *Liverpool Green Infrastructure Strategy: Technical Document Version 1.0.* 2010. http://www.greeninfrastructurenw.co.uk/liverpool/Technical_Document.pdf.

generally not equally distributed, with people living in more affluent areas having greater access to green infrastructure than those in more deprived areas (83, 101, 102). It is important to increase multi-agency working, recognising the important effects that planning decisions in the design of neighbourhoods and green space initiatives can have on mental health. Providing opportunities for walkable communities, encouraging communities to be more active, will help to improve wellbeing.

Transport and technology – develop policies that address social exclusion: Access to transport can be key in enabling social connection (103). Action can be taken to ensure local bus services have appropriate routes and times and that they meet the range of mobility and sensory needs of passengers. There also needs to be accessible parking for those with restricted mobility (91, 104). In addition to transport, access to technology can be key in promoting wellbeing and enabling social connection, especially amongst older people (103). Older people can be made aware of voluntary organisations that can help, for example Wavelength.org.uk, which provides televisions and radios for isolated and lonely people. A Policy Exchange think tank noted that loneliness amongst older people could be tackled by training more individuals to use the Internet, helping people to stay connected with friends and family (88, 105).

Provide employment support: Employers need to make health and wellbeing a core priority, especially amongst lower paid workers. It is important to encourage local authorities to champion and improve in-work training and development opportunities and the take up of supported employment and job retention schemes, especially for those at the later stages of their working lives (76) (see **Section 3.2 'Worklessness and Workplace Health'**).

Tackle poor housing and homelessness: A settled, safe home is vital for good mental health. The King's Fund note the important role that housing associations have in providing housing for vulnerable individuals and alleviating social isolation for their residents. Many residents are at risk of social isolation because they are on a low income, live alone and have other risk factors. Interventions promoted by housing associations include befriending, volunteering and community schemes, which can improve health and wellbeing and reduce the pressure on NHS and social care services (106).

Provide welfare and debt advice: The scale and pace of changes to the welfare system over the last few years has raised concerns about the impact on vulnerable people, including those with mental health problems (107). There are clear links between financial problems and mental illness and in the other direction, people with mental health problems are at increased risk of economic hardship, debt and losing their home (108). Evidence suggests that providing face-to-face debt advice can be cost-beneficial within five years. The upfront cost of debt advice is more than offset by savings to the NHS, savings in legal aid, and gains in terms of employment productivity (81) (see **Box 6** for examples). The Centre for Mental Health (109) has also shown that providing specialist welfare advice for people using secondary mental health services is good value for money, with saving accrued through reductions in inpatient length of stays, prevention of homelessness and prevention of relapse. The report draws on the experience of the Sheffield Mental Health Citizens Advice Bureau (CAB), one of only two CABs nationally to offer such a service (see **Box 7**).

Encourage social networks and community engagement

It is recognised that **community building and attempts to tackle the effects of poverty and social deprivation** can play an important part in promoting social wellbeing and tackling loneliness (89, 110, 111). The Marmot Review recognised the significant role that social networks have in maintaining and improving health and wellbeing and recommended that locally developed and evidence based community regeneration programmes that reduce social isolation and develop safer neighbourhoods be supported (5, 103, 112).

Recent NICE guidance notes the importance of **developing collaborations and partnership approaches** to encourage and support alliances between community members and statutory, community and voluntary organisations to work towards improving health and wellbeing (111).

Interventions to promote the independence and wellbeing of older people focus on tackling loneliness and social isolation, as detailed in a recent NICE guidance (89). The evidence highlights the need to work together to support, publicise and, consider providing a range of group, one-to-one and volunteering activities that meet the needs and interests of local older people. Evidence suggests that groups with a training/educational component are especially effective at reducing social isolation (113). Examples of activities include social group schemes (such as choirs and art, discussion or writing groups), one-to-one interventions (such as befriending, Community Navigators and mentoring) and wider community engagement (such as volunteering activities and promoting intergenerational activities) (89, 111).

Some GP practices have introduced **social prescribing schemes**, in which older lonely people are directed to social activities and befriending services. In other areas, the fire services have joined forces with Age UK to identify vulnerable people and direct them to appropriate services (see **Box 7**). Strong partnership arrangements are needed between organisations to ensure developed services can be sustained. Interventions at the neighbourhood/ community level have a greater chance of success if they utilise existing community resources and aim to build community capacity. It is important to involve the community at every step, from planning and delivery of programmes, to evaluation (88, 113). Public health interventions in other areas, such as efforts to increase physical activity amongst the over 50s, can be targeted to assist in creating opportunities for increasing social interactions and building social networks (91, 114, 115).The importance of tackling loneliness, depression and low self-esteem amongst those in care homes has been recognised by NICE, with the publication in December 2013 of new standards (116).

The potential costs and benefits of providing meaningful activities for older people are outlined in **Box 8** (118). It has been noted that Health and Wellbeing Boards are appropriately placed to take overall responsibility in joining up action on wellbeing, loneliness and social isolation across separate local strategies (88, 113).

Prevent suicide

Box 7. Examples of local action:

Brightlife social prescribing in Malpas
Brightlife is the first Social Prescribing service in Cheshire West and Chester to help address loneliness and social isolation by referring vulnerable patients directly from their GP into community-led activities *http://www.brightlifecheshire.org.uk/health-professionals/social-prescribing-in-cheshire/*

Springboard, Cheshire
A partnership between Cheshire Fire and Rescue services and Age UK has used advanced data systems to target vulnerable people (e.g. those who have assisted bin collections). Visits are undertaken and people are connected to local resources such as befriending schemes and tea/coffee clubs.
http://www.cheshirefire.gov.uk/partnerships/springboard

'Make Time', Cheshire & Merseyside
Make Time' is a Cheshire and Merseyside campaign based on the Five Ways to Wellbeing, with the aim of encouraging individuals to look after their mental wellbeing. The five evidence based steps for individual action on ways to wellbeing are:

- Connect with people around you
- Be active: go for a walk; cycle; run; play a game
- Give/ do something nice for a friend or stranger
- Take notice – be aware of the world around you
- Keep learning – try something new

Box 8. Costs and benefits of providing meaningful activities for older people

Providing activities for older people can be funded from existing resources where possible. NICE note that some additional costs related to organisation and delivery may be incurred locally. However, any additional costs may be offset by savings from reductions in: the number of GP appointments needed; the number of falls; diabetes, stroke and coronary heart disease; and depression and dementia

NICE, 2015: Putting NICE guidance into practice: Resource impact report: Older people: independence and mental wellbeing (NG32).

All of the above actions will also help to prevent suicide. In addition, specific actions to prevent suicide are outlined in the Cheshire and Merseyside Suicide Reduction Action Plan (SRAP) (83, 119). Actions are detailed under the following headings:

- *Ensure all nine local authorities achieve Suicide Safer Community accreditation.* This would include assessing needs in the local population and agreeing and commissioning strategies. Continue to support local initiatives such as State of Mind, Opening Up Cricket, CALM, SOBS, Papyrus and Samaritans.
- *Transformation of the health care system*, including effective suicide risk assessment, safety plans and treatment. This would include staff training, targeting preventive interventions at vulnerable groups and reducing access to the means of suicide.
- *Provide support for those exposed to suicide,* and provide effective responses to suicide clusters.
- *Ensure a strong integrated Suicide Reduction Network* to provide oversight and governance. This would include supporting the media to follow the Samaritan's guidelines in delivering sensitive approaches to the reporting of suicide and suicidal behaviour(120).

Build information about mental wellbeing and provide staff training and awareness raising

Improvements in information sharing locally, between services, will contribute to national action in developing a Mental Health Intelligence Network (MHIN), drawing together comprehensive information about mental health and wellbeing to provide a greater insight into the promotion of good mental health and inform commissioning (30). This work should draw on the experience and opinions of people in the local community.

Improved staff training and awareness raising around mental health and wellbeing issues is important. This would include staff in all health and social care sectors. For example those working with young people in Cheshire and Merseyside are being offered 'Connect 5 mental wellbeing training sessions' (121).

It is important to draw together information about mental health and wellbeing, developing a Mental Health Intelligence Network (MHIN) to inform commissioning. Health and Wellbeing Boards should have plans in place to promote good mental health, prevent problems arising and improve mental health services, based on detailed local data for risk factors, protective factors and levels of unmet need. Plans should be drawn up in collaboration with clinicians and 'experts-by-experience' (31).

Summary of interventions for improved mental health and wellbeing

Evidence based intervention	Action by who/ level	Impact
Start early, with support for new mothers and their children and action on wellbeing in schools	Health visitors, primary and secondary schools	Improved social and emotional wellbeing. Reduced pressure on NHS and social care services.
Create pleasant and safer neighbourhoods, with for example equal access to green spaces and extra street lighting.	Local authority departments working in partnership with each other and with the voluntary sector, including planning, transport, employment/jobs, environmental health and public health..	Improved social and emotional wellbeing. . Reduced pressure on NHS and social care services.
Provide employment support.	Local authority employment/jobs department, working with the wider business community.	Retention of workforce and reduced sickness absence.
Develop transport policies that foster social networks and address social exclusion.	Local authority transport department and voluntary and private providers.	Improved social and emotional wellbeing and reduced social isolation. Reduced pressure on NHS and social care services.
Build community capacity, including promoting settled, safe housing and welfare/debt advice.	Local authority housing departments and housing associations and for welfare advice, primary and secondary health services.	Improved health and wellbeing and reduced pressure on NHS and social care services
Encourage social networks and develop wider community engagement, including promoting the 'five ways to wellbeing'.	Involve the community at every step of planning and delivery of schemes/programmes. Develop partnership approaches, with local authorities working in partnership with social care, housing associations, primary care (social prescribing) and other organisations in the public, private, voluntary and community sectors.	Reduced risk of depression; reduced anxiety and enhanced mood and self-esteem; improvement of physical health; improvement of general health, mobility and independence; improved wellbeing and quality of life. Reduction in number of GP and hospital visits and reduced pressure on the social care sector.
Continue work on the Suicide Reduction Action Plan.	Local authorities and health services working with other stakeholders.	Reductions in suicide and the negative impacts on those exposed to suicide.
Build information about mental wellbeing and provide staff training and awareness raising.	Local authorities and health services, working with the local community.	Improved wellbeing resulting from improved awareness.
Gather data and put plans in place to promote good mental health.	Local authorities, Health & Wellbeing Boards, working with clinicians and 'experts-by-experience'.	

3.4 Mental health problems

Why focus on mental health problems?

Common mental health disorders cause marked emotional distress and interfere with daily function. They comprise different types of depression and anxiety and can often remain undiagnosed. Amongst children and young people, it is estimated that that 9.3% of those aged 5–16 years have a clinically diagnosed mental disorder (9.6% in the North West) (122). Across Cheshire and Warrington, estimates are lower than the national and North West average, at 8.4% in Cheshire East, 8.8% in Cheshire West and Chester and 8.9% in Warrington.

Data from GP registers indicates that nationally, around 7.3% of adults are diagnosed with depression (data for 2014/5) (123). However, it is estimated that 50% of patients with depressive disorders do not have their symptoms recognised (124). Based on the national General Practice survey the prevalence of depression is higher at around 12.44% in England. In Cheshire East, levels of depression and anxiety are significantly lower than the national average (**Figure 13**). Levels are similar to the national average in other parts of Cheshire and Warrington, but all are much lower than the North West average of 14.61%. Within Cheshire West and Chester, the area of Vale Royal has significantly higher levels of depression and anxiety. The number of over 65s with depression in Cheshire and Warrington is predicted to increase by 21.4% over the next decade, from 16,167 in 2015 to 19,623 in 2025[vii].

NICE guidelines note the substantial economic impact of common mental health disorders, with annual health service costs for treatment reaching £1.7 billion for depression and £1.2 billion for anxiety in England in 2007. Research suggests the costs may now be substantially higher (125), and by 2026 could reach nearly £3 billion for depression and £2 billion for anxiety (126) . Adding to this the costs of lost employment (£5.8 billion for depression and £7.7 billion for anxiety in 2007) demonstrates the major adverse economic impact of these conditions (127), as illustrated in **Table 1**.

Table 1 also includes the financial impact of more severe mental health disorders, which although less prevalent, also incur substantial costs. Severe mental health disorders include psychotic disorders and personality disorders, and are relatively uncommon. Psychotic disorders produce disturbances in thinking and perception severe enough to distort perceptions of reality. The main types of psychotic disorders are schizophrenia and affective psychosis, such as bipolar

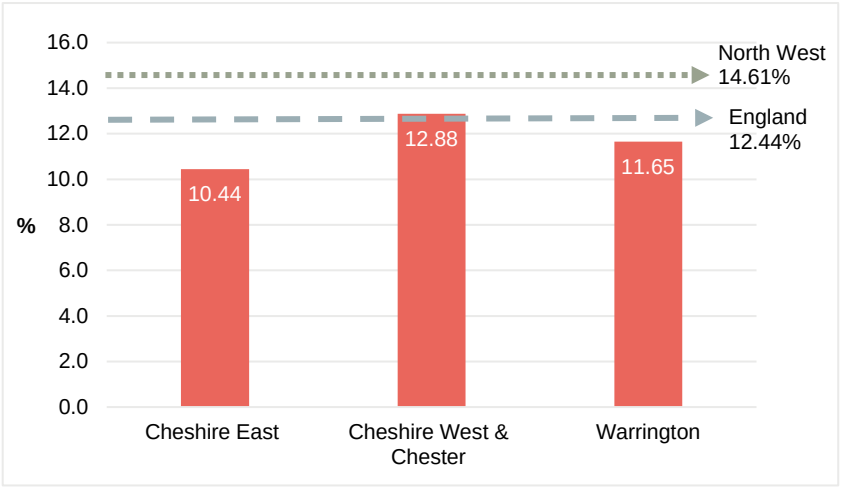

Figure 13: Depression and anxiety amongst people visiting GP, age 18+. Source: PHE Community Mental Health Profiles, GP Patient Survey, 2014/15.

	Service costs (£billion)		Lost earnings (£billion)	
	2007	**2026** including real pay & price effect	**2007**	**2026** including real pay & price effect
Depression	1.68	2.96	5.82	9.19
Anxiety disorders	1.24	2.04	7.7	12.15
Schizophrenic disorders	2.23	3.67	1.78	2.83
Bipolar disorders/related conditions	1.64	2.63	3.57	5.58

Table 1. Current and predicted costs of mental illness in England. Source: McCrone et al, Paying the price. The cost of mental health care in England to 2026. King's Fund, 2008.

[vii] Derived from POPPI data: http://www.poppi.org.uk/

disorder. The 2007 Adult Psychiatric Morbidity Survey (APMS)[viii] reported an overall prevalence of psychotic disorder of 0.4% (93). However, population based surveys may underestimate the prevalence of more severe mental health conditions (128) and data from GP registers indicates a national prevalence of serious mental illness double that estimated from the APMS, at 0.88% for England. **Figure 14** shows that across Cheshire and Warrington, levels of serious mental illness are lower than the national average (significantly so in Cheshire East and Cheshire West & Chester) and much lower than the North West average (122).

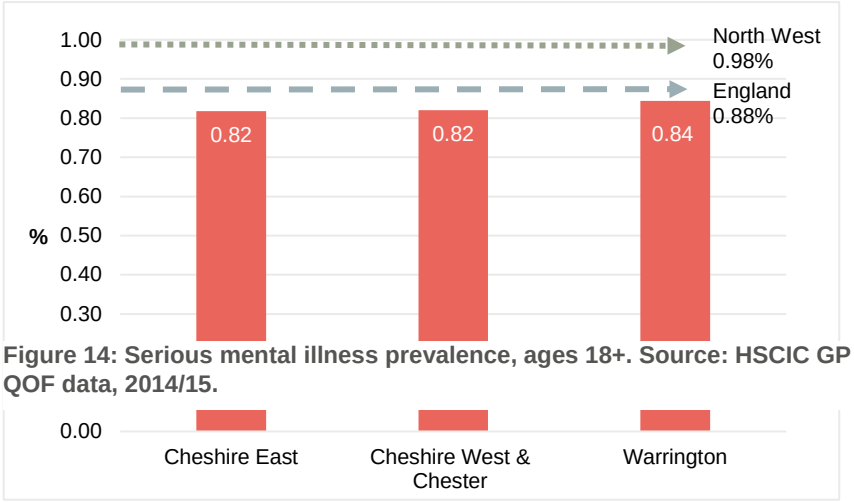

Figure 14: Serious mental illness prevalence, ages 18+. Source: HSCIC GP QOF data, 2014/15.

Although mental health disorders account for 28% of morbidity, they receive only 13% of NHS expenditure. The Royal College of Psychiatrists note that *'under-investment in mental health services and a lack of integration with physical health services has created a bottleneck in health care improvement'* (129). Currently physical and mental health treatments tend to be viewed, and delivered, as separate health services. This means that people with poor mental health are more likely to have poor physical health that goes untreated, or treated too late and vice versa (130). Nearly a third of people with long-term physical conditions have at least one co-morbid mental health problem. This can worsen the person's physical condition and increases the cost of treatment by between 45% and 75% at a cost to the NHS of an estimated £10 billion per year (129).

What can be done?

The challenge is to find creative ways of working to improve mental health in the current climate of welfare reform and benefit cuts. Almost half of Employment Support Allowance (ESA) claims are from people applying primarily because of a mental health problem (131). Welfare reform and cuts to benefits have prompted concerns about the impact of these changes on people with mental health problems and mental health organisations have raised concerns about the Welfare Reform and Work Bill, highlighting the lack of support available to move people with mental health problems back into sustainable employment. Further in their assessment they note that the impact of these changes will likely lead people to seek help from other parts of the system, such as the NHS, and may further impact on their mental health (100). The Five Year Forward View for Mental Health for the NHS in England is a national strategy published earlier this year, covering care and support for all ages. It is first time there has been a strategic approach to improving mental health outcomes across the health and care system. Priority areas identified include the need for improvements in access to high quality services, choice of interventions, integrated physical and mental health care, prevention initiatives, funding and challenging stigma(31, 32). Prevention is a top priority, with specific themes raised including support for new mothers and babies, mental health promotion within schools and workplaces, being able to self-manage mental health, ensuring good overall physical and mental health and wellbeing, and getting help early to stop mental health problems escalating (31).

Start early to reduce the risk of mental health problems

In addition to the steps outlined above in Section 3.3, actions to reduce the risk of mental health problems in children and young people include:

[viii]The results of the 2014 survey will be available in September 2016. http://www.hscic.gov.uk/article/3739/National-Study-of-Health-and-Wellbeing

- *Supporting schools to identify mental health problems sooner*.
  Health and education professionals need to work collaboratively, so that schools can have access to the specialist skills, advice and support that they require to be able to identify mental health problems in their pupils sooner (30)
- *Tackling the problem of lost support as children and young people with mental health needs reach the age of 18*:
  CCGs and Local Authorities will be able to use the specification being developed by NHS England to build on best practice and the evidence from a range of service models to commission high quality services (30, 132, 133). For example services could be based on the model adopted by many UK Early Intervention in Psychosis Teams and some general mental health teams and voluntary counselling agencies, which offer a distinct service for young people up to the age of 25, rather than having a cut-off at age 18 (132).

Tackle the wider determinants of health

Tackling the wider determinants of health will help to reduce an individual's risk of developing mental health problems and assist in support and management if such problems do develop. As mentioned in the previous section, having pleasant, safe outdoor spaces and green spaces can have a significant impact on mental health and wellbeing (98-101), as can access to public transport and the promotion of active travel. Protective factors (and assets) for mental health also include being in employment, having a good education, settled housing, being free from debt and poverty, having good physical health, being physically active and having strong social networks and community engagement (31, 83). Protective factors and assets were discussed in more detail in the previous section, relating to mental health and wellbeing. It is important to tackle the inequalities in these factors that can both contribute to and result from poor mental health. In addition, it is necessary to address inequalities in service provision – in access, experience and outcomes (81).

Box 9: Savings resulting from improved access to services

- Fewer inappropriate referrals to secondary mental health care services (such as community mental health teams).
- Reduced use of hospital-based services as a result of increasing access to services in the local community.
- Costs avoided from reduced use of medications such as antidepressants resulting from successful use of psychological interventions. The annual cost of antidepressants per patient is estimated to range from £189 to £449.
- Fewer GP visits to monitor progress and response to medication.
- Fewer GP visits due to earlier identification, particularly for people presenting with medically unexplained symptoms.
- Wider economic savings due to the improved employability of people recovering from a common mental health disorder. This would deliver savings in the form of additional tax receipts and reduced welfare benefits payments.

NICE 2011: Common mental health disorders: identification and pathways to care

Improve the early identification of mental health problems

Pregnancy and childbirth: Identification and treatment of anxiety and depression for women during pregnancy and after childbirth is one of the nine priority areas identified by the Centre for Mental Health where there is good evidence of cost-effective interventions that are not currently available widely (see **Box 9**). This could be achieved with more screening and assessment, and provision of psychological therapy to all who would benefit. This would be cost effective, reducing health service use by both mothers and children (22) (see also **Section 3.1 'Best start in Life'**).

Training and awareness raising: There is a need to improve awareness of mental health issues amongst staff in various sectors relating to vulnerable groups, for example housing sector staff and frontline staff in primary care (83). Housing associations, for example, have an important role in offering appropriate support and accommodation to people recovering from a mental health problem (106). They can also play a role in signposting people to relevant community-based mental health services and work with mental health providers to ensure treatment is provided in appropriate settings.

The current under- identification of depression in primary care indicates that greater investment in training to identify and assess depression may be required. A positive image of mental health should be promoted, emphasising that recovery from mental illness is possible (127).

Improve access to services and therapies

Evidence suggests the need for **prompt access to mental health services for all**, with strong community mental health teams, which work alongside primary care services and allow for familiarity and continuity of care (30, 129). **Integrated services across primary and secondary care**, which take a collaborative approach to service development (for example, involving service users, their families and carers in service redesign where possible) are most effective (81). Improving access to services for those with common mental health problems will lead to significant cost savings (see **Box 9**) (127, 134, 135) . NICE guidelines suggest that local needs assessments are used as the basis for the structure and distribution of services across settings (127, 134, 136).

There is a need for improved access to psychological therapies, including for children and young people (30). Providing **psychosocial interventions** for people with depression is effective and can reduce an individual's usage of NHS services (both physical and mental health services), with good rates of recovery in the short term and significantly reduced rates of relapse in the longer term (22, 127, 137) . In addition to reduced health costs, other expected outcomes include reduced long-term disability and premature mortality; improved employment and training prospects; and the prevention of relapse (127). For those with psychosis or schizophrenia, it is recommended that Cognitive Behavioural Therapy (CBT) should be offered, started either during the acute phase or later, including in inpatient settings (73, 137, 138). **Structured exercise** may also be considered as a treatment option for patients with depression (139).http://www.sign.ac.uk/pdf/sign114.pdf

NICE guidelines on the prevention and management of more serious mental health problems note the importance of early assessment and referral without delay to a specialist mental health service or **an early intervention in psychosis service,** which can promote recovery and prevent relapse (22, 73, 137, 138, 140, 141) (and see **Box 10**).

Box 10: The nine priorities for investment in mental health

Where there is good evidence of cost-effective interventions that are not currently widely available.

1. Identification and treatment of anxiety and depression for women during pregnancy and after childbirth
2. Treatment of conduct disorder in young children
3. Early intervention services for first episode psychosis
4. Liaison psychiatry services in acute hospitals
5. Integrated care for people with long-term physical and mental health conditions
6. Improved management of medically unexplained symptoms and related complex needs
7. Supported employment services for people with severe mental illness
8. Community-based alternatives to acute inpatient care for people in a crisis
9. Interventions to improve the physical health of people with severe mental illness, especially smoking cessation.

Centre for Mental Health (2016) https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report

Improve the types of management and support available

Employment: (also see **Section 3.2 'Worklessness and Workplace Health'**) The evidence that work can promote good physical and mental is strong (22, 57). Stable employment promotes recovery for people with mental illness, particularly for younger adults with a recent diagnosis, and enhances income and quality of life (22, 142). New approaches should be developed to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work (30). It is important to support employers to help more people with mental health problems to remain in or move into work (22, 30) (see **Box 10**). **Individual Placement and Support** (IPS) is beneficial for people with

severe mental health problems [72]. Early referral to workplace based support for vulnerable employees and those experiencing personal crises or psychiatric symptoms can help to avert employment breakdown and aid recovery (30, 31, 83). Vocational rehabilitation can help to overcome barriers to working (143). Awareness raising and training for employers is necessary to help to overcome the disadvantages faced by people with a history of mental illness in the open employment market. Such disadvantages include stigma, a reluctance to employ people with mental health problems and the 'benefits trap' (143). NICE noted the importance of identifying and offering assistance with any employment, education and financial problems that may result from the behaviour associated with an individual's mental health condition. If the individual agrees, this could include talking directly with employers, education staff and creditors about mental health conditions and their possible effects, and how the person can be supported (140).

Good quality settled housing: Poor housing or homelessness can contribute to mental ill health or can make an episode of mental distress more difficult to manage (144, 145). Stable housing can help to aid recovery(31). People with mental health problems face inequalities in access to good-quality, affordable, safe housing (83). Actions to improve the situation include the following:

- Ensure that more people with mental health problems live in homes that support recovery (30), for example the Government have suggested exploring the case for using NHS land to make more supported housing available for vulnerable people with mental health problems (31).
- Give consideration to making it a requirement that social landlords recognise and refer tenants with mental health problems.
- Encourage housing and health agencies to work together, recognising that housing problems are frequently cited as a reason for a person being admitted or re-admitted to inpatient mental health care.
- Ensure housing sector staff (for example, Local Authority Homeless Persons Units) have awareness of mental health issues. Also ensure mental health support staff have greater awareness of housing issues.

Develop partnerships between physical and mental healthcare and other public services

The government is committed to ensuring that mental health care and physical health care will be better integrated at every level (30-32). The new 'Five Year Forward View' mental health strategy calls for the provision of 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 (31). Parity between physical and mental health can often be improved with small changes in service provision, such as training (physical) clinicians and other professionals in mental health screening and brief interventions. Including these changes in existing service specifications can be low cost (130). NHS England note that many of the people who require support for mental health issues from the NHS are the same people who are interacting with other public services, such as housing, the criminal justice system or other parts of the NHS. This presents the opportunity to design services and draw up contracts that build in these local partners. NHS England note the key to achieving parity between physical and mental health is to design services that are integrated and 'wrap around' the service user no matter whether their needs are physical, mental or social. Various contracting arrangements that will incentivise integration are suggested (22, 130, 146) (also see **Box 10**).

Summary of interventions for mental health problems

Evidence based intervention	Action by who/ level	Impact
Risk reduction		
Support schools to identify mental health problems	Local authorities, schools and health services working in partnership (academies & role of LA?)	Improved social and emotional wellbeing and reduced prevalence and incidence of mental health problems. Reductions in health service use.
Improve the transition between child and adult mental health services		
Tackle the wider determinants of health and develop community assets, which will increase resilience (see p.30).	Local authority departments working in partnership, including planning, transport, employment/jobs, housing, environmental health and public health.	
Provide employment schemes (e.g. IPS) and support and supported housing	All local authority departments, working with the wider business community, the NHS, housing providers and other agencies.	
Gather data and put plans in place to promote good mental health (see p. 30)	Local authorities, Health & Wellbeing Boards, working with clinicians and 'experts-by-experience'.	
Early identification and management		
Identify women with anxiety and depression during pregnancy and childbirth	Health visitors and primary care	Improvements in early identification and management of mental health problems.
Training and awareness raising for staff in various sectors.	All local authority departments and primary care	
Improved access to services and therapies, for common mental health problems and more serious mental health problems.	NHS commissioners, with community mental health teams working alongside primary care services.	
Develop partnerships between physical and mental health care and other public services	Primary and secondary health services working with local authority departments and the voluntary sector.	'Parity of esteem' between mental and physical health care

4 Conclusions

This report has outlined a range of key actions that can be taken to address public health challenges in the Cheshire West & Chester, Cheshire East and Warrington Sub-region. Direct collective and collaborative local action with an emphasis on tackling the social determinants of health is key for achieving sustainable improvements in health and wellbeing and to reduce health inequalities.

In addition to interventions to address specific public health challenges this report identifies a number of cross cutting themes that can help to maximise improvements in health and wellbeing.

- Identifying needs early throughout the life course and having appropriate support in place to address these needs.
- Developing integrated 'wrap around' services to meet needs whether they be physical, mental or social.
- Improving access to high quality employment and training for local residents, and supporting those with long term conditions to remain in work.
- Improving the quality and affordability of housing, recognising that housing problems contribute to, and exacerbate, poor health and wellbeing.
- Action to support wider community engagement and development of social networks.

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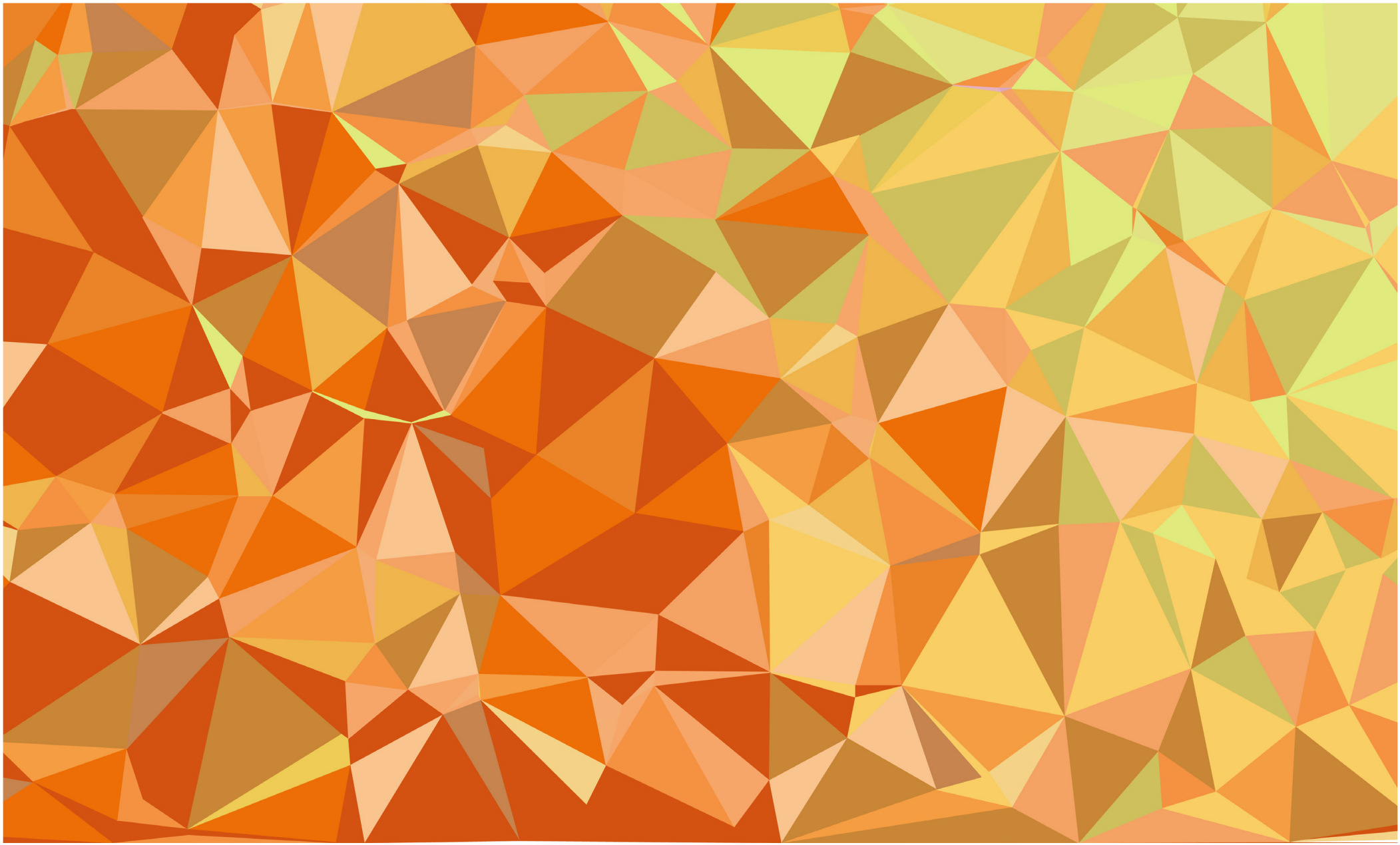

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