Barking and Havering Health Authority

Annual Report of the Director of Public Health 1999/2000

Health in the Barking Primary Care Group Area

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Executive summary

Barking is an area of high deprivation and the population has many social and economic characteristics that have an adverse effect on health. Adult literacy levels are low, unemployment rates high and the proportion of people living on low incomes high, as evidenced through people claiming benefits. Some aspects of the physical environment are poor, with a third of people having no central heating. All these factors will contribute to poorer health.

Overall death and illness rates are higher than London and national rates and are the highest of Barking and Havering Health Authority's (BHHA) primary care group (PCG) areas. Trends in all cause death rates in all age groups over the last decade show a general decline but the decline is less than the national decline. Thus, Barking is not keeping pace with the general improvement in health nationally and is becoming relatively worse off. High death rates are also reflected in high admission rates for all ages, except children, and hospital admission rates for women 15-64 years are the second highest in London.

Barking continues to have significantly higher death rates from coronary heart disease (CHD) than national rates. Although trends in CHD deaths have been declining, the decreases have not been as great as national decreases, particularly for males under 65 years.

Deaths from lung cancer remain extremely high and, unlike the national picture, lung cancer is the most common cause of death from cancer in women. Lung cancer deaths in Barking women are generally increasing. There have been substantial improvements in death rates for colorectal and stomach cancers.

High levels of smoking related diseases are a major reason why death rates in Barking are so high. Cancer, CHD and respiratory diseases are all strongly associated with smoking. Concerted efforts to reduce smoking would have major health benefits for the population. A smoking cessation programme is due to start and this should be strongly supported by all primary care staff.

Hospital admissions for asthma are a significant problem in Barking, which has the highest admission rates for asthma in London. Adult admissions in particular are high. Asthma admissions are undesirable and inconvenient for patients and expensive in care terms. Improved patient education and better symptom control may prevent many admissions. Better understanding of the reasons for the high admission rates would be beneficial. Nurse led training for asthma sufferers and improved practice nurse training may help to reduce admissions.

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The purpose and sources of this report

Purpose
This is the third information pack produced on Barking. The intention is to provide an overview of some of the main health issues that we have derived from routinely available data, or from specific projects that have been undertaken about local health. Key health areas are considered and recommendations made on the basis of the information available.

In this pack reports and recommendations have been contributed by community nurses, using their local knowledge and expertise, and by the Health Promotion Department, as well as by members of the Public Health Department.

The choice of topics has been partly determined by national priorities in the *Our Healthier Nation* strategy and by local priorities. However, other areas have also been considered where they have been thought to be of interest.

Sources of information
Hospital activity data and death rates data are routinely available to the Health Authority. Where possible these have been configured into PCG areas. The Health of Londoners Project has recently produced a report of health in London at PCG area level (*Mapping Health for Primary Care Groups, 2000*) and this has enabled comparisons to be made with other London PCGs.

Some nationally produced data are only available at borough level. Data have, therefore, been presented for the London Borough of Barking & Dagenham (LBBD) rather than down to PCG area level.

Data on social variables are mainly derived from the 1991 census, which inevitably will be out of date for some things. However, Barking has a relatively stable population, particularly compared to other London populations and much of the picture presented probably still holds true in 2000. Some more up-to date data are presented where available.

Community nurses' reports have used routinely available data and their own local knowledge of services and needs to provide a richer understanding of the local community.

Authors
This report was prepared by the Public Health lead. Other contributions are acknowledged in the report.

The population of Barking

The public health data set for 1999/00 is available on our website
www.bhha.org.uk

An update on population characteristics
We have previously reported that the population of Barking is a deprived one. Most of our information about social variables is derived from the 1991 census, which will not be updated until after 2001. However, further census information and some more recent socio-economic data from other sources are presented here.

The population of adults aged under 75 years with limiting and longstanding illness or permanent sickness is considerably higher than in London and is 16th and 14th highest respectively out of 66 London PCGs: see Table 1. A third of people have no central heating – the highest in London: see Table 2. This will have significant effects on health, particularly in winter. This is likely to contribute particularly to respiratory disease.

Table 1 Census-based indicators of long-term illness, BHHA by PCG area and London

Area	Standardised limiting long-term illness ratios for household residents aged under 75	Rank relative to other PCGs in London	% of total adult population unable to work due to permanent sickness	Rank relative to other PCGs in London	% of adults in households recorded as unable to work due to permanent sickness	Rank relative to other PCGs in London
Barking PCG	115	16	4.0	16	3.9	16
Dagenham PCG	114	17	4.1	14	4.0	14
Hornchurch PCG	82	51	2.6	51	2.5	48
Romford PCG	87	47	2.8	46	2.7	45
Upminster PCG	87	46	3.2	36	2.9	39
London	100	N/A	3.4	N/A	3.2	N/A

Source: Mapping Health for Primary Care Groups, Health of Londoners Project, 2000

Table 2 Selected census-based indicators affecting need or access to health services

Area	% of households with no car available to household members	Rank relative to other PCGs in London	% of households without central heating	Rank relative to other PCGs in London
Barking PCG	44	23	34	1
Dagenham PCG	40	31	33	2
Hornchurch PCG	25	63	13	55
Romford PCG	27	60	17	38
Upminster PCG	27	52	14	51
London	41	N/A	19	N/A

Source: Mapping Health for Primary Care Groups, Health of Londoners 2000

Educational levels in general are lower than in most of London. In LBBD adult literacy is third lowest in the country. The proportion of people with post A level qualifications, at 5.3%, is less than a third of the London average of 17.5%, and is the second lowest in London, Dagenham being the lowest. This is likely to have implications for how health information is presented to people. This was highlighted in the National Survey of Patients' Views of General Practice in which it was found that Barking, Dagenham and Havering respondents were much more likely than people in other parts of the country to feel that they had not been given enough information by their doctors. They were also less likely to feel that they had understood information that they were given.

Improving the quality, quantity and accessibility of information that is given to patients should be a priority for primary care as this is likely to encourage earlier presentation of serious disease and improve compliance with treatment regimes.

Compared to the London average, a higher proportion of people are claiming benefits and family credit and income support. Rates for people claiming disability allowances are also high. Barking has the fourth highest attendance allowance rates for people over 65 years, second highest rates for disability allowances for people under 65 years, and the 7th highest rates for incapacity allowance for people of working age: see Table 3.

Over half the population lives in rented accommodation – 54% at the 1991 census – primarily local authority housing. In some wards, e.g. Gascoigne, this is nearly 80%. Unemployment figures in 1999 were twice as high in Barking as in Havering. Unemployment rates in Thames, Gascoigne and Abbey, were the highest in BHHA. There is known to be a link between unemployment rates and illness.

Table 3 Proportion of the population in receipt of 'disability benefits'

Area	Attendance allowance/ 1000 residents aged >65	Rank*	Disability living allowance /1000 residents < 65	Rank*	Incapacity benefit/ 1000 residents aged 15 – pension age	Rank*	SDA/1000 residents aged < 65	Rank*
Barking PCG	163	4	44	2	81	7	5.7	31
Dagenham PCG	175	1	51	1	80	8	6.3	19
Hornchurch PCG	117	40	28	39	45	45	4.3	61
Romford PCG	141	13	32	20	49	38	5.4	38
Upminster PCG	124	33	34	13	48	39	6.9	10
London	124		29		55		5.7	

*Out of 66 PCGs in London

Source: Mapping Health for Primary Care Groups, Health of Londoners 2000

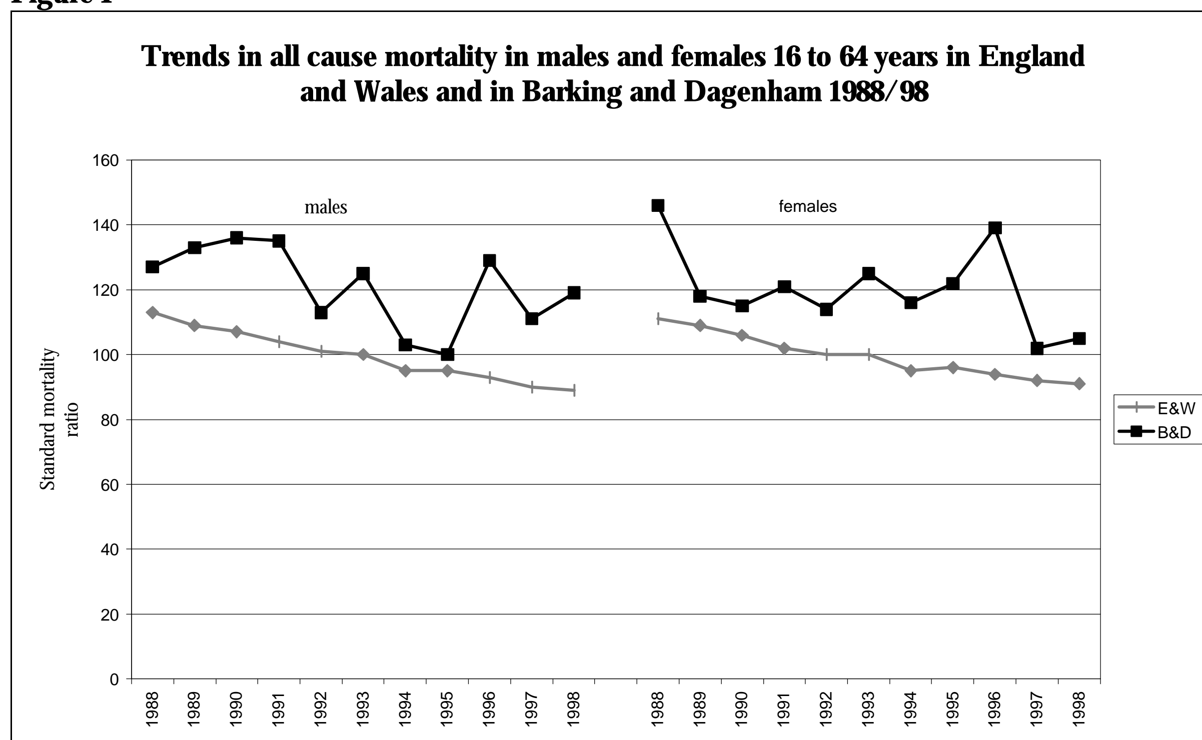
In previous information packs we have reported on local smoking rates. It has been estimated that differences in smoking rates account for two thirds of the differences in death rates between different social groups. Thus reduction in smoking would have major health benefits in reducing illness and death rates from respiratory disease, CHD and cancer.

Rates of death and illness

Deaths from all causes

Barking has significantly higher death rates at all ages than London and significantly higher premature death rates than Havering or London. Trends in deaths over the last decade for LBBD show that for men, although there has been an overall decline, that decline has not been quite as great in Barking as for the country as a whole: see Figure 1. Relatively speaking therefore men are worse off in Barking than they were ten years ago. For women, however, the trends have been similar to the national trend. Premature deaths – that is, of people aged under 65 years – have been consistently higher in Barking for both men and women and there has not been a consistent pattern of decline.

Figure 1



Standardised Mortality Ratio: England and Wales in 1993 = 100
Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Table 4 Hospital admissions, all cases and emergencies

Area	All admissions		Emergencies	
	SAR*	95% CI**	SAR*	95% CI
Barking PCG	114	112 - 116	116	113 - 119
Dagenham PCG	109	108 - 111	113	110 - 115
Hornchurch PCG	88	87 - 90	88	85 - 90
Romford PCG	98	96 - 99	98	96 - 101
Upminster PCG	93	91 - 94	95	92 - 97
London	100		100	

* SAR= standardised admission ratio; i.e. age standardised admission ratios standardised to London rates
** CI = confidence intervals
Source: Mapping Health for Primary Care Groups, Health of Londoners 2000

Hospital admission rates
Overall admission rates for Barking are the highest of London PCGs areas (see Table 4). However, there is variation between different age groups. Admission rates for children are similar to London average rates, whilst those for women aged 15-64 years are very high: see Table 5.

Table 5 Hospital admissions per 1,000 population by age group, Barking 1997/98

Age group	Barking		London
	Rate per 1,000	Rank*	Rate per 1,000
0-14 years	81.0	32	82.9
15-64 years males	142.4	10	122.4
15-64 years females	239.2	2	197.8
65+ years	438.0	6	389.4

*Out of 66 PCGs in London
Source: Mapping Health for Primary Care Groups, Health of Londoners 2000

Whilst high admission rates are likely to reflect the poorer health of the Barking population and therefore a greater need for health care, the PCG should look critically at whether admissions in some areas could be reduced. Although emergency admission rates in Barking are not as high relatively as all admission rates, they still remain high in comparison to other London PCG areas. High emergency admissions can suggest that care in the primary setting could be improved.

Cancers

Author: Dr Frances Haste

Key points of interest

For LBBD as a whole

- Cancer causes 27% of deaths, but 35% of deaths in people under 65 years.
- Lung cancer is the most common cause of cancer deaths in males and in females.
- Cancer death rates are consistently higher than London rates.
- Deaths under 65 years are 5th highest for males and 2nd highest for females in London.
- There has been a decline in lung cancer death rates in males similar to national patterns but death rates in females are increasing.
- There has been a substantial decline in death rates from both colorectal and stomach cancers which is larger than national patterns.
- There has been a decline in deaths from breast cancer similar to the national picture but rates continue to be higher than national rates.

For Barking in particular

- Death rates from cancer in males were the 8th highest in London in 1998.
- Death rates from lung cancer were significantly higher than in London in 1998.
- Death rates from breast cancer were lower than national and London rates.

Key action points

- Reduction in smoking would have major health benefits in Barking. Primary care should encourage a range of smoking prevention measures.
- Early detection of cancer is vital to survival. GPs should follow the new cancer referral guidelines to encourage early detection and treatment.
- GPs should encourage eligible women to attend for breast screening.

Sources and forms of data

Information about trends in death rates from cancer is based on data for the Local Authority area. Recent years' death rates are based on the registered population of the PCG area except where otherwise stated. Standardised death rates ratios provide a comparison with national figures where the England and Wales rates are standardised to 100. Males and females are standardised separately. Data have recently become available for all 66 PCGs in London and these have been used for comparison where appropriate.

Deaths from cancer: all age groups

Numbers of deaths from each tumour type in LBBD in 1998 are detailed in Table 6. Lung cancer was the most common cause of death in both men and women, although nearly twice as common in men. Breast cancer was the next most common in women and prostate cancer next most common in men.

Table 6 Cancers: numbers of deaths by major tumour site and sex, LBBD 1998

Site	Males	Females
Lip, oral, pharynx	2	3
Digestive system	49	52
• oesophagus	9	6
• stomach	13	4
• lower gastrointestinal tract	12	24
• pancreas	7	12
Respiratory system	82	46
• larynx	1	1
• bronchus, trachea, lung	81	45
Skin	4	1
Breast	-	40
Genito-urinary system	48	37
• uterus	-	5
• cervix	-	5
• ovary	-	12
• prostate	26	-
• bladder	17	9
• kidney	5	1
Nervous system	5	4
Lymphatic/haematological	14	8
All sites	**242**	**222**

Source: Public Health Mortality File

Male cancer death rates in all age groups in Barking are the 8th highest in London out of 66 PCGs. Female cancer death rates are similar to the London average.

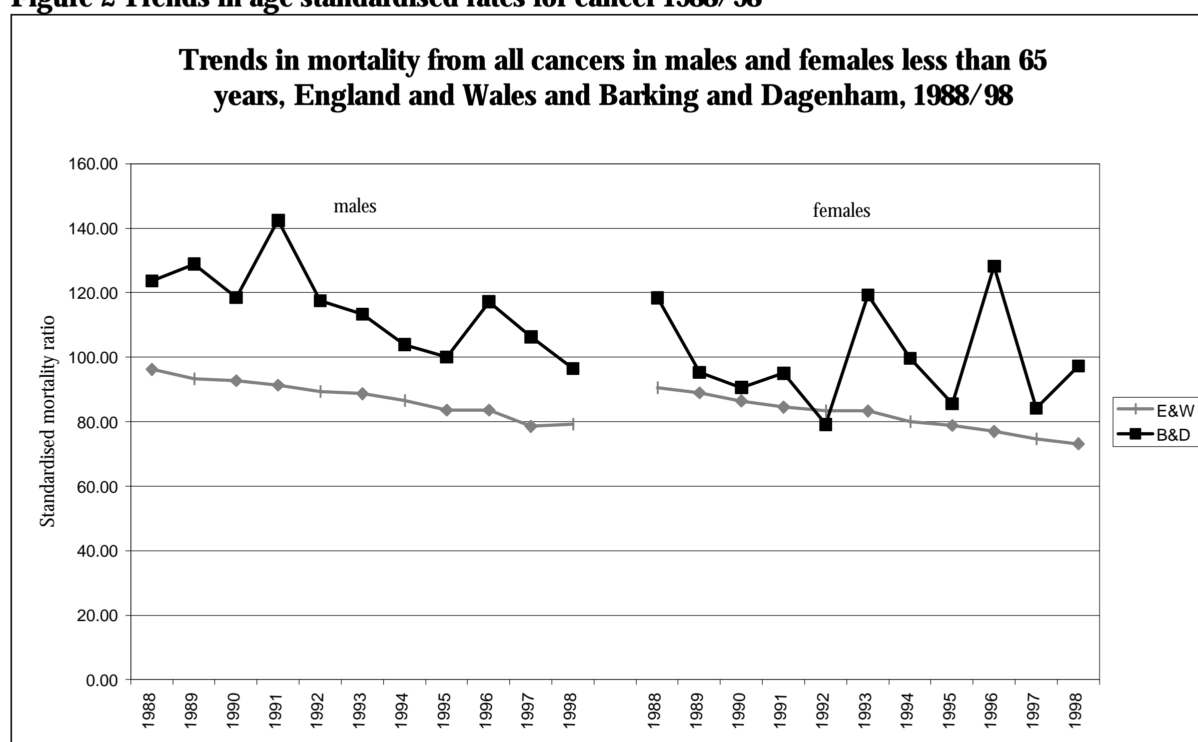
Premature deaths from cancer

Cancer accounted for 30% of all male deaths and 25% of all female deaths in 1998. For the same period it accounted for 35% of deaths of people aged under 65 (27% of male deaths and 51% of female deaths).

In line with national trends, there has been a general decrease in LBBD in deaths from cancer for people under 65 years of about 25% in the last decade. However, rates in LBBD still remain considerably higher than nationally: see Figure 2. In 1998 the death rate in males was 5th highest in London and for females it was 2nd highest in London. There has been a greater decline for men than for women.

Using the registered population base, there were 94 deaths from cancer in people under 75 years in Barking in 1998. Death rates in Barking were slightly higher than London rates: see Table 7.

Figure 2 Trends in age standardised rates for cancer 1988/98



Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Table 7 Cancer death rates: Barking, London and England and Wales 1997/98

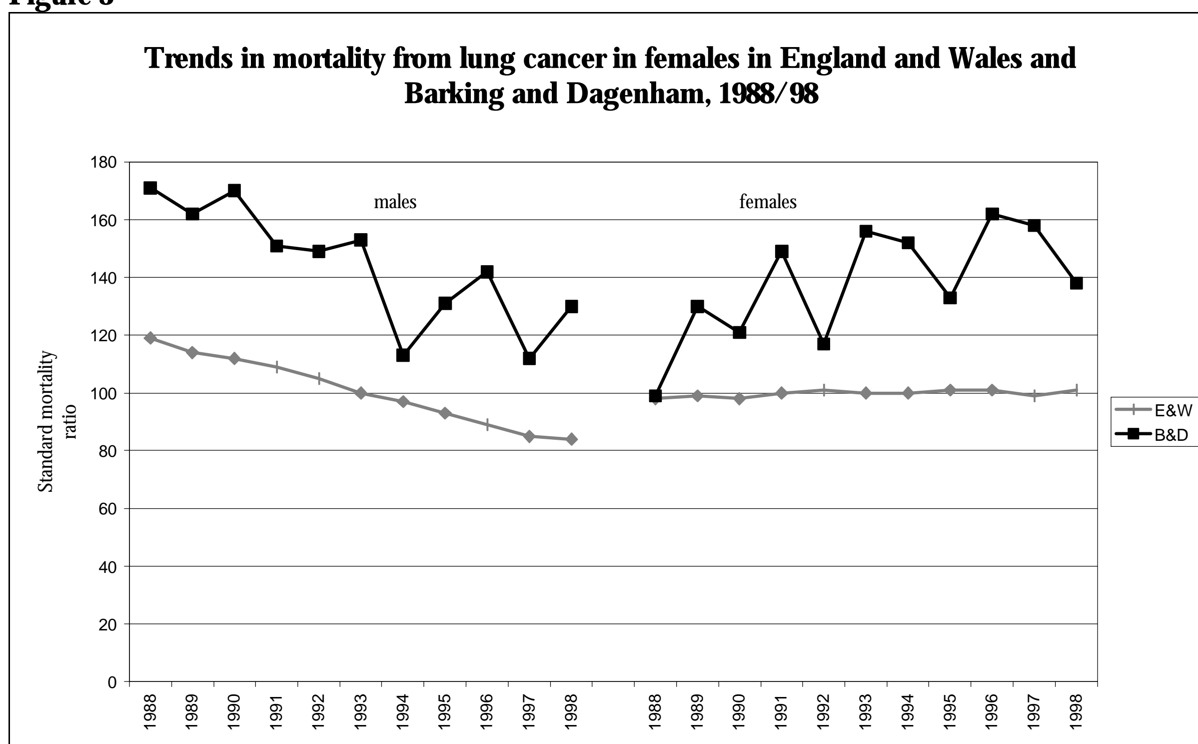
Area	Cancer in males, all ages SMR*	Cancer in females, all ages SMR*	Death rates in people less than 75 years Rate per 100,000
Barking	112	102	145
London	101	101	138
England and Wales	100	100	135

Standardised Mortality Ratio where England and Wales =100.
Source: Mapping Health for Primary Care Groups, Health of Londoners Project, 2000

Lung cancer

Lung cancer rates in Barking in 1997/98 are significantly higher than London rates and are in the highest fifth of London PCG areas. Trends in deaths from lung cancer in LBBD show that, for females, although rates were higher in 1998 than in 1988 the trend for the last three years has been downward. This is not the case for males, although the overall trend over the decade is downwards: see Figure 3. However, deaths in men under 75 years have been decreasing and were the lowest in 1998 for ten years. They still, however, remain amongst the highest in London.

Figure 3



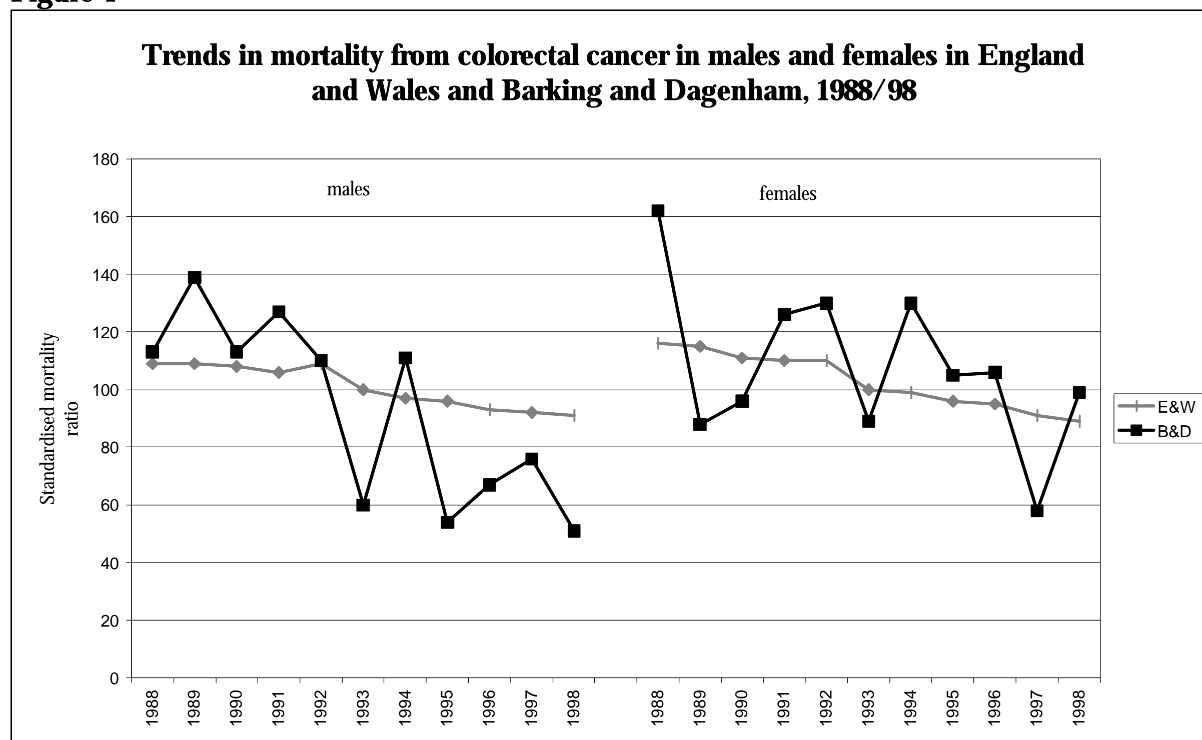
Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring 1999

Colorectal cancer

There have been substantial improvements in death rates from colorectal cancer in LBBD in the last decade. In men it has more than halved and in women it has reduced by a third: see Figure 4.

Overall rates are lower than both London and national rates. LBBD had the third lowest rates in London for men and eighth lowest rates for women in 1998.

Figure 4



Standardised to England and Wales = 100 in 1993
Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring 1999

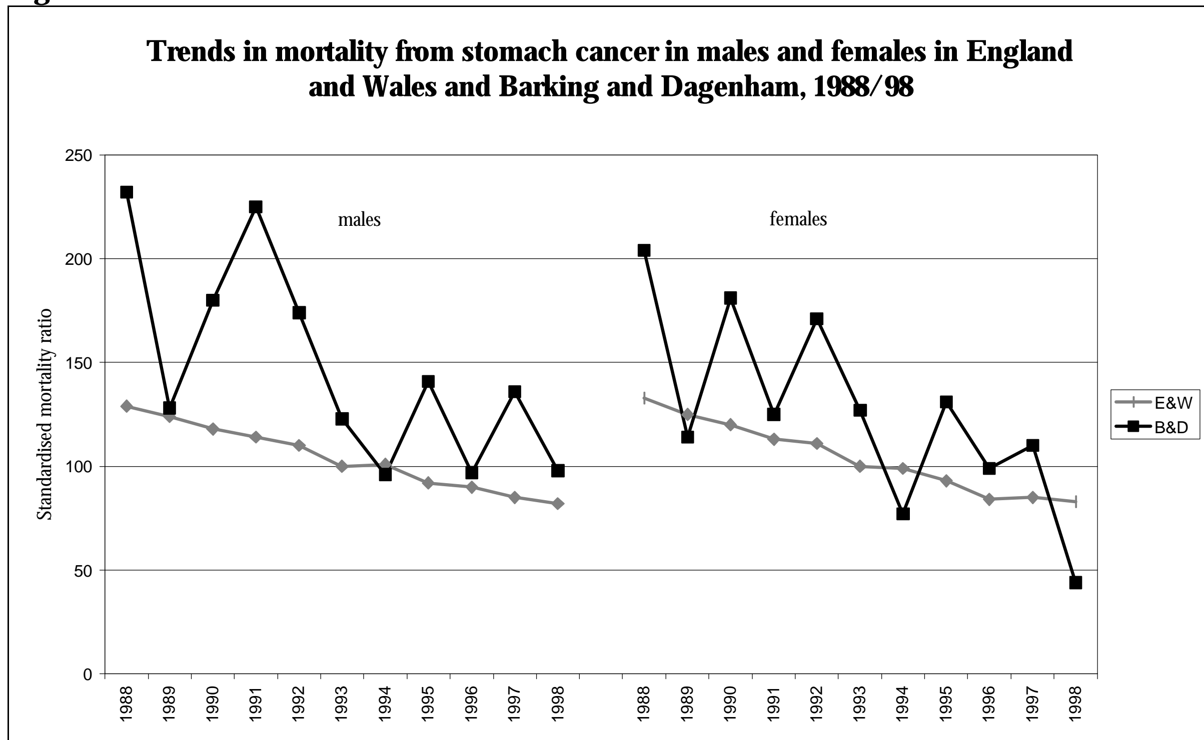
Stomach cancer

Death rates from stomach cancer have halved in the last ten years in LBBD: see Figure 5. Rates are slightly lower than the London average and lower than national rates.

Breast cancer

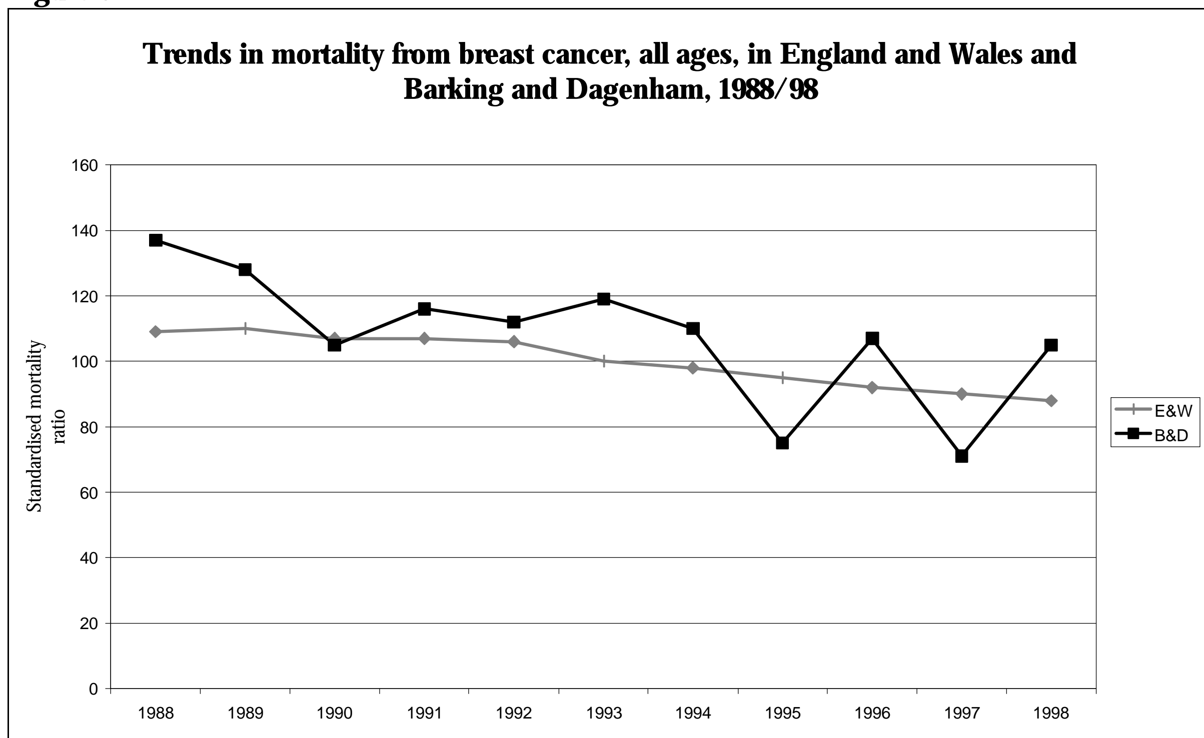
Death rates from breast cancer nationally and in London have shown a steady decline of about 20% in the last ten years. Although there has been some decline in LBBD, rates remain high, although variable from year to year: see Figure 6. In 1998 deaths in LBBD were amongst the highest in London. However, deaths in the previous year were relatively low.

Figure 5



Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Figure 6



Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Coronary heart disease

Author: Dr Mark Ansell

Key points of interest

- CHD remains second only to cancers in terms of deaths caused
- There has been some improvement in terms of death rates.
- However, death rates from CHD remain worse in Barking than in any other local PCG area.
- Admission for heart failure is considerably higher than in any other local PCG area.

Key action points

- Barking, in common with all PCGs must address the National Service Framework for CHD, specifically standards three and four regarding the management of patients with, or at high risk of, CHD. To do this the PCG must assist all practices to develop and maintain disease registers and systematically provide the patient so identified with effective care.
- The PCG should consider how it could reduce admission for heart failure.
- The PCG must also, as a commissioner, engage with NHS Trusts to maintain and improve the management of CHD in hospital.

Summary of trends in death rates
There were 425 deaths from CHD in Barking in the three-year period 1997/99. This represents a 5% reduction on the preceding three-year period: see Table 8.

Sixty-three people under 75 years died from CHD during 1997/99. This represents a 20% decline on the preceding three year period: see Table 9.

Despite the observed decline, CHD remains second only to 'all cancers' in terms of deaths caused in Barking, BHHA and the country as a whole. CHD causes about a quarter of all deaths and about one fifth of deaths in persons aged under 65 years.

Nationally, death rates from CHD continue to decline steadily. The picture in LBBD is less clear: see Figures 7 and 8. Much of the recent decline can be attributed to a reduction in death rates among men aged 65-74. However, a downward trend among women of similar age, and among younger people, is less evident.

Rates of death are higher in Barking than in any other local PCG area. They are also significantly higher than in London or England as a whole: see Tables 8, 9 and 10.

Death rates across all wards in Barking, other than Longbridge, are consistently high: see Tables 11 and 12.

Rates of revascularisation in Barking are higher than those observed in other local PCG areas and are similar to the London average. Even so, rates will have to rise considerably to achieve the ultimate target established in the CHD National Service Framework: see Table 13.

Rates of admission for heart failure, seen as an indicator of effective primary care management, are consistently higher than the Health Authority average and may be increasing: see Figure 9.

Detail of trends in death rates

Table 8 CHD: death rates for persons of any age by PCG area, 1994/96 to 1997/99

Area	1994/96			1997/99		
	No.*	Rate*	SMR*	No.*	Rate*	SMR*
Barking PCG	**446**	**207.5**	**108**	**425**	**190.4**	**114**
Dagenham PCG	866	191.6	103	796	170.6	104
Hornchurch PCG	575	180.1	99	509	157.4	98
Romford PCG	590	176.1	97	516	149.1	95
Upminster PCG	605	177.6	94	530	147.4	92
LBBD	1312	197.0	105	1221	177.3	108
London Borough of Havering (LBH)	1770	177.3	97	1555	151.4	95
BHHA	3082	184.8	100	2776	161.3	100

* No. = number of deaths recorded.
Rate = the directly aged standardised death rates. Rate/100,000.
SMR = standardised mortality ratio
Source: Public Health Mortality File

Table 9 CHD: death rates for persons aged under 75 years by PCG area, 1994/96 to 1997/99

Area	1994/96			1997/99		
	No.*	Rate*	SMR*	No.*	Rate*	SMR*
Barking PCG	**80**	**70.3**	**138**	**63**	**55.4**	**142**
Dagenham PCG	112	50.6	100	95	43.6	111
Hornchurch PCG	87	43.1	85	70	34.9	89
Romford PCG	81	41.0	81	70	35.4	91
Upminster PCG	106	56.7	112	61	32.6	83
LBBD	192	57.2	113	158	47.7	122
LBH	274	46.7	92	201	34.3	88
BHHA	466	50.6	100	359	39.1	100

* See above
Source: Public Health Mortality File

Table 10 Ischaemic heart disease: death rates, all ages, BHHA PCG areas, London and England 1997/98

Area	SMR	95% Confidence interval
Barking PCG	**115**	**104 – 128**
Dagenham PCG	109	99 – 120
Hornchurch PCG	90	80 – 101
Romford PCG	104	95 – 115
Upminster PCG	96	87 – 107
London	92	90 – 93
England	100	

Source: Mapping Health for Primary Care Groups, Health of Londoners Project, 2000

Table 11 CHD: deaths of persons aged under 75, Barking by ward, 1992/95 to 1996/99

Ward	1992/95				1996/99			
	Annual rate per 100,000 population	SMR	Deaths over period	Rank in 1992/95	Annual rate per 100,000 population	SMR	Deaths over period	Rank in 1996/99
Abbey	165	144	44	1	122	129	29	7
Cambell	117	108	44	18	131	144	44	3
Eastbury	142	135	45	4	117	125	33	12
Gascoigne	158	141	43	2	111	116	27	16
Longbridge	74	69	32	41	65	74	26	38
Parsloes	132	128	45	10	120	132	36	5
Thames	131	131	42	6	136	146	37	2

Source: Public Health Mortality File

Table 12 CHD: deaths of persons of any age, Barking by ward, 1992/95 to 1996/99

Ward	1992/95				1996/99			
	Annual rate per 100,000	SMR	Deaths over period	Rank	Annual rate per 100,000	SMR	Deaths over period	Rank
Abbey	259	126	88	4	273	158	94	2
Cambell	198	100	93	26	210	117	95	9
Eastbury	223	115	87	10	198	107	74	14
Gascoigne	236	117	81	6	192	104	65	16
Longbridge	144	76	86	42	141	86	85	37
Parsloes	220	115	96	9	195	104	78	17
Thames	234	129	78	2	248	144	78	3

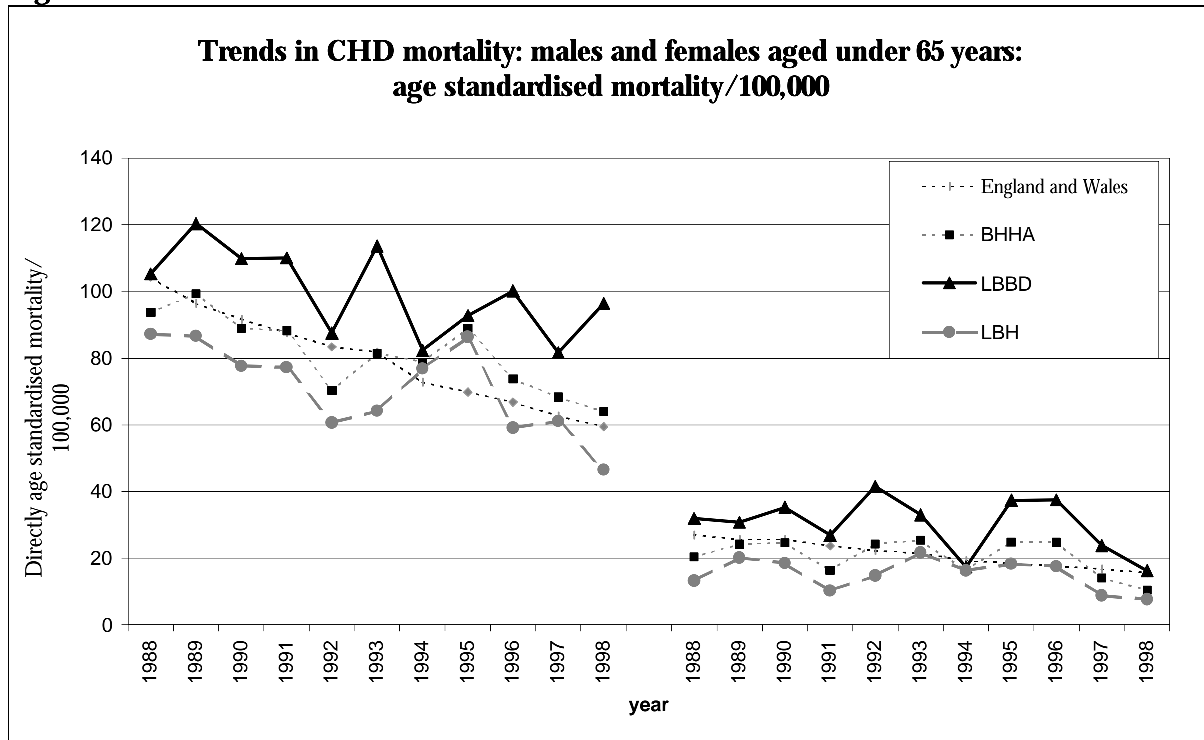
Source: Public Health Mortality File

Table 13 Coronary artery bypass grafts (CABG) and percutaneous translumenal angiography (PTCA): age standardised hospital admission rates (ASR), BHHA by PCG and London

Area	ASR	95% CI
Barking PCG	**62.7**	**45.5 - 86.4**
Dagenham PCG	35.4	24.4 - 51.3
Hornchurch PCG	51.2	38.0 - 69.0
Romford PCG	45.0	33.2 - 61.0
Upminster PCG	35.7	24.8 - 51.4
London	78.2	76.0 - 80.5

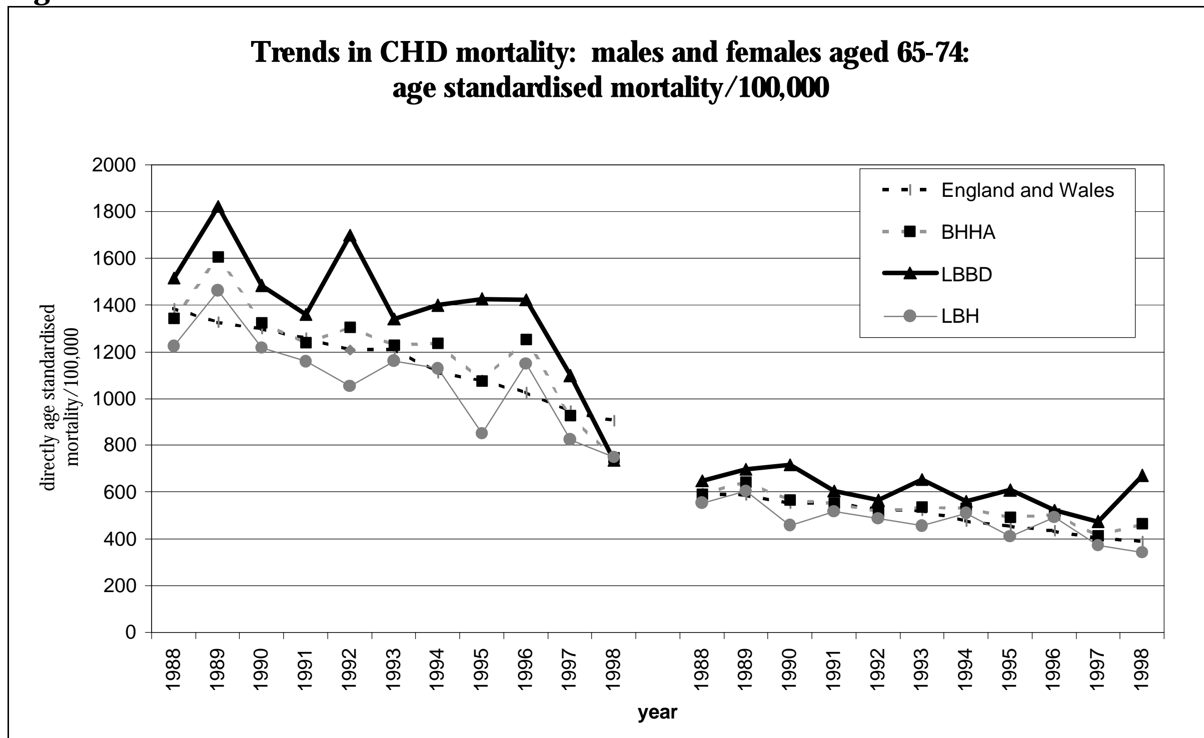
Source: Mapping Health for Primary Care Groups, Health of Londoners Project, 2000

Figure 7



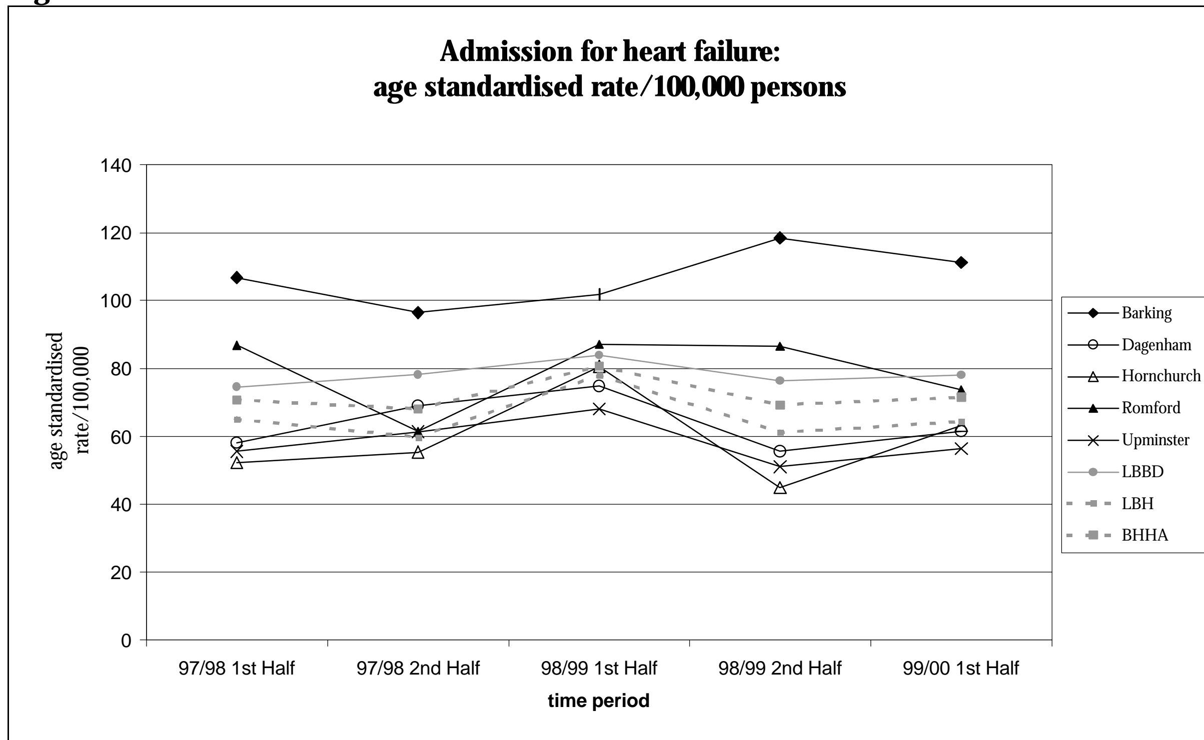
Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring 1999

Figure 8



Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring 1999

Figure 9



Source: Hospital Episode Statistics

Mental health

Authors: Dr Richard Beaver and Dr Peter Messent

Key points of interest

- Mental health in a population is related to many variables. The most significant is the level of deprivation.
- The closure of Warley Hospital and the development of new community-based services are being actively progressed. PCGs, together with the Community Mental Health Teams to which they relate, and the Health Authority should consider the implications for primary care services.
- PCGs should review and commission services within primary care to meet the mental distress or mental health needs not covered by services for the seriously mentally ill.

Key action points

The action plan for mental health services is contained within the HImP. It includes plans to:

- improve mental health rehabilitation services;
- re-align community mental health services to PCGs and further improve links with general practice;
- reprovide acute mental health services for the population of BHHA in modern facilities in the area, and complete the total closure of Warley Hospital by the year 2003;
- close long-stay accommodation in Warley Hospital by the end of 1999;
- develop alternatives to hospital admission to ensure that people with a serious mental illness are admitted to a hospital only when their mental health status requires inpatient care.

Suggested service improvements under National Service Framework Standards 2 and 3 include:

- local practice-by-practice work to develop primary care links with specialist mental health services;
- equitable and quality provision of counselling in primary care;
- consistent framework for assessment, referral and treatment of common mental health problems, including better co-ordination of the current dispersed range of services;
- support for GP management of people with serious mental illness.

Data

Data at PCG area level in Information Pack No. 2 are still current. There are important areas of mental health where information has not and/or cannot be obtained at PCG area level. Needs assessment reports are available from the Public Health Directorate.

These include:-

- Report No. 69 Child and adolescent mental health
- Report No. 60 Mental health services for patients who present with severely challenging and offending behaviour
- Report No. 54 Drug abuse: an epidemiological review

New important documents include the National Service Framework for Mental Health and the local implementation plan: summary report.[1] This summary has been produced by the National Service Framework co-ordinating team, which includes representatives from BHHA, BHB, LBBD and LBH Social Services, one of the local PCGs and voluntary and user organisations.

[1] Copies available from BHHA, Martin Bould, Assistant Director Mental Health

Osteoporosis

Author: Dr Richard Beaver

Key points of interest

- The variance of illness and death rates due to osteoporosis between the PCG areas and the local authorities is relatively small. All PCGs will need to address the prevention and treatment of osteoporosis in their residents.
- PCGs should ensure that health promotion programmes to people of all ages target measures that support and promote lifestyles enabling the development of normal bone mass and density.
- Accident prevention should form a key task for all who provide services to people, especially those who visit or inspect homes and institutions caring for older people.
- Hormone replacement therapy (HRT) should be prescribed for women at high risk of osteoporosis. When HRT is contra-indicated in women or bone densiometry indicates osteoporosis in both sexes, the use of other bone mineral content maintaining therapies such as the bisphosphonates should be considered. In older men and women, supplements of calcium and vitamin D are recommended.
- PCGs should commission bone density measurement by means of dual X-ray absorbtiometry (DEXA) in accordance with guidelines approved by local practitioners and the Department of Health for:
  (i) the assessment and management of patients with established osteoporosis;
  (ii) case finding among individuals with a variety of predisposing conditions.
- Doctors and nurses working with patients who receive long-term steroids should be fully aware of the association of steroid use and osteoporosis. Prescription of calcium and vitamin D or HRT, if appropriate, to patients with long term steroid use should form part of the package of care for such patients.
- Osteoporosis care should be subject to agreed professional guidelines and protocols for prevention and management, and be the subject of quality monitoring and clinical audit of the care process and the expected outcomes.

Key action points

- Improve road safety.
- Implement a health promotion plan to promote healthy lifestyles and prevent accidents at home and in institutions for older people.
- Prescribe drugs effective in maintaining bone density for high-risk patients.
- Implement protocols and guidelines to prevent and manage osteoporosis.
- Provide increased access to DEXA by general practitioners.
- Ensure clinical audit of management of fracture of femur in local hospitals.

Please refer to Information Pack 2. A more comprehensive discussion can be found in Public Health Report No. 96.

Respiratory diseases

Dr Kishor Padki

Key points of interest

- Chronic obstructive pulmonary disease (COPD) is a chronic, slowly progressive disorder characterised by airflow obstruction, which does not change markedly over time. Airflow limitation in COPD is due to varying combinations of airways disease (chronic bronchitis) and emphysema.
- COPD is an important cause of death rates and has a major impact on the sufferers' quality of life.
- Cigarette smoking is by far the most important cause of COPD. The greater a person's cigarette consumption over their lifetime, the greater is the risk of developing COPD.
- COPD is often under diagnosed and under treated. COPD patients are at greater risk of hospital admission and re-admission, sometimes with long lengths of stay in hospitals.
- Specialist nurses team for COPD have achieved better management of patients and reduced hospital usage.
- Locally owned COPD guidelines in the Health Authority offer a structured approach to managing patients.
- Spirometry remains the main tool in diagnosis and the assessment of the severity of COPD.
- Admission rates for asthma in adults are considerably higher in Barking. Nurse led training for asthma sufferers and better preventative prescribing can reduce admissions for asthma.

Key action points

- The Respiratory Specialist Nurses Team has already started group education programmes for COPD patients and training courses for practice nurses in COPD management.
- Smoking cessation sessions are being held for COPD patients and guidelines are being implemented in reducing this major risk factor.
- Access to spirometry has improved with purchases and training in the use of spirometers.
- A new patient information leaflet on COPD is being produced for use by specialist nurses in their training sessions.
- The locally developed guidelines, based on British Thoracic Society guidelines, have been distributed widely and implementation is under way.

Deaths from COPD

Barking had 106 deaths from COPD in the three-year period 1997/00. The death rate and the standardised mortality ratio (SMR) are considerably higher than for BHHA . The wards of Abbey and Parsloes have the highest SMRs within the Health Authority.

Table 14 Chronic obstructive pulmonary disease (COPD)*: deaths, all ages, Barking by ward, LBBD and BHHA 1997/00

Area	Number of deaths	Rate per 100,000 population**	Standardised Mortality Ratio (SMR)
Abbey	21	118.8	208
Cambell	14	52.8	93
Eastbury	15	72.1	126
Gascoigne	15	80.0	140
Longbridge	8	23.7	42
Parsloes	19	89.4	157
Thames	14	75.5	132
Barking PCG	106	67.4	118
LBBD	333	69.4	122
BHHA	665	57.1	100

* ICD9 code 490-496 (underlying cause of death)
** Indirect age-standardisation using the BHHA population.
Source: Public Health Mortality file

Hospital admissions for COPD

The admission rate and standardised admission ratio (SAR) for COPD in Barking are considerably higher than for BHHA . There were 744 admissions for all ages in 1997/00.

Table 15 Chronic obstructive pulmonary disease (COPD): hospital admissions, all ages, Barking, LBBD and BHHA 1997/00

Area	Number of admissions	*Rate per 100,000 population per year	SAR
Barking PCG	744	390.2	123
LBBD	2,248	402.8	127
BHHA	4,302	310.3	100

*ICD10 code J40—J47 as primary diagnosis
Source: Hospital Episode Statistics

Hospital admissions for asthma

The admission rates and standardised admission ratio for asthma in Barking are considerably higher than for BHHA across all age groups. Barking has the highest admission rates for asthma among adults of all PCG areas in London, at nearly twice the London average.

Table 16 Asthma*: hospital admissions by age group, Barking, LBBD and BHHA 1997/00

Area	Number of admissions	Rate per 100,000 population per year	Standardised Admission Ratio (SAR)
Age 0-14 years			
Barking	120	309.8	108
LBBD	312	300.2	105
BHHA	632	286.6	100
Age 15-44 years			
Barking	88	122.5	146
LBBD	207	104.4	123
BHHA	409	84.3	100
Age 45-64 years			
Barking	46	151.5	172
LBBD	122	136.4	156
BHHA	220	87.1	100
Age 65+ years			
Barking	27	109.0	132
LBBD	71	93.8	114
BHHA	152	79.8	100
All ages			
Barking	281	169.5	128
LBBD	712	154.3	118
BHHA	1,413	129.0	100

*ICD10 code J45, J46 as primary diagnosis
Source: Hospital Episode Statistics

Diabetes mellitus

Author: Dr Kishor Padki

Key points of interest

- Diabetes is a serious disease with no known cure; much of the burden of care falls on individuals and primary care health professionals.
- A conservative estimate of the prevalence is 2% of the population, although many people are undiagnosed and numbers are rising rapidly. The prevalence of diabetes increases markedly with advancing age.
- It is estimated that 1,140 persons could be affected with diabetes in Barking.
- Death rates for diabetes are higher in Barking than in BHHA .
- The burden of hospital admission for diabetes, as the primary cause of admission, is lower in Barking compared to BHHA .
- Recent evidence from UK Prospective Diabetes Study suggests that tight control of blood glucose and blood pressure is important in reducing complications from diabetes. Annual review is an important element of this regime. Considerable potential exists for reducing the burden of complications.
- A multi-disciplinary team of specialist nurses, dieticians and chiropodists is essential for providing optimal care of diabetes in a primary care setting.
- A properly implemented retinopathy-screening programme can prevent blindness in diabetic patients.
- PCGs have a vital role in implementing locally agreed diabetes guidelines.

Key action points

- A multi-disciplinary specialist diabetes nurses team has been established to support primary care management. The team has undertaken group education programmes and enhancing self-management skills people with diabetes, along with training of practice nurses.
- The specialist health promotion team has developed patient information packs and posters promoting optimum diabetes care in the community.
- Funding for a Health Authority wide retinopathy screening programme has been secured and an audit facilitator to promote and implement the programme has been appointed. As with any other population based screening programme, our objective will be to achieve the highest possible uptake by diabetic patients.
- Locally produced joint care guidelines have been distributed widely to primary care health professionals and implementation is under way.

Death rates

There were 18 deaths from diabetes mellitus as the underlying cause of death within Barking in the three-year period 1997/00. There were no deaths in persons below 45 years of age. Diabetes is a known risk factor for CHD and stroke. Deaths from these conditions, when diabetes mellitus is an important co-morbidity, are not included in the above figures. The death

rate and the standardised mortality ratio (SMR) are higher in Barking than in BHHA . These data therefore give a picture of admissions primarily caused by complications of diabetes.

Table 17 Diabetes mellitus*: deaths (underlying cause of death) by age group, Barking, LBBD, and BHHA 1997/00

Area	Number of deaths	Rate per 100,000 population per year			SMR**
		Age 1-44	Age 45+	All ages	
Barking	18	0.0	22.8	8.2	131
LBBD	39	0.0	16.4	5.9	95
BHHA	103	0.0	17.3	6.2	100

*ICD 9 code 250 as underlying cause of death.
** Standardised death rates ratio where BHHA is standardised to = 100
Source: Public Health Mortality file

Hospital admissions

The admission rate and standardised admissions ratio for Barking are lower than for BHHA . There were 114 finished consultant episodes (FCEs) with diabetes mellitus as the main cause of admission. We have excluded all FCEs where diabetes mellitus is mentioned in any other diagnosis field (i.e. not as the main reason for admission). This will exclude, for instance, admissions from CHD and stroke if diabetes mellitus is mentioned in one of the other diagnosis fields.

Table 18 Diabetes mellitus*: finished consultant episodes, Barking, LBBD, and BHHA 1997/00

Area	Number of admissions	Rate per 100,000 population per year	Standardised Admission Ratio (SAR)
Barking	114	69.1	82
LBBD	449	90.6	111
BHHA	1,013	78.0	100

*ICD 10 code E10-E14
Source: Hospital Episode Statistics

The health of mothers and infants

Author: Dr Frances Haste

Key points of interest

(1) Teenage pregnancies are among the highest in London. There has been no consistent decline in LBBD over the period 1992/97.
(2) The Barking wards with the highest conceptions have shown decreases.
(3) The proportion of lone parents is increasing.
(4) The proportion of babies with low birthweight is high, particularly in younger women.
(5) Termination rates in young women are the second lowest in London.

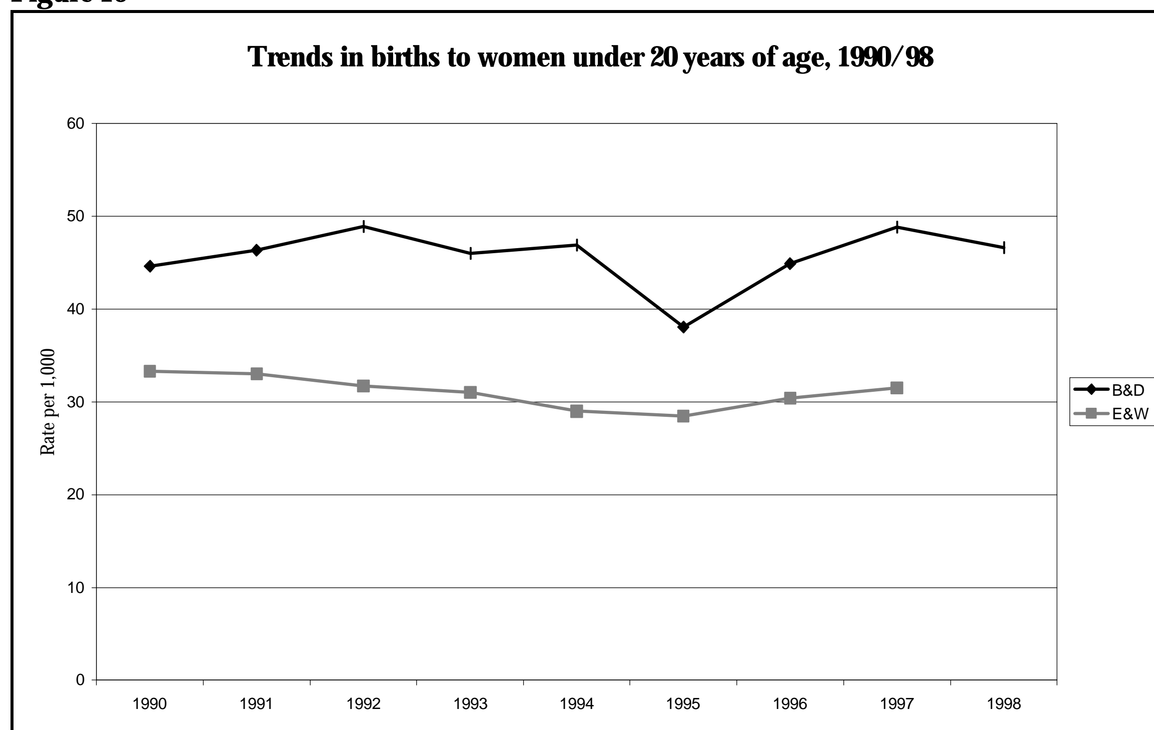
Key action points

- The PCG should ensure that appropriate contraceptive services are available for young people.
- Young and/or lone parents could be targeted for extra support to reduce the cycle of poor health, which may follow low birthweight.
- Availability of terminations should be reviewed.
- The PCG should continue to work closely with the Health Authority Teenage Pregnancy Co-ordinator and with other agencies to ensure concerted action to reduce teenage pregnancy rates.

Teenage pregnancies

Teenage pregnancies have already been highlighted as an issue of concern in Barking. Teenage pregnancy rates are considerably higher in LBBD than nationally. There has been no consistent decline in the last decade: see Figure 10.

Figure 10



Source: Office of National Statistics (ONS)

Barking had the 6th highest conception rate in women under 20 years old among London PCG areas. Overall in Barking there was a slight increase in teenage conceptions between 1992/94 and 1995/97. However, there was variation between wards. In four out of seven wards conceptions increased but decreased in the other three: see Table 19.

Table 19 Conceptions by women aged under 18, in Barking, by ward 1992/94, 1995/97

Wards	1992/94	1995/97
Abbey	31	36
Cambell	27	33
Eastbury	18	16
Gascoigne	64	56
Longbridge	13	11
Parsloes	13	24
Thames	37	32
All Barking wards	**203**	**208**

Source: ONS

Marital status

In line with national trends there has been a slight decrease in the proportion of babies born within marriage from 60.6% in Barking in 1993/95 to 58.8% in 1996/98. There has also been a slight increase in the proportion of women who register their babies with only one named parent. Sole registration generally indicates a lone parent.

Birthweight
The proportion of babies that are of low birthweight (less than 2,500g, about 5¼lb) has decreased among married and cohabiting women, but increased among lone mothers. Babies of lone parents are more likely to have low birthweight babies: see Table 20.

Table 20 Marital status and low birthweight in Barking, 1993/95 and 1996/98

Time period	% of births within marriage	% of births in marriage that are less than 2,500g	% of births which are lone registrations	% of lone registrations where birthweight is less than 2,500g
1993/95	60.6	8.2	11.4	9.4
1996/98	58.8	6.7	12.0	11.1

Source: ONS

Barking had a higher proportion of babies of low birthweight in 1997/99 than nationally or in London: see Table 8.3. This seems to be mainly due to the higher rates of low birthweight among younger women, particularly women less than 20 years old: see Figure 11.

In general, high maternal age (40 years old or above) is also associated with low birthweight, but this does not appear to be the case in Barking. Barking has a smaller proportion of older mothers than England and Wales or London: see Table 22.

The proportion of babies born to women under 20 years in Barking has increased from 8.3% in 1995/97 to 9.7% in 1997/99.

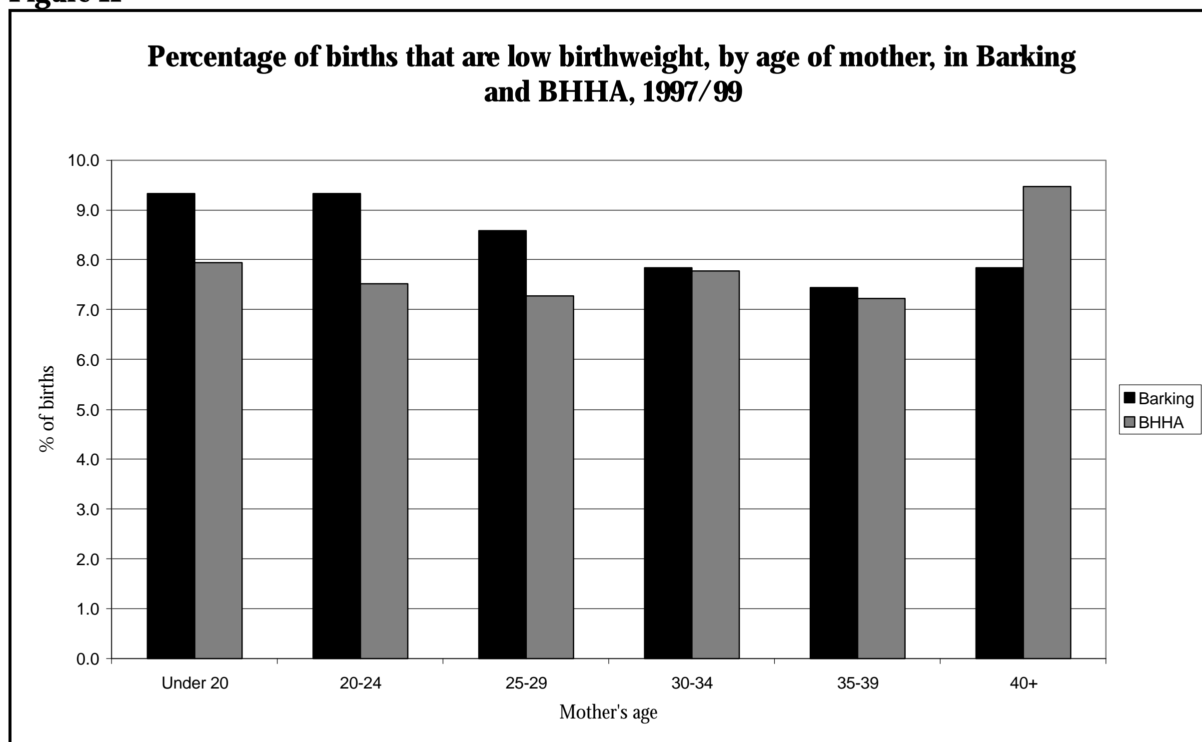
LBBD had the second lowest termination rates in London for women aged under 18 years in 1995/97.

Table 21 Rates of low birthweight, Barking, BHHA, London and England and Wales, years as shown

Area	% of babies born less than 2,500g
Barking 1997/99	8.6
BHHA 1997/99	7.6
London 1998	8.3
England and Wales 1998	7.8

Source: RICHS

Figure 11



Source: RICHS

Table 22 Proportion of births to younger and older women, Barking, BHHA, London, and England and Wales, years as shown

Area	% of babies born to women aged under 20	% of babies born to women aged 35+
Barking 1997/99	9.7	9.6
BHHA 1997/99	6.8	12.4
London 1998	5.2	18.6
England and Wales 1998	7.6	14.5

Source: RICHS

Health needs identified in community nursing

Authors: Barking Community Nursing Team

Introduction

In response to the increased emphasis on the public health role of nurses in government policy[1] BHB Community Health Care NHS Trust (BHB) in partnership with BHHA Public Health Department has developed a needs assessment template for community nurses to use in preparing local profiles. The template is designed for producing an annual needs assessment profile for each PCG that focuses on identifying:

- local health needs and target activities at the primary care integrated team level and/or the PCG area level;
- specific health problems and issues within those populations in which community nurses work within the primary care setting;
- what community nurses currently do and how they work with those populations;
- whether there are important gaps in current service provision;
- how the work of community nurses currently addresses the priorities of the HImP and the Primary Care Investment Plan and how these can be addressed in the future.

The data and information used in producing the profiles has been drawn from a range of sources. These include the Office for National Statistics; PCG Public Health Reports; analysis of current caseloads and the new Regional Integrated Child Health Surveillance system (RICHS) that encapsulates both patient information and nursing contacts. The RICHS system's reliability is currently being strengthened in respect of data collection and collation. However, current data does provide an adequate information source to analyse health visitor and district nurse activity.

Staffing

There are three self-managed integrated teams of community nurses in Barking. Team 1 operates out of Julia Engwell Health Centre, Team 2 out of Vicarage Fields Health Centre and Team 3 out of Thames View and Orchards Health Centres. Each team includes district nurses, community staff nurses, nursing auxiliaries, health visitors, community nursery nurse, practice nurses (employed by BHB), community support workers and administrative/clerical staff. The community nurses are aligned to designated GP practices and cover all their clients/patients that live in the Barking area.

There is a public health nurse in the Integrated Team 3 who works with refugees and asylum seekers. Team 2 has a combined health visiting and practice nursing post.

Health visiting

Population profile

Barking has a higher than average proportion of children under five years (7.6%) compared to BHHA (6.8%). Gascoigne ward has the highest percentage of children under five years, 14.8%, compared to 11% in Thames and 10% in Abbey. Other wards have less than 6.5%. All Barking wards except Longbridge score highly on the Jarman deprivation score in the 1991 census, which means there is a higher level of health and social care needs in this area.

Health visiting service
Health visitors work predominantly with children under five years and their families. Their role is to prevent ill health and promote good health to the population by working in partnership with them.

Team 3 has the support of a community nursery nurse to reinforce parenting skills and behaviour management strategy. Extra community nursery nurses are being recruited for Team 1 and 2 to further develop skill mix within the team.

Factors which affect the workload
The key local features which have an affect on health visitors' workload are:
- high fertility rate of twice the national average - Gascoigne had 205 new births last year and is the highest in Barking followed closely by Thames with 132;
- high incidence of low birth weight babies with an average of 10.4% of new births under 2500gm and Thames having the second highest percentage of under 1,500g babies (3.4%) in Barking;
- high rate of teenage pregnancy at 16.7%, with Thames the highest of all pregnancies.

See Table 23.

Table 23 Births and low birthweight, Barking by wards and BHHA

Wards	Number of new births	Birthweight >2,500g	Birthweight >1,500g	Teenage mothers	Lone parents
Abbey	203	24 (11.8%)	7 (3.4%)	17 (8.4%)	6.2%
Cambell	127	5 (3.9%)	2 (1.6%)	10 (7.9%)	5.7%
Gascoigne	205	24 (11.7%)	7 (3.4%)	22 (10.7%)	15.6%
Longbridge	85	5 (5,9%)	1 (1.2%)	2 (2.4%)	1.7%
Eastbury	87	12 (13.8%)	7 (8.0%)	6 (6.9%)	4.2%
Parsloes	74	3 (4.1%)	0	4 (5.4%)	4.6%
Thames	132	12 (9.1%)	5 (3.8%)	22 (16.7%)	9.7%
All Barking wards	913 (19%)	85 (9.3%)	29 (3.2%)	83 (9.1%)	N/K
BHHA	4832(100%)	364 (7.5%)	100 (2.1%)	342 (7.1%)	N/K

Source: RICHS

Child protection
Barking has a higher incidence of child protection investigations and a higher number of children under five years on the Child Protection Register - 35 children under five years in Barking compared with 28 children in Dagenham. Thirty four percent of BHHA's children under five years that are on Child Protection Register live in Barking, with Gascoigne having 40% of Barking's total.

Table 24 Numbers of children on Child Protection Register, Barking by ward and Dagenham, January 2000

Ward	No
Abbey	3
Cambell	6
Gascoigne	14
Longbridge	1
Eastbury	4
Parsloes	1
Thames	6
Barking PCG	35
Dagenham	28

Source: BHB Child Protection Register

Vulnerable families

Local knowledge also informs that vulnerable children and families are increasingly in evidence as the result of factors such as domestic violence (3,180 reported incidences in 1996). Other negative factors include poor parenting skills, drug dependent parent(s) unemployment/poverty, post-natal depression and generalised depression. These factors often lead to social exclusion and affect the health of the clients and increase the workload of the health visiting team.

Health visitors provide extra support to vulnerable families and encourage clients to share and identify their problems through actively listening and facilitate finding a solution. Health visitors act as a resource for these clients in accessing other appropriate services and advocating for them if the need arises.

Health visitors at Gascoigne have started a 'toddler taming' programme and this will be evaluated and rolled out to rest of the locality if proved to be successful. The 'Young Women Time Out' group in Thames targets young mothers under the age of 24 and focuses mainly on building confidence and self-esteem of the young mothers.

Table 25 Vulnerable families and children with special needs from caseload count, Barking January 2000

Integrated Team	1	2	3	Barking
Vulnerable families	48	46	82	171
Children with special needs	25	38	40	103

Special needs children

At present, all children are seen by the health visiting team for their 7-9 months and 2 years key-age development assessment. These assessments are valuable tools to identify any developmental delays. They are also a key opportunity to identify other issues within the family and to offer anticipatory guidance on child health promotion.

Children identified with special needs and their families need extra health visitor input. Health visitors have a key liaison role between agencies and parent(s) to ensure the child has access to appropriate care and services. Community nursery nurses also support the family in play and behaviour management.

Population trends

Overall

The increase of population in the area as the result of the housing developments will have a significant impact on the workload of community nurses, especially health visitors, as the majority of the new residents are of childbearing age.

Homeless families

The Homeless Person Unit for Barking on the Gascoigne estate and the two bed and breakfast hotels in Longbridge ward accommodate a significant number of homeless families. Health visitors from the team in their public health role work with these families to ensure they have equal access to primary care services.

Ethnic minority clients

The 1991 census showed Abbey ward had the highest proportion (33%) of ethnic population and Thames had the lowest. The majority is of Black African, West Indian and Asian origin. Recent information from maternity statistics shows that there has been a noticeable increase in the number of ethnic clients under the category of 'other' which may include Kosovan, Albanian and Turkish.

Professional/service issues

For health visiting, the major issue is the high caseload in some of the areas with highest needs, e.g. three caseloads in Gascoigne and Thames have over 400 children under five years.

The increase of refugees and asylum seekers into Barking has had a great impact on the workload of health visiting and district nursing teams. The main problem is the language barrier, even with an excellent interpreting service. Community nurses have found great difficulty in arranging home visits initially. Initiatives such as 'Language Line' should be considered to provide immediate access to interpreters.

Other service issues include:

- the long waiting lists for the majority of secondary services, e.g. between 3 to 6 months for speech therapy and family and children consultation services;
- no paediatric dietician;
- no special needs playgroup/nursery in the Barking area;
- no support for post-natal depression;
- access to hospital services – there is only a minor ailment unit in Barking.

Population/client issues

Deprivation level

The percentage of children living in poverty as result of unemployment is high, with the four following wards out of Barking's seven wards having higher than the London average of 22.6%:-

Gascoigne	41%
Thames	37%
Abbey	36%
Cambell	24.5%

There has been a steady increase in the numbers of teenage pregnancies, lone parent families, the elderly, asylum seekers and refugee families. Poor, inadequate housing is a major issue with many of the clients. These factors, combined with changes in the benefit system, have led to the rise in poverty level, that feeds into the cycle of deprivation and ill health.

Key age assessment uptake
Except for Abbey and Gascoigne, all other wards have achieved their target of 90% in child immunisation rates. There is a high defaulter rate for routine development assessments, most noticeable in Abbey (64% for 7-8 month check and 52% for 24-month check). Abbey has the highest rate of ethnic minority clients (58% of births were to ethnic clients in 1999). The language barrier and lack of awareness of the service may account for the non-compliance. Longbridge ward has the highest attendance rate at 87% and 83% respectively.

'Sure Start' programme in Thames View
Insufficient service provision for children under five years from all agencies, combined with the high level of deprivation and needs and the geographical isolation, have meant that Thames ward has been targeted as a 'Sure Start' programme area. It is envisaged that the 'Sure Start' programme will help to break the cycle of deprivation and social exclusion and ensure all children achieve their potential.

Contribution of health visitors to the HImP

Coronary heart disease
As the health visitors' main role is in promoting health and preventing ill health, health promotion and education is integral in their daily work with their clients. Health visitors contribute towards reducing CHD by educating parents to adopt good weaning and dietary practices, and by encouraging and supporting clients to stop smoking and take more exercise.

Mental health
Health visitors work closely with community psychiatric nurses if there are clients with mental health problems. The occurrence of post-natal depression has a significant impact on health visitors' workload, as intense home visiting to support the family is usually the care plan. Early identification of post-natal depression, using a standardised tool, should be formalised. Extra support given to depressed new mothers may prevent deterioration and reduce the need to refer them.

The mental and emotional health of children is the concern of every health visitor. A significant part of health visiting work is in anticipatory guidance and supportive work with parents who are experiencing difficulties in managing their child's behaviour. Health visitors at The Orchards run 'toddler-taming' sessions.

Teenage pregnancy
Barking, particularly in Thames ward, where 16.7% of births are to teenagers, has high rates of teenage pregnancies that contribute to the cycle of deprivation, low achievement and ill health. Health visitors do target teenage mothers offering extra support to improve the health chances of these children but more work needs to done with other services and agencies to devise innovative approaches to reduce the rate of unintended and unwanted pregnancy.

Recommendations

- Review and formalise protocols relating to early detection of post-natal depression to offer timely support to mothers in order to prevent this condition.
- Explore innovative ways to address the high non-compliance rates for child health surveillance key assessment in some of the caseload.
- Extend the practice of giving out condoms to all families at new birth visits by health visitors to prevent unplanned pregnancies.

- Make available leaflets on contraception and family planning clinics. Allowing time for reception staff to give these out on request by clients will improve the service.
- Plan and implement a monthly health promotion stall in the market place to promote health messages and raise the local population's awareness on health issues.
- Extend the interpreting service to include immediate access to interpreting (e.g. Language Line) so reception staff can meet the need of 'walk in' clients who cannot speak English.
- Continue to participate in the Barking working group on reducing the rate of teenage pregnancy.
- Increase the health visiting establishment to enable the service to develop in a proactive way, thus making an impact on the prevention of ill health.

District nursing

Introduction

There are six district nursing teams in Barking with two teams in each of the three integrated nursing teams. A district nurse heads each team with support from community staff nurse and nursing auxiliary.

The district nursing teams work with patients covering a wide age range from adolescence onwards. However, the majority of their clients are housebound elderly who need nursing care, e.g. dressing post-operative wounds, injections and palliative/terminal care. They care for patients with continence problems and indwelling urinary catheters and those who are chronically sick or disabled and needing nursing interventions. Children with nursing needs are referred to and cared for by the community paediatric nursing team.

All clients receive a health needs assessment on referral and ongoing planning and evaluation of care. District nurses participate in multi-disciplinary assessment to identify nursing input for clients with more complex needs. Education of clients and carers to promote independence and positive health and to reduce clinical risk is a routine part of their work.

They also spend time:

- supporting families of their clients;
- liaising with other professionals and agencies;
- assessing and accessing equipment to meet the needs of their clients.

The 24-hour enhanced district nursing service has been in operation since mid-1999. This new initiative provides a continuous twenty-four service. Routine care is provided between 8.30 a.m. to 5 p.m. and emergency care from 5 p.m. to 8.30 a.m. The main aim of the increased level of the service is to prevent inappropriate hospital admissions by improving care at home.

Factors which affect workload/health

The elderly population is increasing as people are living longer. The projected local trend is that this age group will continue to increase, while the number of those under 85 years will decline after peaking in 2001. Many clients have lived in Barking most of their lives. A significant number live alone (33%), although there are relatively good family support structures. The need for community social care provision (e.g. home help and personal care) from social services remains high.

Table 9.4 District nursing caseload, Barking

Caseload age profile	Integrated Team 1	Integrated Team 2	Integrated Team 3
Total number of patients	288	187	130
Number under the age of 75	177	69	63
Number over the age of 75	111	118	102
Number living alone over the age of 75	69	21	72
Number housebound	118	48	66

When the housing estates were built, toilet and bathroom facilities in the houses were normally sited upstairs. A large number of the patients are infirm (about 41%) and have difficulties managing the stairs. There is a long waiting list for adaptation of present accommodation or provision of alternative suitable housing.

The district nurses' caseloads include a high percentage of frail elderly persons who live alone (27%) and some of these patients have difficulties coping even though they are not medically ill. They need rehabilitation rather than hospitalisation but there is always a long waiting list for people needing warden-assisted accommodation or residential care.

Amongst the elderly population in Barking, there is generally a lack of knowledge and awareness about health issues and the effects of lifestyle on health. Smoking is more common in Barking than nationally and there is a lack of knowledge that smoking is a common risk factor linked to CHD, cancer, chronic respiratory disease and osteoporosis. Many housebound patients get very little exercise, which results in obesity and its consequent effect on health. A significant number of patients seen by the service need rehabilitation care rather than nursing care.

Poverty is also a factor, with a significant number of elderly people dependent on benefits.

A significant proportion of district nursing intervention in Barking (50.9%) is on wound care management. This includes holistic assessment, treatment and evaluation of pressure ulcers, leg ulcers, lacerations, scalds, burns and post operative wounds and fungating lesions. For mobile clients there is a weekly leg ulcer clinic in central Barking.

Cancer patients account for a tenth of caseloads. The most common form of cancer to be found on caseloads is lung cancer (20% in Team 1 and 25% in Team 3). District nurses provide palliative and terminal care of cancer patients, including management of syringe drivers with support from hospice staff. A great deal of time is spent in supporting the patient and their family.

Diabetic patients make up 10% of caseloads. The nursing teams spend a significant amount of time in diabetes management, including health promotion and education on diet, blood glucose monitoring and administration of insulin.

Urological care including continence assessment, promotion of continence, management of incontinence, cauterisation and catheter care is another major area of district nurses' work. One nursing team has 35% of their patients in this category.

Professional/service issues

There are a high number of patients with cancer. The district nursing teams work closely with the community palliative care team to provide a seamless service but there is a need to increase

inpatient beds for respite and terminal care. The Hospice at Home scheme should be implemented to enable patients to die at home if they so wish and to support their family during this stressful time.

The lack of sufficient social and personal care provisions and suitable supportive accommodation needs to be addressed if the needs of the increasing number of elderly are to be met. The re-referral process for social care creates additional work and needs reviewing.

There is a shortfall in the chiropody service leading to a long waiting list for the majority of clients. The exception is diabetic patients who are seen as a priority.

The impending appointment of a tissue viability nurse will provide much needed support in wounds and leg ulcers management.

Health promotion and advice on diet, exercise and smoking cessation for relevant clients needs formalisation and support by health promotion literature. A coronary aftercare/ lifestyle clinic is needed to provide preventative work for clients who have suffered a coronary.

Population/client issues

There is generally a lack of knowledge and awareness about health issues amongst the elderly. This may be the reason why the community nursing teams are experiencing some difficulties in compliance.

LBBD has one of the smallest ethnic minority communities in London. This is expected to change as the recently arrived refugees and asylum seekers will add to the numbers of ethnic minorities. The language barrier is a major issue and may be a reason for non-compliance with treatment and medication. The projected continuous increase in numbers of those over 85 years will place additional demands on community nursing services in the near future.

Contribution of community nurses to the HImP

CHD and cancer

Currently, the district nursing service provides informal health promotion/education as an integral part of their daily work during their contact with their clients. This needs to be formalised to achieve health improvement. There are plans to develop health promotion sessions in various day facilities for the elderly and to hold a monthly health promotion market stall.

Preventing falls

District nurses routinely assess safety within the patients' homes as part of their holistic assessment and advise accordingly.

Recommendations

- Develop a coronary aftercare clinic to provide education and support for changes in lifestyle.
- Implement the Hospice at Home scheme.
- Increase the level of the chiropody service, thus reducing the waiting list.
- Consider employing a health worker for the elderly to work with them on preventative health.
- Develop health promotion sessions in day centres or clubs for the elderly.
- Work with the relevant service to review and simplify the continence re-assessment process.

Reference

1. Department of Health. *Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and health care.* London HMSO 1999

Health promotion

Authors: BHB Health Promotion

Key action points

- The PCG Health Promotion lead to continue to attend the Health Promotion Strategic Alliance.
- The Health Promotion Strategic Alliance to work in partnership with the Local Medical Committee Health Promotion Committee to develop a PCT based scheme.
- The Health Promotion Unit and Community Health Council to work with the PCG to develop and implement a patient participation group model of working.
- Ensure staff participate in locally organised training on smoking cessation advice.
- Identify and train staff to provide intermediate interventions for smoking cessation.
- Identify suitable referral pathways and venues to run Specialist Smoking Cessation Service group treatment programmes.
- Support the Healthy Schools Initiative.
- Ensure appropriate nutrition advice and information is provided to clients and staff.
- Support and develop work as outlined in the National Service Framework for CHD.
- Invest in co-ordinating cancer and diabetes awareness campaigns to coincide with national and local authority-wide events.
- Support accident avoidance by providing local representation on the Accident Avoidance Forum.

Health Promotion Unit reorganisation

In line with proposals to establish local primary care trusts (PCTs), health promotion staff have been re-organised to support the development of PCT based programmes. This involves:

- One Health Promotion Programme Development Manager assigned to each PCT. Each manager will work extremely closely with PCT management to develop and evaluate health promotion programmes.
- Organising health promotion officers and specialist workers into teams assigned to each PCT.
- Allocating operational budgets to support agreed PCT-based programmes/projects.

We believe this will maximise the potential for health promotion and ensure appropriate support and skills are available to primary and community health care staff.

GP health promotion scheme

The current scheme needs to be updated to reflect the needs of the evolving PCTs. This will maximise the effectiveness of the scheme in meeting local priorities and targets. It is proposed that the Health Promotion Strategic Alliance works in partnership with the Local Medical Committee Health Promotion Committee to develop a PCT based scheme.

Patient participation groups
It has been established locally that practice based patient participation groups can be used to support general practice in developing and promoting a broad range of health promotion activity. It is proposed that the Health Promotion Unit and the Community Health Council work with Barking PCG to develop and implement an appropriate patient participation group model of working.

Specialist smoking cessation services
BHHA has received an allocation of £114,000 for this financial year to develop local specialist smoking cessation services. This includes providing a free one-week's supply of nicotine replacement therapy to eligible clients and monitoring and recording their cessation activity. Practitioners may be paid to provide this service and will be registered with the Specialist Smoking Cessation Service. There will be further funding available until March 2003. PCGs should begin to implement the agreed smoking cessation service development plan.

Healthy Schools Initiative
The BHB Healthy Schools Initiative is now well-established in local primary schools. The Health Promotion Strategic Alliance, in partnership with LBBD and LBH, have agreed funding to extend the initiative into local secondary schools. There are currently three primary schools signed up to the Healthy Schools Initiative in Barking: see Table 27.

Table 27 Barking schools involved in the Healthy Schools Initiative

	Breakfast clubs	Environment	Staff health and welfare	Pupil empowerment	Drug education	Sex and relationships Education and policy	Physical activity	Healthy eating	Smoke free environment	Road safety and fitter travel	Active play	Peer mediation	Health fare
Manor Junior				[shaded]			[shaded]				[shaded]		
Thames View Junior								[shaded]					[shaded]
Northbury Infants		[shaded]											

CHD
The BHHA Food and Nutrition Steering Group have developed a local food and nutrition policy. The policy aims to improve healthy eating in the local community and increase awareness of nutrition interventions that may assist in the treatment and prevention of nutrition related disease. A working group has been established to assist with implementation of the policy within the primary care setting.

The PCG commissioning group has allocated money for up to three years for developing community based primary prevention initiatives.

Cancers
Work programmes have focused on raising awareness of risk behaviours and the benefit of participating in screening programmes. Skin, testicular and cervical cancers have been targeted via high profile campaigns.

Accidents
The Accident Avoidance Forum was convened to bring together expertise from local authority and health disciplines with the purpose of mapping out current work and developing a comprehensive local authority-wide accident avoidance strategy. The priority is to provide accident risk assessment training targeted at those personnel who come into contact with the elderly in either their own homes or other care environments.

COPD
The BHHA Respiratory Focus Group have developed a patient information pack to empower patients to take an active role in managing their condition. Public Health and Health Promotion have funded the initial print for this financial year. It is proposed from April 2001 that the cost of producing this resource be shared between the PCTs.

Diabetes
The BHHA Diabetes Strategy Group has developed resources to promote the new retinopathy service, community awareness of diabetes and patient information to empower patients to take an active role in managing their condition.

Recommendations
- That the Barking PCG Health Promotion lead continues to attend the Health Promotion Strategic Alliance to establish, co-ordinate and monitor agreed action plans.
- That primary care staff participate in locally organised training on brief smoking cessation advice and support smokers on an opportunistic basis.
- That a small number of staff be identified and trained to provide intermediate intervention to clients who are motivated to stop smoking.
- That suitable referral pathways and appropriate venues for the Specialist Smoking Cessation Service to run group treatment programmes be identified.
- That the Healthy Schools Initiative be supported through school nursing input, guidance on leadership, managing change, staff professional development, school ethos, health related policy and on pupil, parent/carer and local community involvement.
- That nutrition advice be provided to clients by health professionals based on nationally recommended nutritional guidelines and consistent healthy eating messages.
- that information and training of primary care staff be provided in order to standardise the healthy eating advice.
- That work on community based primary prevention initiatives in accordance with the standards outlined in the National Service Framework for CHD be supported and developed.
- That investment be made in cancer prevention by co-ordinating awareness campaigns within primary care to coincide with national and local authority wide events.
- That accident prevention work be supported by providing local representation on the Accident Avoidance Forum when it is reconvened later this year.

- That investment be made in diabetes services by co-ordinating awareness campaigns within primary care to coincide with national and local authority-wide events.