

# **Barking and Havering Health Authority**

## **Annual Report of the Director of Public Health 1999/2000**

### **Health in the Dagenham Primary Care Group Area**

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## **Executive summary**

Primary care groups (PCG) have been encouraged to identify priorities for health improvement after consideration of data regarding local need, such as is presented here, the opinions of local health professionals and national guidance. Dagenham PCG chose CHD and chronic obstructive pulmonary disease (COPD) as priorities for action in 1999/00.

Nationally, CHD remains second only to 'all cancers' in terms of deaths caused. The situation in Dagenham is no different, despite encouraging signs of a small reduction in premature deaths in recent years. COPD remains a significant local issue as death rates and admissions remain 20-30% higher than Barking and Havering Health Authority (BHHA) average.

Clearly, the PCG should persist with its plans to improve the management of these conditions. Local plans for CHD need to conform to the model set out in the CHD National Service Framework.

The population served by the Dagenham PCG is more likely to be admitted to hospital for asthma, diabetes and epilepsy than one might expect. Effective primary care management of these conditions is expected to minimise the need for hospital admission. Accordingly, admission rates for these three conditions are included within the Performance Assessment Framework as indicators of the effectiveness of primary care services. Addressing these and other similar issues regarding the management of other chronic diseases such as COPD and CHD will require action on a variety of fronts, including enhanced staffing levels, education and training, improved practice organisation and usage of IT. The PCG has already produced a detailed primary care development plan outlining developments in these areas. It is likely that the PCG will need to maintain this focus on equipping primary care to systematically deliver effective care for patients with chronic disease for some time to come.

As mentioned above, cancers are the single largest cause of death nationally and in Dagenham. Dagenham has a particular problem with lung cancer. Enhanced treatment and prevention is required. A health authority wide specialist smoking cessation service will be established this year. All PCGs will need to ensure that health professionals in primary care are trained to routinely provide effective brief advice to smokers and, where appropriate, refer smokers motivated to quit to this specialist service. PCGs should also promote the use of the new cancer referral guidelines.

The cancer referral guidelines are one example of best practice being established at national level. Others include the CHD and Mental Health National Service Frameworks. Further NSFs about diabetes and older persons are expected in 2000/01. The PCG is obliged to implement the recommended models of care contained within these National Service Frameworks and meet the stated targets and milestones. The PCG needs to consider how it can meet these challenges and identify the financial and human resources to do so.

As has been highlighted in previous reports, Dagenham is a deprived area. The link between material deprivation and ill health is well accepted and as one might expect Dagenham residents experience higher levels of illness and death than are evident in more affluent communities. Dagenham PCG, and the proposed Barking and Dagenham Primary Care Trust must aim to

achieve ultimately comparability in terms of health status with more affluent areas. More immediately, the PCG must ensure year on year improvement in health outcomes and the quality of health care services provided.

<p>The Public Health lead is Dr Mark Ansell. Telephone 020 8532 6364 The Health Promotion lead is Tim Baggs at BHB Health Promotion Telephone 01708 465723</p>
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## **The purpose and sources of this report**

### **Purpose**

PCG profiles have been developed to inform decision making, whether about the commissioning of services, investment in primary care, the development of programmes of professional education or quality improvement initiatives. In such circumstances, PCGs will have to choose between competing claims on limited resources that best meet the needs of the local population. The profile provides an objective, quantitative picture of the health needs of each PCG using routinely collected data, which will complement the experience and local knowledge of Board members.

### **Sources**

This document is the third in a series and should be viewed in conjunction with Information Packs 1 and 2. It provides updated information regarding measures of death, disease and service usage. The report covers the same areas included within Report 2. Where no new information is available, the report restates the commentary made last year. The data underpinning these statements is not provided but is included within Report 2.

PCGs with particular information needs not met by these reports should liaise with their designated Public Health support in the first instance.

Each section within the PCG profile has been written by the member of the Public Health Department with lead responsibility for that topic. The public health lead for each specific PCG has contributed the Executive Summary, which gives an overview of the PCG as a whole.

To give a more rounded picture of local health needs, community nurses and the Health Promotion Service of BHB Community Health Care NHS Trust (BHB) have each been asked to comment on their assessment of need within the PCG area.

### **Using the report**

PCGs should not feel constrained to adopt the priorities identified in the PCG profile wholesale. There are several ways of identifying priorities. In making their decisions PCGs will need to consider not only the absolute and relative size of the problem but also the effectiveness and cost of possible interventions, in the light of their own knowledge of local professionals, patients and carers.

The Public Health Department would hope to assist PCGs in identifying the needs of their population and selecting priorities in a systematic fashion. Development of this information pack is only a first step in this process. It is hoped that an initial presentation of these data to PCG Boards will stimulate further collaborative work in the future.

**Authors:** This report was prepared by the Public Health PCG lead, Dr Mark Ansell. Other contributors are acknowledged in the text.

## The population of Dagenham

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

### **An update on population characteristics**

Demographic information impacting on health has already been reported on in previous PCG profiles. These remain largely unchanged and will remain so until after publication of the 2001 census.

Newly published data from the Health of Londoners Project allows comparisons to be made at PCG area level regarding indicators of long term illness and disability across the whole of London. Data from the same source are also presented about car ownership and central heating.

The Dagenham population reports high levels of long term illness relative to local PCG areas and London: see Table 1.

**Table 1 Census-based indicators of long-term illness, BHHA by PCG area and London 1991**

Area	Standardised limiting long term illness for household residents under age of 75	Rank relative to other PCG areas in London	% of total adult population unable to work due to permanent sickness	Rank relative to other PCG areas in London	% of adults in households recorded as unable to work due to permanent sickness	Rank relative to other PCG areas 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

Relative to London, a higher proportion of the Dagenham population is in receipt of benefits due to disability: see Table 2.

Relative to other local PCG areas and London the population of Dagenham is more dependent on public transport: see Table 3. The availability of public transport should be included in any assessment of the accessibility of health care services.

Relative to London, a greater proportion of the Dagenham population lives in accommodation without central heating: see Table 3. A lack of central heating is associated with respiratory disease, which is a problem in Dagenham: see section 6 of this report.

**Table 2 Proportion of population in receipt of 'disability benefits', BHHA by PCG area and London**

Area	Attendance allowance/ 1000 residents aged >65	Rank	Disability living allowance /1000 residents aged <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	

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

**Table 3 Selected census-based indicators affecting need or access to health care services, BHHA by PCG area and London**

Area	% of households with no car available to household members	Rank relative to other PCG areas in London	% of households without central heating	Rank relative to other PCG areas 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 Project, 2000

### Rates of death and illness

Data about deaths from all causes are presented in Table 4 and Figures 1 and 2 as an indicator of overall health status. It is evident that rates of death from all causes are higher in the London Borough of Barking & Dagenham (LBBD) than the London average. The trend appears to be downward but needs to be monitored, particularly with regard to death rates for women.

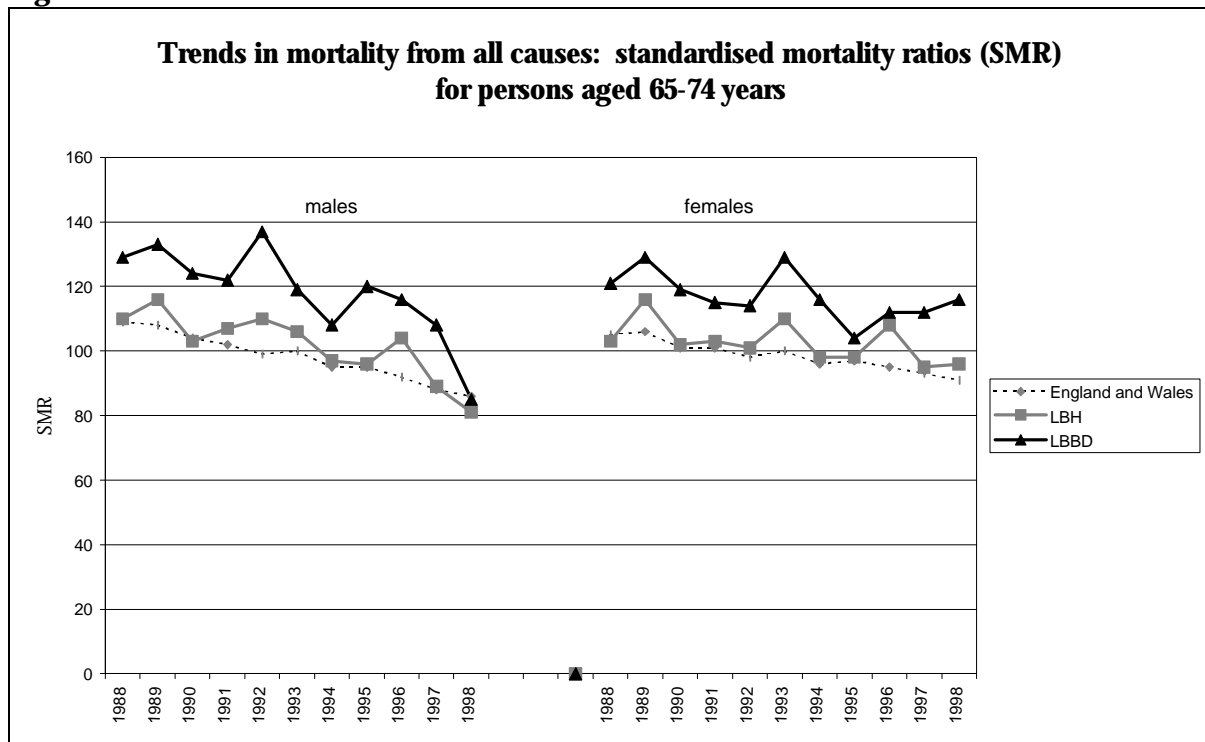
**Table 4 Standardised mortality ratios (SMRs), all causes of death by age group, BHHA by PCG and London 1995/97**

Area	Age <65		Age <75		All ages	
	SMR	95% CI	SMR	95% CI	SMR	95% CI
Barking PCG	126	114 - 138	119	112 - 127	105	101 - 110
Dagenham PCG	120	110 - 131	118	112 - 125	110	106 - 114
Hornchurch PCG	88	80 - 97	93	87 - 99	94	90 - 98
Romford PCG	92	84 - 101	98	92 - 104	108	104 - 112
Upminster PCG	90	81 - 99	95	90 - 102	102	98 - 106
London	107	106 - 108	104	103 - 105	99	99 - 100

CI = Confidence intervals

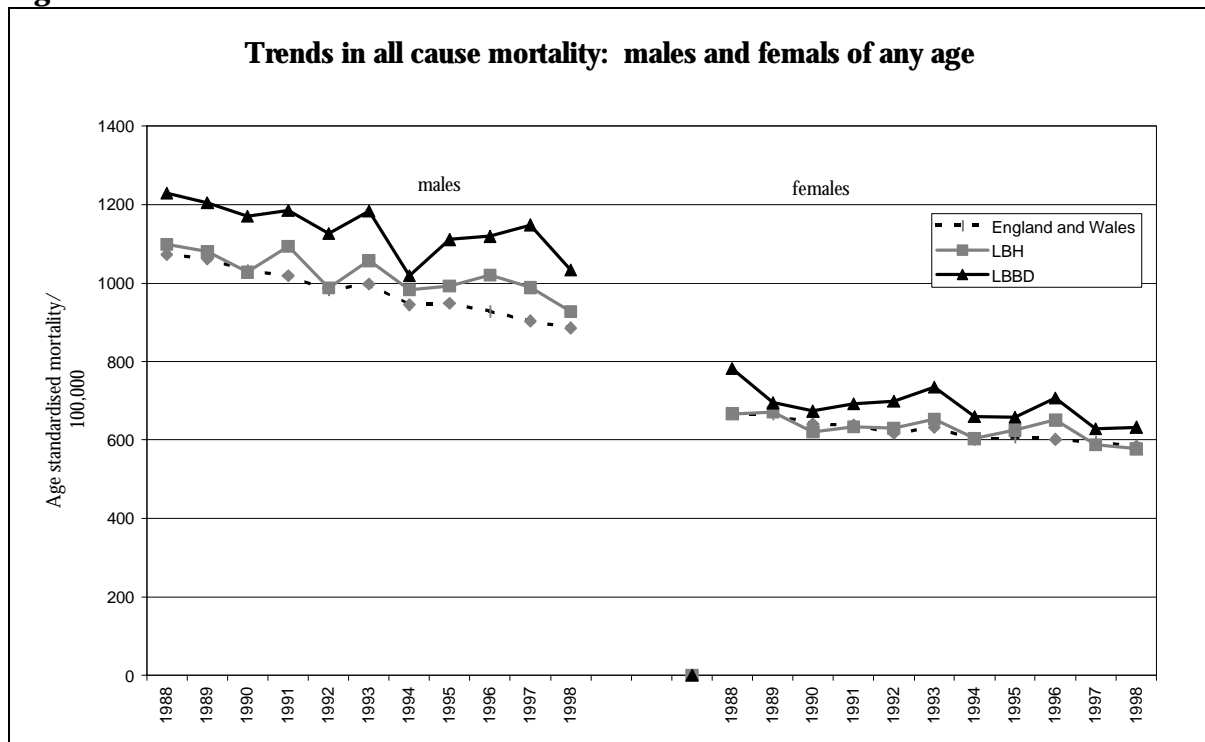
Source: Mapping Health for Primary Care Groups, Health of Londoners Project, 2000

**Figure 1**



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

**Figure 2**



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

The people of Dagenham are high users of hospital services, particularly in terms of emergency admissions, relative to London and to other local PCG areas in BHHA except Barking: see Table 5.

**Table 5 Hospital admissions, standardised ratios (SARs), all causes and emergencies, BHHA PCG areas and London 1997/99**

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	

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

Rates of admission for asthma, diabetes and epilepsy are similar to those seen in Barking, and significantly higher than rates observed in other local PCG areas and London: see Table 6. Admission rates for all three conditions have been included in the NHS Performance Assessment Framework as indicators of primary care performance. The high rates reflect poorly on local services.

**Table 6 Asthma, diabetes and epilepsy: hospital admissions, standardised ratios, all ages, BHHA by PCG area and London 1997/99**

Area	Asthma		Diabetes		Epilepsy	
	SAR	95% CI	SAR	95% CI	SAR	95% CI
Barking PCG	667	610 - 730	747	688 - 811	168	140 - 201
Dagenham PCG	564	515 - 618	705	634 - 761	201	173 - 233
Hornchurch PCG	281	246 - 321	491	448 - 538	142	118 - 170
Romford PCG	359	322 - 400	520	479 - 565	152	129 - 179
Upminster PCG	325	287 - 368	512	471 - 558	169	144 - 200
London	353	349 - 358	508	503 - 514	144	141 - 146

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

## 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 old.
- 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 5<sup>th</sup> highest for males and 2<sup>nd</sup> highest for females in London.
- There has been a decline in lung cancer deaths in males similar to national patterns but deaths in females are increasing.
- There has been a substantial decline in deaths 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 Dagenham in particular:***

- Death rates from cancer in people under 75 years were the 4<sup>th</sup> highest in London in 1998.
- Death rates from lung cancer and stomach cancer were the 4<sup>th</sup> highest in London in 1998.
- Death rates from breast cancer were lower than national and London rates.

### Key action points

- 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 deaths 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 mortality ratios provide a comparison with national figures where England and Wales are standardised to 100. Males and females are standardised separately. Data have recently become available for all 66 PCG areas in London and these have been used for comparison where appropriate.

### Deaths from cancer: all ages

Numbers of deaths from each tumour type in LBBD in 1998 are detailed in Table 7. Lung cancer was the most common cause of death in both men and women (although nearly twice as common in men) with breast cancer next most common in women and prostate cancer next most common in men.

**Table 7 Cancers: numbers of deaths by major tumour site and sex, LBBB 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
<b>All sites</b>	<b>242</b>	<b>222</b>

Source: Mortality statistics, Office of National Statistics (ONS)

Male cancer deaths in Dagenham are the 6<sup>th</sup> highest in London (out of 66 PCG areas). Female cancer death rates are just above the London average.

### ***Premature deaths from cancer***

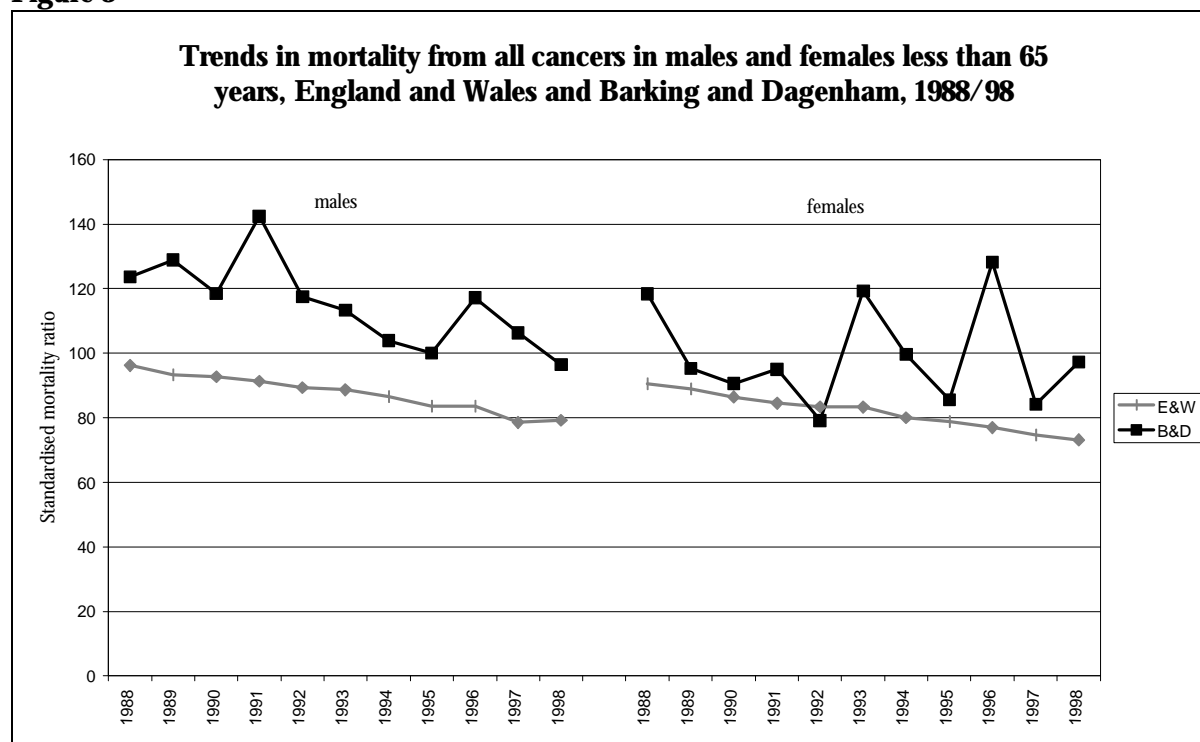
Cancer accounted for 30% of male deaths and 25% of female deaths in LBBB in 1998. For the same year, it accounted for 35% of deaths in people of less than 65 years (27% male deaths but 51% of female deaths).

In line with national trends, there has been a general decrease in LBBB in deaths from cancer for people under 65 years of about 25% in the last decade. There has been a greater decline for men than for women : see Figure 3.

However, rates in LBBB still remain considerably higher than nationally and the London average: see Table 8.

In 1998 the death rate in males was fifth highest in London and for females it was second highest in London.

**Figure 3**



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

Using the registered population base there were 133 deaths from cancer in people under 75 years in Dagenham PCG in 1998. This represents the fourth highest rate in London.

**Table 8 Cancers: Death rates by sex, Dagenham, London and England and Wales 1998**

Area	Cancer in males, all ages SMR*	Cancer in females, all ages SMR*	Death rates in people less than 75 years old Rate per 100,000 population
Dagenham	114	106	162
London	101	101	138
England & Wales	100	100	135

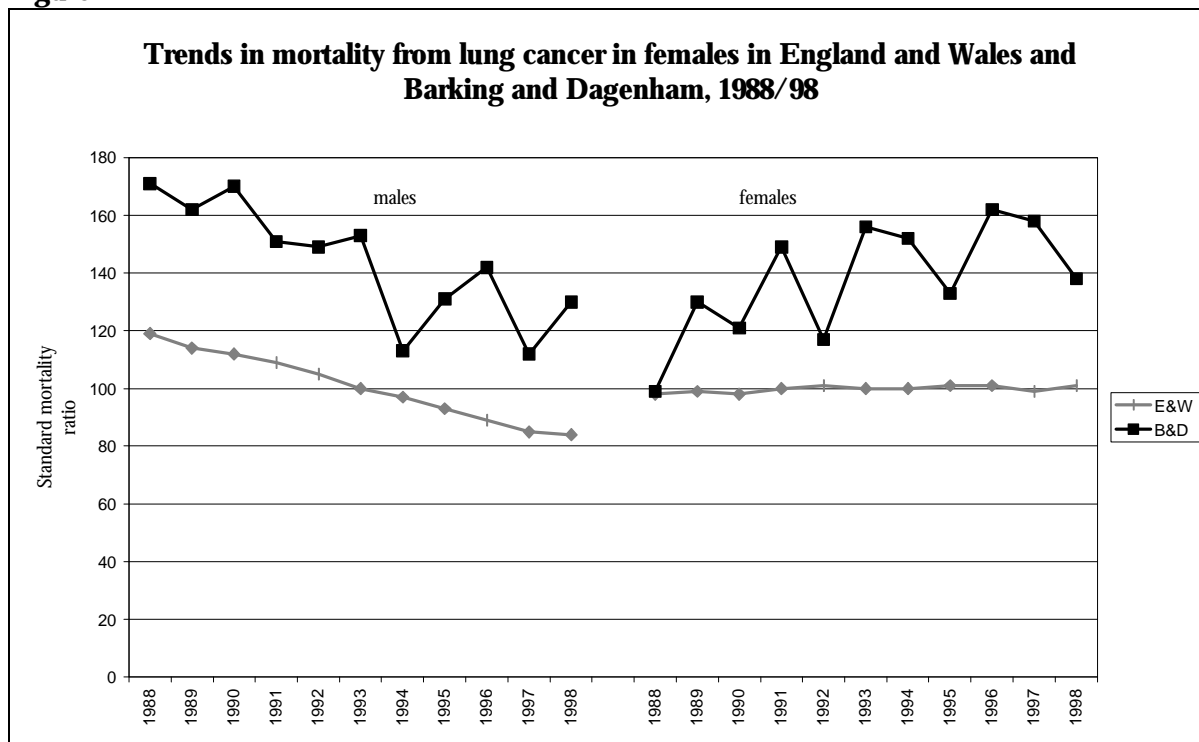
\*Standardised Mortality Ratio where England and Wales = 100

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

### Lung cancer

Lung cancer rates in Dagenham in 1997/98 were significantly higher than London rates and are the fourth highest of London PCG areas. Trends in deaths from lung cancer in LBBDD show that in the last ten years rates have been decreasing for males and increasing for females. In the last three years for females, the trend has been downward: see Figure 4. This is not the case for males, although the overall trend over the decade is downwards. Deaths in men under 75 years have been decreasing and were the lowest in 1998 for ten years. Yet they still remain amongst the highest in London.

**Figure 4**

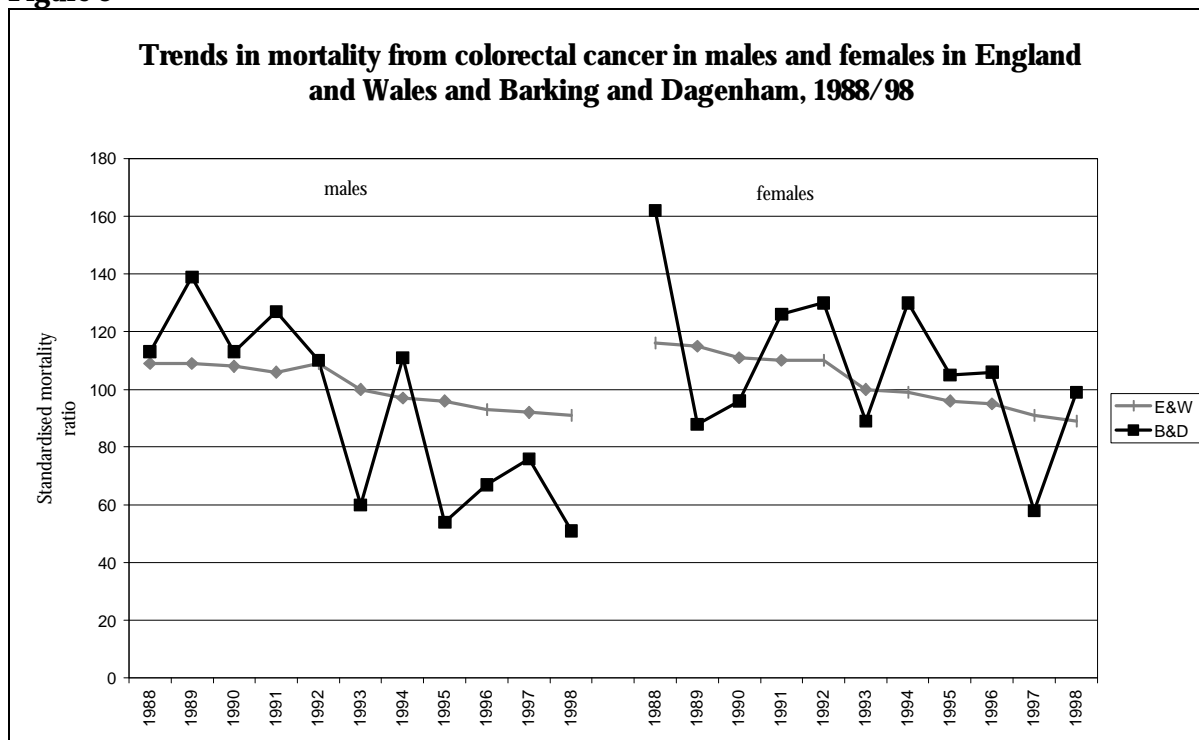


Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

### 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 5.

**Figure 5**

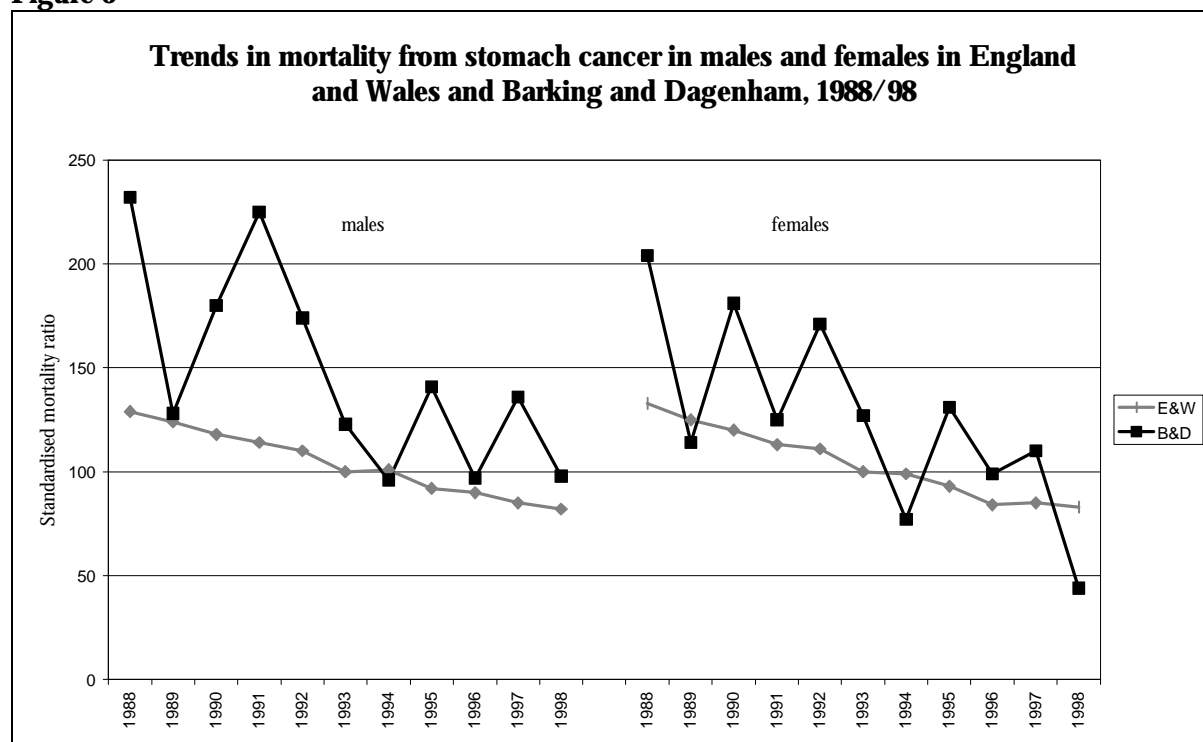


Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999  
 Overall rates are lower than both London and national rates. LBBB had the third lowest rates in London for men and eighth lowest rates for women in 1998.

**Stomach cancer**

Deaths from stomach cancer have halved in the last ten years in LBBB and rates are similar to the London average and lower than national rates: see Figure 6. However, death rates from stomach cancer in Dagenham were the 4<sup>th</sup> highest in London in 1998.

**Figure 6**

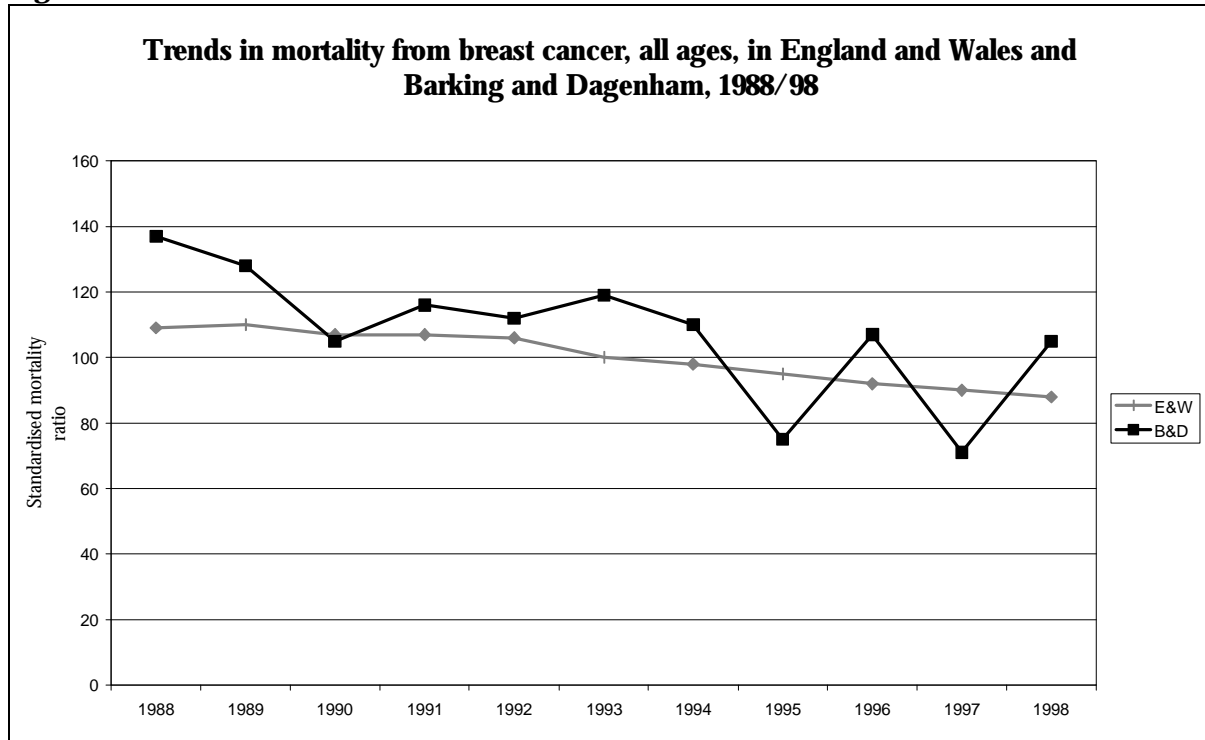


Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring 1999

**Breast cancer**

Deaths 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 LBBB, rates remain high, although variable from year to year: see Figure 7

**Figure 7**



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

## **Coronary heart disease**

**Author: Mark Ansell**

### **Key points of interest**

- CHD remains second only to cancers in terms of deaths caused.
- There is some evidence of slight improvement.
- However, deaths in Dagenham remain higher than the BHHA average.

### **Key action points**

- Dagenham PCG, in common with all PCGs, must address the National Service Framework for CHD, specifically standards three and four regarding the management of persons with or at high risk of CHD. To do this the PCG must assist individual practices to develop and maintain a register of these persons and systematically provide the patient so identified with effective care.
- The PCG must also, as a commissioner, engage with NHS Trusts to maintain and improve the management of CHD in hospital. The PCG should monitor access to revascularisation to ensure equity

### **Summary of trends in death rates**

There were 796 deaths from CHD in Dagenham in the three-year period 1997/99. This represents a 8% reduction on the preceding three-year period: see Table 9.

Ninety five deaths were recorded in persons aged under 75 years during 1997/99. This represents a 15% decline on the preceding three year period: see Table 10.

Despite the observed decline, CHD remains second only to 'all cancers' in terms of deaths caused in Dagenham, 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, deaths from CHD continue to decline steadily. The picture locally is less clear. Figures 8 and 9 show the trend over a ten year period. Much of the recent decline can be attributed to a reduction in death rates amongst men aged 65-74: see Figure 8. A steady decline among women of similar age or younger people of either sex is less evident: see Figures 8 and 9.

Except for Barking, rates of death from CHD are higher in Dagenham than in any other PCG areas and are higher than the BHHA average: see Tables 8, 9 and 10

The death rate is similar to that across the country as a whole, but is higher than the London average: see Table 11.

Death rates at ward level vary widely over time due to the small number of events involved. However Valence and Alibon wards have ranked consistently highly when compared with other wards in BHHA: see Tables 12 and 13.

Rates of revascularisation in Dagenham are lower (not significantly) than in any other PCG area: see Table 14.

Admissions for heart failure are similar to the BHHA average: see Figure 10.

### Detail of trends in death rates

**Table 9 CHD: deaths of persons of any age, Barking, Dagenham and Havering by PCG area, local authority and health authority area 1994/96 and 1997/99**

Area	1994/96			1997/99		
	No.*	Rate*	SMR*	No.*	Rate*	SMR*
Barking	446	207.5	108	425	190.4	114
Dagenham	866	191.6	103	796	170.6	104
Hornchurch	575	180.1	99	509	157.4	98
Romford	590	176.1	97	516	149.1	95
Upminster	605	177.6	94	530	147.4	92
LBBB	1,312	197.0	105	1221	177.3	108
LBH	1,770	177.3	97	1555	151.4	95
BHHA	3,082	184.8	100	2776	161.3	100

\*No. = number of deaths recorded

Rate = the directly aged standardised mortality rate/100,000

SMR = standardised mortality ratio

Source: Public Health Mortality File

**Table 10 CHD: deaths of persons aged under 75 years, Barking, Dagenham and Havering by PCG area, local authority and health authority area 1994/96 and 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
LBBB	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

Source: Public Health Mortality File

**Table 11 Ischaemic heart disease: standardised mortality ratios (SMRs), BHHA by PCG area, London and England 1997/98**

Area	SMR	95% CI
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 12 CHD: deaths of persons aged under 75, Dagenham residents by ward 1992/95 and 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
Alibon	132	129	39	9	118	143	34	4
Becontree	n/a	n/a	n/a	n/a	97	112	26	18
Chadwell Heath	90	85	38	34	82	88	28	29
Eastbrook	105	101	45	24	92	105	34	21
Fanshawe	115	108	49	17	104	123	43	13
Goresbrook	130	115	35	12	89	89	21	28
Heath	117	118	56	11	104	110	37	19
Manor	136	134	40	5	110	127	33	10
Marks Gate	107	107	19	20	118	97	21	25
River	117	114	29	14	166	188	32	1
Triptons	138	130	57	8	87	102	38	22
Valence	154	138	66	3	104	130	49	6
Village	112	104	48	23	119	128	45	9

No. = number of deaths recorded

Rate = the directly aged standardised mortality rate/100,000

SMR = standardised mortality ratio.

Rank = rank across BHHA, total no. of wards in BHHA is 45

Source: Public Health Mortality File

**Table 13 CHD: deaths of persons of any age, Dagenham residents by ward 1992/95 and 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
Alibon	239	128	87	3	172	97	62	25
Becontree	n/a	n/a	n/a	n/a	170	101	60	22
Chadwell Heath	153	80	83	38	166	96	81	27
Eastbrook	200	107	99	16	222	139	114	4
Fanshawe	214	113	123	11	187	111	106	11
Goresbrook	217	106	80	17	183	103	67	18
Heath	208	113	111	12	192	111	86	12
Manor	224	116	88	7	166	89	72	34
Marks Gate	199	105	36	19	193	95	51	30
River	180	97	51	31	343	196	75	1
Triptons	214	106	125	18	159	94	100	31
Valence	252	125	153	5	194	117	135	8
Village	199	103	118	21	204	113	102	10

No. = number of deaths recorded

Rate = the directly aged standardised mortality rate/100000

SMR = standardised mortality ratio

Rank = rank across BHHA. Total no. of wards in BHHA is 45.

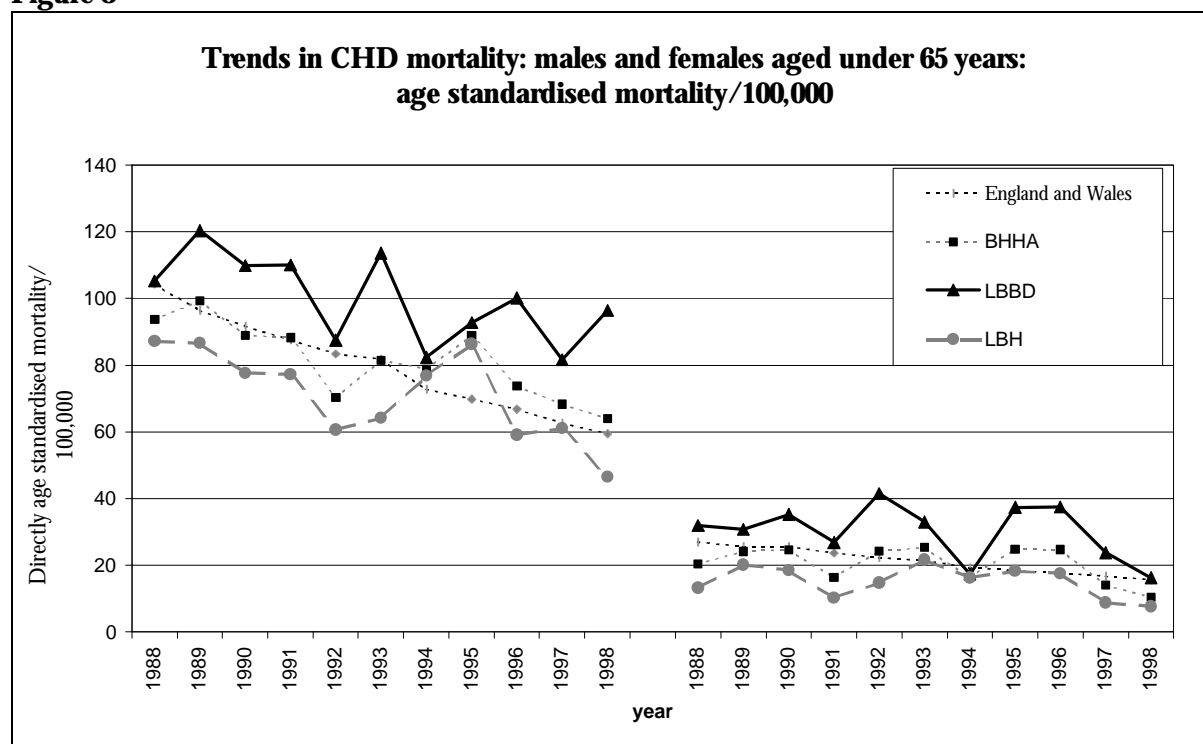
Source: Public Health Mortality File

**Table 14 CHD: age standardised hospital admission rates (ASR) for coronary artery bypass grafts (CABG) and percutaneous transluminal angioplasty (PTCA), BHHA by PCG area and London**

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

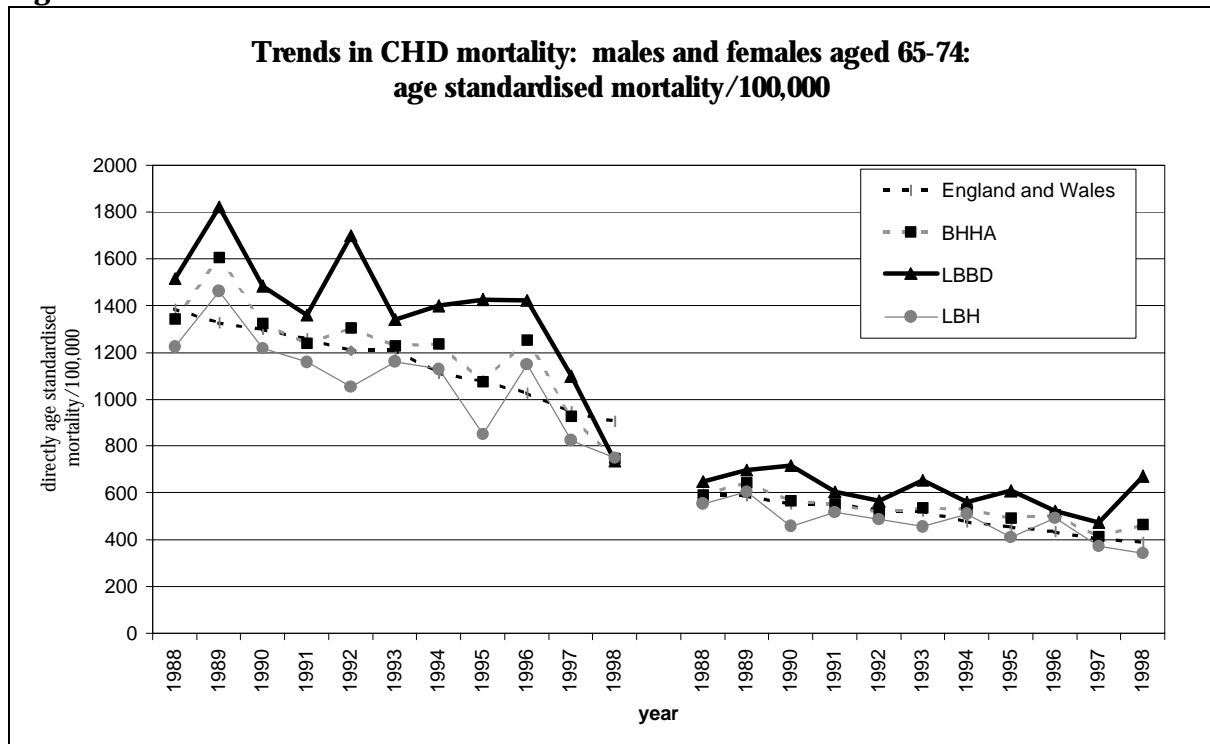
Source: Mapping Health for Primary Care Groups, Health of Londoners Project, 2000

**Figure 8**



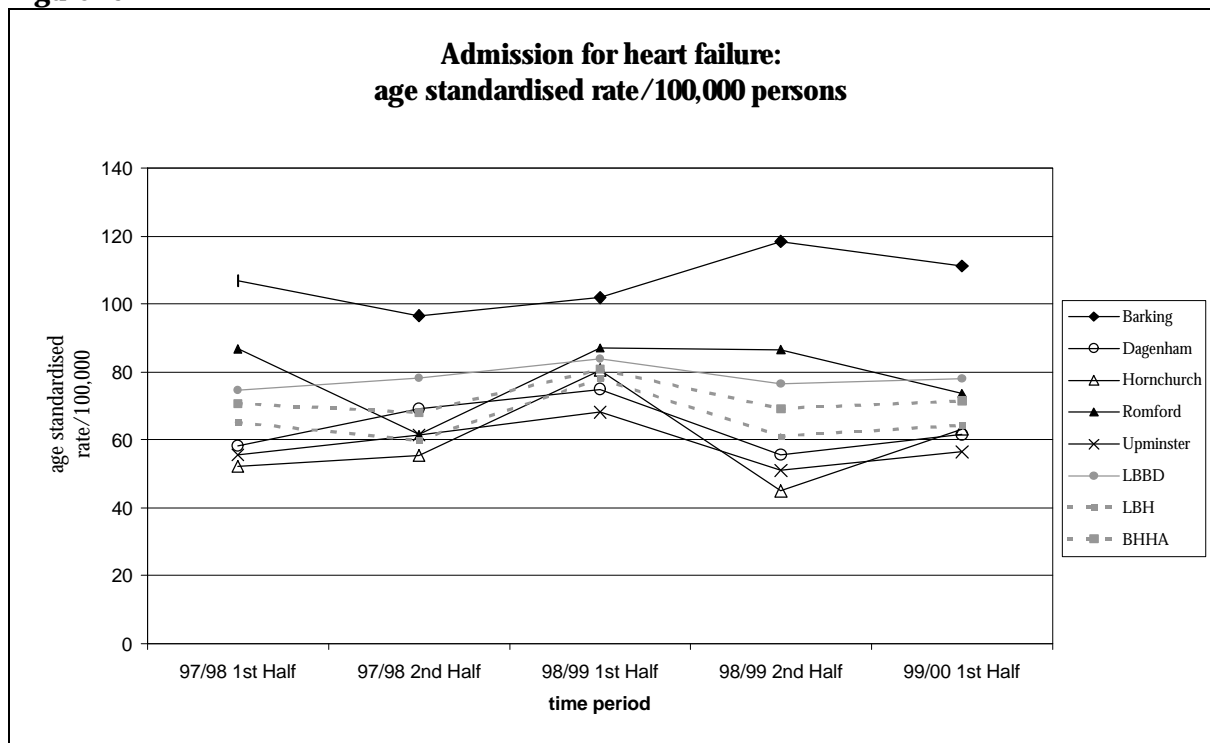
Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring 1999

**Figure 9**



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

**Figure 10**



Source: Hospital Episode Statistics

## **Mental health**

**Authors: Dr Richard Beaver and Dr Peter Messent**

There are no new data pertinent to mental health available for inclusion in this report. The points presented below are reproduced from Report Number 2, with modification to reflect new developments such as the mental health National Service Framework.

### **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 BHHA 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 local action plan for mental health services is contained within the Health Improvement Programme (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;
- 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 approaches to address standards 2 and 3 of the National Service Framework:

- practice-by-practice work to develop primary care links with specialist mental health services;
- the equitable provision of high quality counselling in primary care;
- development of a 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.

## **Osteoporosis**

**Author: Dr Richard Beaver**

There are no new data pertinent to osteoporosis available for inclusion in this report. The points presented below are reproduced from Report 2.

### **Key points of interest**

- The variance of illness and death 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, 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 densitometry 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 is recommended.
- PCGs should commission bone density measurement by means of dual X-ray absorptiometry (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 and
  - (ii) case finding among individuals with a variety of conditions that predispose them to osteoporosis.
- 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.



## **Respiratory diseases**

**Author: Dr Kishor Padki**

### **Key points of interest**

- Chronic obstructive pulmonary disease (COPD) is a chronic, slowly progressive disorder characterised by airflow obstruction that does not change markedly over time. Airflow limitation in COPD is due to varying combinations of airway disease (chronic bronchitis) and emphysema.
- COPD is an important cause of death and has a major impact on the sufferer's 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 with sometimes 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 BHHA offer a structured approach to managing patients.
- Spirometry remains the main tool in the diagnosis and assessing the severity of COPD.
- Admission rates for asthma are higher in Dagenham PCG. 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 of 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**

Dagenham had 227 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. Only three wards (Alibon, Chadwell Heath and Heath) have lower SMRs, with the remaining ten wards having higher SMRs: see Table 15

**Table 15 Chronic obstructive pulmonary disease\*: deaths, all ages, Dagenham by ward, LBBD, and BHHA 1997/00**

Area	Number of deaths	**Rate per 100 thousand population	Standardised Mortality Ratio (SMR)
Alibon	10	50.0	88
Chadwell Heath	15	52.1	91
Eastbrook	22	86.6	152
Fanshawe	18	61.1	107
Goresbrook	19	88.2	155
Heath	11	39.3	69
Manor	20	81.3	142
Marks Gate	13	75.1	131
River	8	60.2	106
Triptons	25	76.3	134
Valence	24	76.5	134
Village	20	78.0	137
Becontree	22	90.6	159
Dagenham PCG	227	70.4	123
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 rates and standardised admission ratio (SAR) for COPD in Dagenham are considerably higher than for BHHA: see Table 16.

**Table 16 Chronic obstructive pulmonary disease \*: hospital admissions, all ages, Dagenham, LBBD, and BHHA 1997/00**

Area	Number of admissions	*Rate per 100,000 population	Standardised Admission Ratio (SAR)
Dagenham PCG	1,504	409.1	129
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 Dagenham are higher than for BHHA across all age groups. There were 431 admissions from asthma in the three year period 1997/00, of which 192 admissions were accounted for by children aged up to 14: see Table 17.

**Table 17 Asthma\*: hospital admissions by age group, Dagenham, LBBD, and BHHA 1997/00**

	<b>Number of admissions (3 years)</b>	<b>Rate per 100,000 population per year</b>	<b>Standardised Admission Ratio (SAR)</b>
<b>Age 0-14 years</b>			
Dagenham	192	295.2	103
LBBD	312	300.2	105
BHHA	632	286.6	100
<b>Age 15-44 years</b>			
Dagenham	119	94.5	111
LBBD	207	104.4	123
BHHA	409	84.3	100
<b>Age 45-64 years</b>			
Dagenham	76	128.4	148
LBBD	122	136.4	156
BHHA	220	87.1	100
<b>Age 65 + years</b>			
Dagenham	44	86.2	105
LBBD	71	93.8	114
BHHA	152	79.8	100
<b>All ages</b>			
Dagenham	431	146.2	111
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: Kishor Padki**

### **Key points of interest**

- Diabetes is a serious disease with no known cure and 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 are undiagnosed and numbers are rising rapidly. The prevalence of diabetes increases markedly with advancing age.
- It is estimated that 2,050 persons could be affected with diabetes in Dagenham.
- Death rates for diabetes are lower in Dagenham.
- The burden of hospital admission for diabetes (as the primary cause of admission) is higher in Dagenham 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 are 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. Group education programmes and enhancing self-management skills in people with diabetes, along with training of practice nurses, have been undertaken by the team.
- 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.

### **Deaths**

There were 22 deaths from diabetes mellitus as the underlying cause of death within Dagenham in the three year period 1997/00. There were no deaths of 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 are lower than for BHHA: see Table 18

**Table 18 Diabetes mellitus\* (underlying cause of death): deaths by age group, Dagenham, LBBD, and BHHA 1997/00**

Area	Number of deaths (3 Years)	Rate per 100,000 population per year			Standardised mortality ratio (SMR)
		Age 1-44	Age 45+	All Ages	
Dagenham	22	0.0	13.3	4.8	77
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

Source: Public Health Mortality file

### Hospital admissions

The admission rate and standardised admissions ratio for Dagenham PCG are higher than for BHHA. The ratio is nearly 1.5 times higher than for Barking PCG. There were 335 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. This will exclude, for instance, admissions from CHD and stroke if diabetes mellitus is mentioned in one of the other diagnosis fields: see Table 19.

**Table 19 Diabetes mellitus\*: finished consultant episodes, all ages, Dagenham, LBBD, and BHHA 1997/00**

Area	Number of admissions (3 years)	Rate per 100,000 population per year	Standardised Admission Ratio (SAR)
Dagenham	335	102.1	126
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**

- Teenage pregnancies are among the highest in London. There has been no consistent decline over the period 1992/97.
- There has been a 50% increase in conceptions among women aged less than 18 and rates in all wards except one have increased.
- The proportion of lone parents is increasing.
- The proportion of babies with low birth weight has increased in lone parents.
- The proportion of babies that are of low birth weight is lower than for BHHA, national or London rates, particularly those of young mothers.
- 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 in Dagenham.
- Lone parents could be targeted for extra support to reduce the cycle of poor health that may follow low birthweight.
- Availability of terminations should be reviewed.

### **Teenage pregnancies**

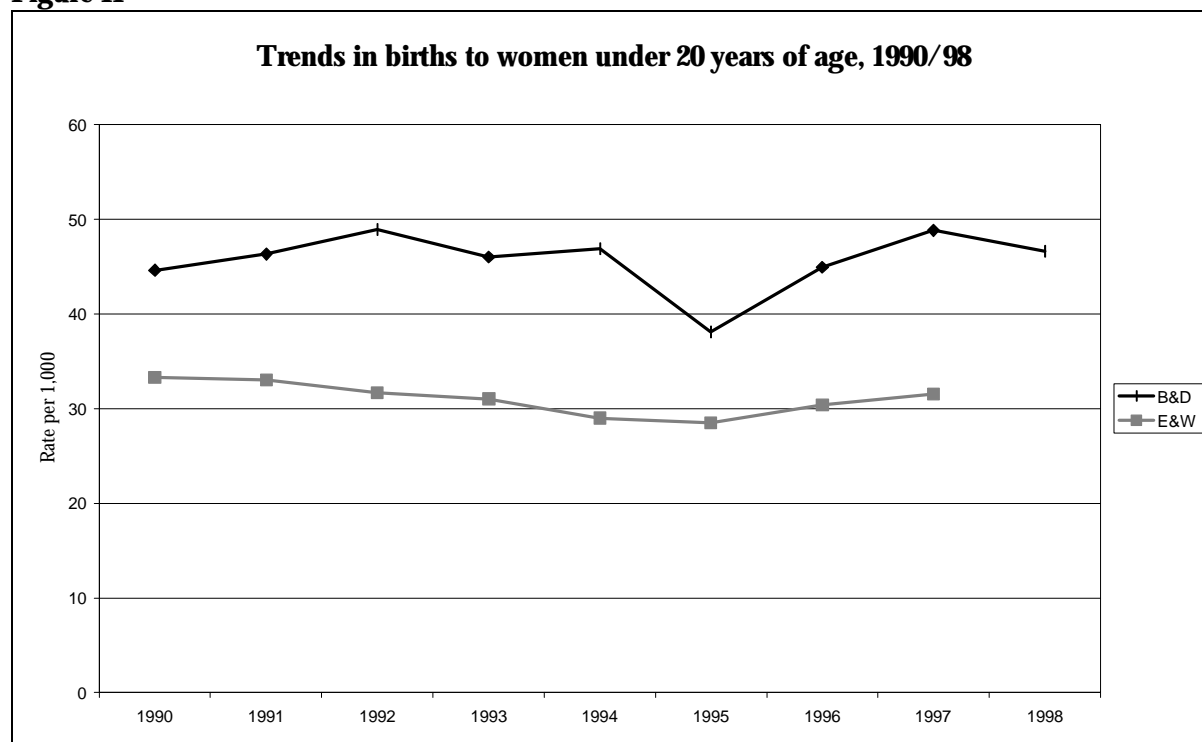
Teenage pregnancies have already been highlighted as an area of concern in Dagenham. The rate in LBBD is higher than that for the country as a whole. There has been no consistent decline in the last decade: see Figure 11. Dagenham has a conception rate among women less than 20 years which is in the highest 20% of London PCG areas. Overall in Dagenham there was a 50% increase in teenage conceptions between 1992/94 and 1995/97. The increase occurred in all wards except one: see Table 20.

### **Marital status**

In line with national trends there has been a large decrease in the proportion of babies born within marriage from 59% in Dagenham in 1993/95 to 50% in 1996/98. There has also been an increase in the proportion of women who register their babies with only one named parent: see Table 21. Sole registration generally indicates lone parent status.

The proportion of babies that are of low birthweight (less than 2,500g, about 5¼lb) has also slightly decreased among married and cohabiting women in that period, but has substantially increased in lone parents. Babies of lone parents are more likely to have low birthweights.

**Figure 11**



Source: ONS

**Table 20 Conceptions by young women aged under 18, Dagenham by ward 1992/94 and 1995/97**

Ward	1992/94	1995/97
Alibon	7	16
Chadwell Heath	11	18
Eastbrook	19	28
Fanshawe	20	27
Goresbrook	21	24
Heath	28	51
Manor	16	15
Marks Gate	14	26
River	13	24
Triptons	15	34
Valence	18	23
Village	24	35
Becontree	22	26
<b>Dagenham</b>	<b>228</b>	<b>347</b>

Source: ONS

**Table 21 Marital status and low birthweight, Dagenham 1993/95 and 1996/98**

Years	% of births within marriage	% of births within marriage that are <2,500g	% of births which are lone registrations	% of lone registrations where birthweight is <2,500g
1993/95	59.1	6.8	6.0	7.8
1996/98	50.3	6.6	9.1	11.3

Source: ONS

## Birthweight

Dagenham had a lower proportion of babies of low birthweight in 1997/99 than national or London proportions: see Table 22. This seems to be mainly due to the lower rates of low birth weight in younger women: see Figure 12.

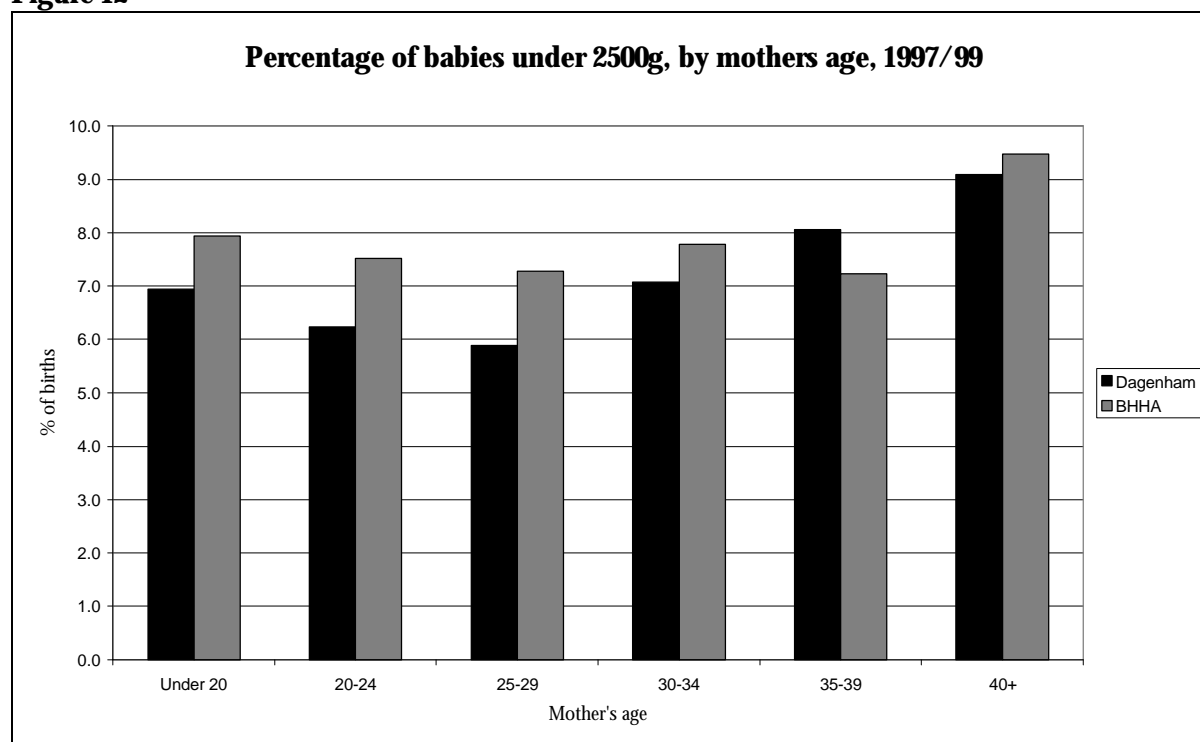
**Table 22 Rates of low birthweight, Dagenham, BHHA, London and England and Wales, years as shown**

Area	% of babies born less than 2,500g
Dagenham 1997/99	6.7
BHHA 1997/99	7.6
London 1998	8.3
England and Wales 1998	7.8

Source: RICHs

However, high maternal age (40+ years) is also associated with low birthweight and, in general, this does appear to be the case in Dagenham. Dagenham has a smaller proportion of older mothers than London or England and Wales: see Table 23. The proportion of babies born to women aged under 20 years has increased from 7.4% in 1995/97 to 8.9% in 1997/99 in Dagenham. In 1995/97 LBBd had the second lowest termination rate in London for women aged under 18 years.

**Figure 12**



Source: RICHs

**Table 23 Proportion of births to younger and older women, Dagenham, BHHA, London and England and Wales, years as shown**

<b>Area</b>	<b>% of babies born to women aged &lt;20 years</b>	<b>% of babies born to women aged 35+ years</b>
Dagenham 1997/99	8.9	11.6
BHHA 1997/99	6.8	12.4
England and Wales 1998	7.6	14.5
London 1998	5.2	18.6

Source: RICHs

## **Health needs identified in community nursing**

**Author: Dagenham Community Nursing Team**

### **Introduction**

In response to the increased emphasis on the public health role of nurses in government policy<sup>1</sup> 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, focusing 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 does and can address the priorities of the HImP and the Primary Care Investment Plan.

The data and information used in producing the profiles has been drawn from a range of sources that include: ONS, PCG Public Health Reports, analysis of current caseloads and the new Regional Integrated Child Health Surveillance (RICHS) system that encapsulated 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.

The nursing teams in Dagenham PCG are based at the following clinics:- Annie Prendergast in Chadwell Heath ward, Five Elms in Valence ward, Oxlow lane in Eastbrook ward and Ford Road in Village ward. The community nurses and health visitors are aligned to GPs.

### **Health visiting**

#### ***Description of caseload***

The main role of the health visitor is to work with children under five and their families.

#### ***Local features/factors affecting health visitor practice***

##### *Deprivation profile*

There are 13 wards covered by Dagenham PCG. With a population generally characteristic of the inner city, with high rates of deprivation, high Jarman scores, high percentage of rented local authority housing, high rates of people on benefit: see Table 24.

**Table 24 Jarman underprivileged area scores (UPA), Dagenham by ward**

Ward	Jarman UPA score
Alibon	17.5
Chadwell Heath	6.6
Eastbrook	4.9
Fanshawe	19.2
Goresbrook	20.9
Heath	27.1
Manor	18.5
Marks Gate	28.9
River	16.4
Triptons	16.7
Valence	20.5
Village	22.4
Becontree	20.9

National average = 0. Positive scores indicate higher than average deprivation  
 Source: Annual report of the Director of Public Health, BHHA 1995

### *Fertility*

Overall fertility rates are high in Dagenham, both general fertility rate (numbers of births per 1,000 women aged 15 to 44 years) and total period fertility rates (average number of children women would be expected to have if women had the age specific rates through childbearing years). Fertility rates are particularly high in the 15 to 24 age group, where rates are 50% higher than for BHHA. There is however high variation between wards.<sup>2</sup> Fertility in the older age groups is similar to BHHA.<sup>2</sup>

In two wards, Heath and Marks Gate, more than 12% of births are to women under 20 years.<sup>2</sup> Rates of low birthweight are lower than for BHHA, but Heath and Goresbrook have higher rates. See Table 25.

**Table 25 Births with significant factors, current residents, Dagenham by ward 1998/99**

Ward	Number of new births	>2500g Number %	>1500g Number %	Number of teenage mothers
Alibon	64	3	1	6
Chadwell Heath	91	7	0	3
Eastbrook	123	7	2	10
Fanshawe	123	5	2	12
Goresbrook	115	11	6	10
Heath	156	10	5	20
Manor	82	4	3	4
Marks Gate	54	2	0	10
River	96	2	0	10
Triptons	105	5	0	7
Valence	101	7	1	9
Village	183	12	4	22
Becontree	-	-	-	-
Dagenham	1,293	75 5.8%	24 1.8%	123 9.5%
BHHA	4,832	364 7.5%	100 2.1%	342 7.1%

NB Becontree data not given as at 02.09.99

Source: RICHs

*Vulnerable families with social or special needs*

Dagenham has a higher incidence of child protection investigations than BHHA and 20% of the children on the Child Protection Register in BHHA are in Dagenham: see Table 26.

**Table 26 Number of vulnerable families with social or special needs where extra community nursing input is given, BHHA by PCG area January 2000**

Primary care group area	Number of families with social or special needs	Number of under 5s on child protection register
Barking	201	35
Dagenham	296	28
Romford	195	16
Hornchurch	data not available	15
Upminster	166	22

Source: BHB Child Protection Register

***Child health surveillance and under 5 years immunisations***

**Table 27 Child development checks and under 5 years immunisations, current residents, percentage completed, Dagenham by ward 1998/99**

Ward	Development checks			Immunisation		
	6 week check	7-8 month check	24 month check	36 month check	Triple and HIB	MMR
Alibon	93%	82%	74%	51%	93%	83%
Chadwell Heath	89%	90%	73%	59%	95%	86%
Eastbrook	96%	86%	77%	66%	96%	89%
Fanshawe	93%	91%	77%	50%	93%	91%
Goresbrook	94%	89%	74%	53%	97%	95%
Heath	95%	90%	73%	50%	94%	85%
Manor	95%	86%	72%	40%	96%	90%
Marks Gate	95%	88%	88%	52%	99%	96%
River	95%	85%	85%	77%	89%	92%
Triptons	95%	79%	72%	54%	96%	88%
Valence	98%	90%	78%	57%	96%	90%
Village	96%	86%	70%	58%	94%	89%
Becontree	-	-	-	-	-	-

Note: Becontree data not given as at 02.09.99

HIB Haemophilus influenzae B MMR Measles, mumps and rubella

Source: RICHS

Except for Alibon, Chadwell Heath, Heath and Triptons all other wards have achieved their target of 90% in immunisation rates. Initial take up of child health checks is greater than 90%. However, there is a high defaulter rate for routine development assessments, most noticeable in Manor where only 40% of 36 month checks are taken up. Drop off rates between the 24 months and 36 months checks are most noticeable in Alibon, Fanshawe and Marks Gate.

*Other factors that impact on the caseloads*

- No IT linkage between community nursing staff and GP surgeries. The PCG has been looking at GP requirements for clinical governance baseline assessment.
- The families are constantly changing their telephone numbers which makes contact difficult.
- The population is mobile.

- Some GPs are in a different PCG area to their nursing team.
- Easier access to specialist services could improve treatment for post natal and other depression and other common mental health disorders.

#### *Other developments*

- Two new postnatal parent groups have been set up in the last six months.
- A refugee support group has been set up at Ford Road Clinic.
- Nursery nurses are being appointed to our teams.
- Speech and language and behavioural groups are taking place at Oxlow Lane Clinic.
- In LBBD, Social Services have just recently done a matching needs and services audit.
- Home Start is being developed.

## **District nursing**

### ***Caseload description***

District nurses work predominantly with elderly people and their families. Table 28 shows district nursing interventions.

**Table 28 Number of district nurse interventions by care category, Dagenham and BHB average April/June 1999**

<b>Intervention</b>	<b>Dagenham: number of interventions</b>	<b>Dagenham % total duration</b>	<b>BHB Trust % total duration</b>
Blood pressure	137	0.9	0.6
Cancer care	559	7.0	10.3
Continence	1040	9.7	10.0
Diabetes	2352	11.5	8.3
Elderly care	302	3.7	2.5
Eye care	743	4.1	3.2
Wound management	5253	48.2	50.1
Other advice/counselling	268	3.3	2.3
Other assessment	190	2.5	2.3
Other: injection/Hickman/VP	303	1.7	1.8

*Note* % total duration - this is the time spent on each activity group expressed as % of total time spent  
Source: RICHs

### ***Local features/factors affecting district nurse practice***

#### *Population features*

The elderly population is increasing with nineteen percent of LBBD's population aged over 65. The projected trend is that this age group will continue to increase, while the number of under eighty fives will decline after peaking in 2001.<sup>2</sup> Significant numbers live alone (33%), although there are relatively good family support structures. The poverty profile reported that there were 4793 pensioner households receiving income support in LBBD, indicating that there are a significant number of elderly persons on low income.<sup>3</sup>

#### *Diabetes*

Some 11.5% of district nurse interventions are in this care category compared to the Trust average of 8.3%. It is estimated that nearly 1,250 persons could be affected by diabetes in Dagenham PCG area.<sup>3</sup>

*Wound management*

Some 48.2% of district nurse interventions are in this care category.

**References**

1. Department of Health. *Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. London: HMSO 1999.
2. Barking and Havering Health Authority. *Public Health Report Information Report Number 2: Dagenham 1999*.
3. London Borough of Barking & Dagenham. *Changing times: a poverty profile of Barking and Dagenham 1997*

## **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 Dagenham 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 LBB and LBH, have agreed funding to extend the initiative into local secondary schools. There are currently nine primary schools signed up to the Healthy Schools Initiative in Dagenham: see Table 29.

**Table 29 Dagenham 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
Grafton Infants													
Trinity													
John Perry													
Leys Primary													
Grafton Junior													
Rush Green Junior													
Rush Green Infants													
Godwin Primary													
Thomas Arnold													

## **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.