

Barking and Havering Health Authority

Annual Report of the Director of Public Health 1999/2000

Health in Hornchurch Primary Care Group Area

Barking and Havering Health Authority
The Clock House, East Street, Barking, IG11 8EY
Telephone 020 8532 6216
www.bhha.org.uk

©Barking and Havering Health Authority
September 2000
ISSN 0968 9818

Contents

Executive summary	3
The purpose and sources of this report.....	5
The population of Hornchurch.....	6
Cancers.....	9
Coronary heart disease.....	15
Mental health.....	20
Osteoporosis.....	22
Respiratory diseases	23
Diabetes mellitus.....	26
The health of mothers and infants	28
Health needs identified in community nursing	31
Health promotion	37

Executive summary

This report updates Information Packs Numbers 1 and 2 and, where appropriate, includes another year's data. It also contains some comparisons with all 66 primary care group (PCG) areas in London and a section by the Hornchurch Community Nurses describing their work and areas of local concern. The commentary is much abbreviated and readers are encouraged to use this report in conjunction with Information Pack Numbers 1 and 2 and the most recent Primary Care Investment Plan (PCIP) for Hornchurch PCG.

The recent PCIP demonstrates that Hornchurch PCG is already actively addressing recommendations made in this and previous information packs. For example, two priority areas both nationally and locally are cancers and coronary heart disease (CHD). In each of these areas Hornchurch PCG has an action plan.

So far as cancers are concerned, the following public health recommendations have been made:-

- GPs should encourage eligible women to attend for breast screening.
- 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.

In connection with the Hornchurch PCIP, the following are recommended:-

- Ensure practice professionals are aware of breast screening programmes and use their skills to teach women breast awareness and provide relevant literature.
- Reduce the incidence of smoking by smoking cessation clinics and reporting results with pregnant women in particular.
- Audit Havering Hospital Trust compliance with two-week wait and appropriate referrals. In conjunction with these priorities, work will continue to ensure that all practices continue to meet cervical cytology targets

For CHD, the following public health recommendations have been made:-

- Hornchurch PCG, 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 patients 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.

In connection with the Hornchurch PCIP, work will continue with other partners and at a practice level to reduce the incidence of CHD. It will throughout 2000/2001:

- determine optimum arrangements for CHD screening services with primary care;
- ensure by the end of March 2001 that all practices will be using standardised/effective chronic disease registers;
- work with public health, PCGs and local trusts to establish a co-ordinated approach in the treatment of patients with CHD in accordance with National Service Framework for CHD.

Hornchurch PCG is not only active in addressing national priorities. They have been responsive to local needs and introduced two new innovative services.

They have established four locally based Dermatology Outpatient Clinics in Rainham, South Hornchurch, Elm Park and Hornchurch. This has reduced outpatient waiting times for dermatology assessment from twenty four weeks to three weeks and resulting minor operations from 6 months to 2 months and helped reduce outpatient waiting time for hospital based services. Approximately 500 patients will be seen in a primary care setting during the year.

Three locally based Phlebotomy Clinics have also been established and are held in Elm Park, South Hornchurch and Rainham. This has improved accessibility (open access) and acceptability for patients requiring investigations and reduced pressure on hospital services. Approximately 850-1000 patients will now be seen in local clinics in a year.

The Hornchurch community nurses also make a series of important recommendations to:-

- better meet the needs of refugee/homeless families;
- increase the uptake of breast feeding; to improve care for diabetic patients; and
- improve wound management.

<p>The Public Health lead is Dr Peter Messent. Telephone 020 8532 6359 The Health Promotion lead is Rashida Choudhery at BHB Health Promotion. Telephone 01708 465723</p>

The purpose and sources of this report

Purpose

PCG profiles have been developed to help inform decision making, whether about the commissioning of services, investment in primary care, the development of programmes of professional education or quality improvement initiatives. PCGs have to choose between competing claims on limited funds. The profiles aim to provide evidence of the health needs of each PCG using routinely collected data, to complement the experience and local knowledge of Board members.

Sources

This report is the third in a series and should be viewed in conjunction with Information Packs Numbers 1 and 2. This report continues to provide information regarding measures of death, disease and service usage. Topics included in the pack have been selected because they are deemed 'important' to the NHS nationally. The topics are the four areas included in the *Our Healthier Nation* Green Paper (cancers, CHD/stroke, accidents and mental health), or identified as issues of local concern and included in the HImP for Barking, Dagenham and Havering (diabetes, respiratory disease, child and maternal health).

These data were previously only available by locality, local authority and health authority. Reconfiguring these data has entailed considerable work that has been undertaken by the IM&T department of Barking and Havering Health Authority (BHHA). This process is ongoing and further data will become available in due course. PCGs with particular information needs should liaise with their designated public health support in the first instance.

Each section within the PCG profile has either been written by a member of the Public Health Department with lead responsibility for that topic, BHB Health Promotion or the Hornchurch Community Nursing Team. The public health lead for Hornchurch has contributed an overview of the needs of Hornchurch PCG.

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 third information pack is another step in this process.

Authors

This report was prepared by the Public Health PCG lead, Dr Peter Messent. Other contributions are acknowledged in the text.

The population of Hornchurch

Author: Dr Peter Messent

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

An update on population characteristics

Many census variables have already been reported on in previous PCG profiles. These remain unchanged and will remain so until the census of 2001. Only new data or data not previously presented are given below.

The Hornchurch population reports low levels of long term illness relative to local PCGs and London as a whole: see Table 1. Relative to London, a lower proportion of the Hornchurch population is in receipt of benefits due to disability: see Table 2.

Relative to other local PCGs and London, the population of Hornchurch is less dependent on public transport and a smaller proportion live in accommodation without central heating: see Table 3.

Table 1 Census-based indicators of long term illness, Barking, Dagenham and Havering PCG areas and London

Area	Standardised limiting long-term illness rate for household residents aged under 75	Rank relative to other PCGs in London	% of 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 Proportion of population in receipt of 'disability benefits', Barking, Dagenham and Havering PCG areas and London

Area	Attendance allowance/ 1,000 residents aged >65	Rank	Disability living allowance/ 1,000 residents < 65	Rank	Incapacity benefit/ 1,000 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 effecting need or access to health care services, Barking, Dagenham and Havering PCG areas and London

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 Project, 2000

Rates of death and illness

A variety of indicators suggest that the population of Hornchurch experience low levels of deaths and illness. The population of Hornchurch experience lower rates of death than the other local PCGs and London: see 4. The population of Hornchurch are low users of hospital services, particularly for emergencies relative to London and other local PCGs: see Table 5. Rates of admission for asthma, diabetes and epilepsy are lower than rates observed in other local PCGs 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 low rates reflect well on local services.

Table 4 Standardised mortality ratios (SMR), all causes of death, Barking, Dagenham and Havering PCG areas and London 1995/97

Area	< 65		< 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

Table 5 Hospital admissions, all cases and emergencies, Barking, Dagenham and Havering PCG areas and London

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	

CI = Confidence intervals

Source: Mapping Health for primary care groups, Health of Londoners Project 2000

Table 6 Age standardised hospital admission rates (ASRs) for asthma, diabetes and epilepsy, Barking, Dagenham and Havering PCG areas and London

Area	Asthma		Diabetes		Epilepsy	
	ASR	95% CI	ASR	95% CI	ASR	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

CI = Confidence interval

Source: Mapping Health for primary care groups, Health of Londoners Project 2000

Cancers

Author: Dr Frances Haste

Key points of interest

For the London Borough of Havering (LBH):

- Cancer causes 27% of deaths but 44% of deaths in people under 65 years.
- Lung cancer is the most common cause of cancer deaths in males and breast cancer in females.
- Cancer death rates are similar to London rates.
- There has been a decline in lung cancer deaths similar to national patterns.
- There has been a substantial decline in deaths from colorectal cancer in females and stomach cancer that is similar to national patterns.
- There has been no decline in deaths from breast cancer in the last five years, unlike the national picture that has shown a continuing decline over the last ten years.

For Hornchurch in particular:

- All age cancer death rates are similar to those in London.
- Deaths from cancers in people under 75 years were 10th lowest in London in 1998.
- Lung cancer death rates are similar to London rates.
- Death rates from stomach cancer are slightly higher than London rates.
- Breast cancer deaths are higher than London rates but not significantly so.

Key action points

- GPs should encourage eligible women to attend for breast screening.
- 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.

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 age groups

Numbers of deaths from each tumour type in LBH in 1998 are detailed in Table 7. Lung cancer was the most common cause of death in men and breast cancer the most common in women. Prostate cancer is the next most common in men and lung next most common in women.

Table 7 Cancers: numbers of deaths by major tumour site and sex, LBH 1998

Site	Males	Females
Lip, oral, pharynx	1	3
Digestive system	110	76
• oesophagus	15	8
• stomach	23	10
• lower gastrointestinal tract	37	28
• pancreas	20	16
Respiratory system	83	49
• larynx	0	1
• bronchus, trachea, lung	83	48
Skin	5	4
Breast	-	62
Genito-urinary system	58	38
• uterus	-	8
• cervix	-	4
• ovary	-	13
• prostate	36	-
• bladder	10	6
• kidney	11	6
Nervous system	9	7
Lymphatic/haematological	27	24
All sites	335	303

Source: Mortality Statistics, Office of National Statistics

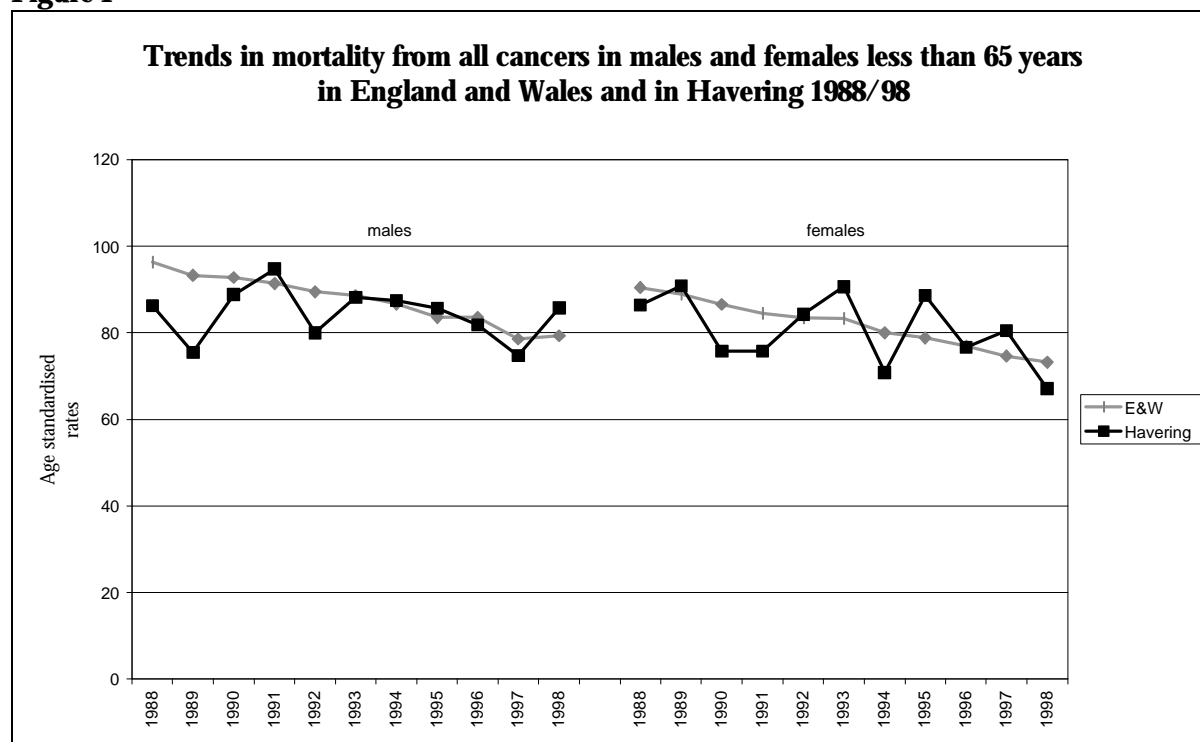
Male cancer deaths in Hornchurch are slightly but not significantly higher than in London. Female cancer deaths are slightly but not significantly lower than in London.

Premature deaths from cancer

Cancer accounted for 30% of male deaths and 25% of female deaths in LBH in 1998. For the same period it accounted for 44% of deaths in people of less than 65 years (38% male deaths but 55% of female deaths).

National trends show a general decrease in deaths from cancer for people <65 years of about 18% over the last decade: see Figure 1. Rates in LBH have been similar to those in London and nationally. However, the decline for men has been much less than that for women. Whilst death rates for women are lower than London rates, those for men are higher.

Figure 1



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

Of the three PCG areas in LBH, Hornchurch has the lowest rates of cancer mortality in people less than 75 years and the 10th lowest in London. Using the registered population base there were 103 deaths from cancer in people under 75 years in Hornchurch in 1998: see Table 8.

Table 8 Cancers: death rates, in Hornchurch, London and England and Wales, 1998

Area	Males, all ages SMR*	Females, all ages SMR*	Deaths per 100,000 population aged under 75
Hornchurch	108	95	123
London	101	101	138
England and Wales	100	100	135

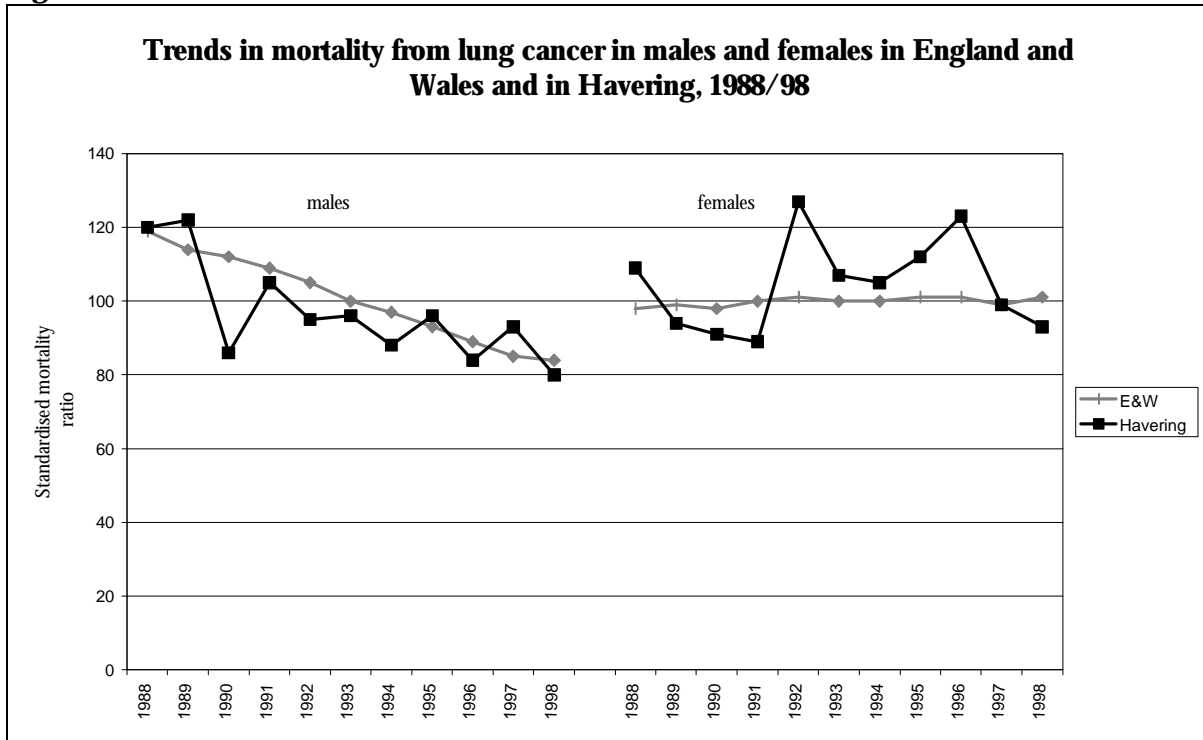
Standardised Mortality Ratio where England and Wales = 100

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

Lung cancer

Lung cancer rates in Hornchurch in 1997/8 were similar to London rates. Trends in deaths from lung cancer in LBH show a similar decrease to national trends but there are big differences between men and women. There has been a decrease of 20-25% over the decade for males, but no overall decrease for females. Year on year patterns have, however, been very variable: see Figure 2. The pattern for people under 75 years is similar.

Figure 2

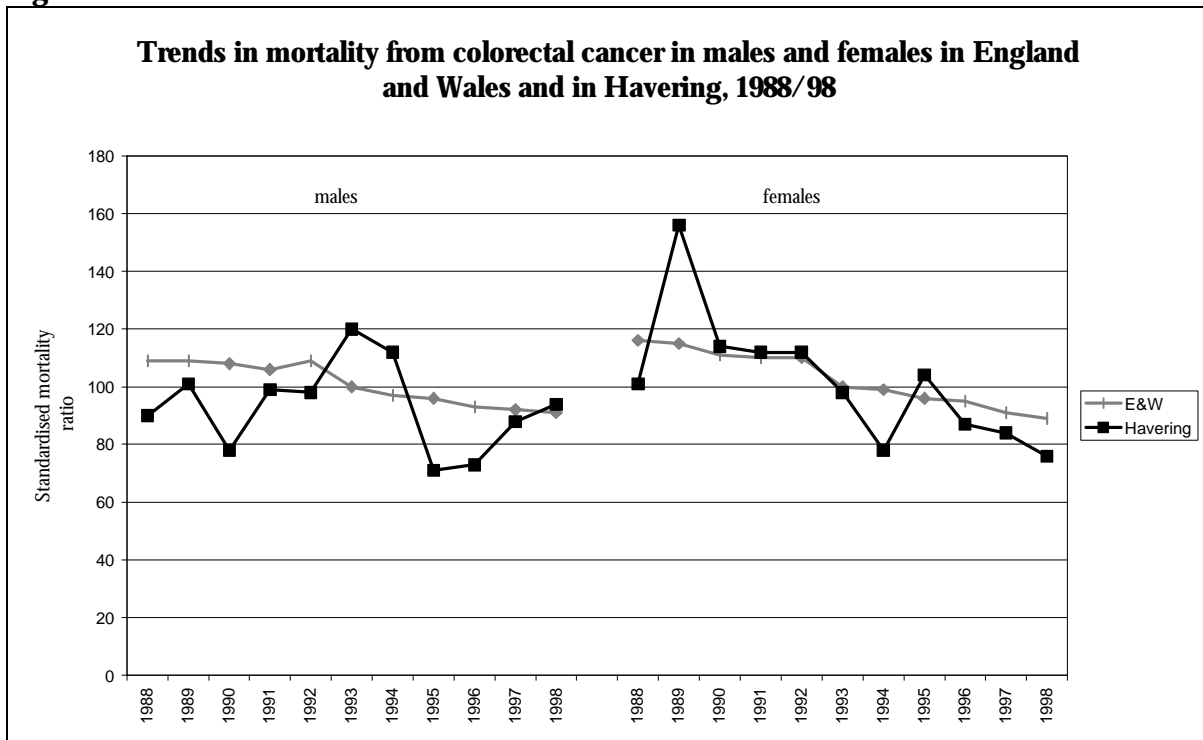


Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Colorectal cancer

There have been some improvements in death rates from colorectal cancer in LBH. In the last decade in women it has reduced by a third. In men, however, there has been no overall trend: see Figure 3. Overall rates are slightly higher for both men and women than London rates.

Figure 3

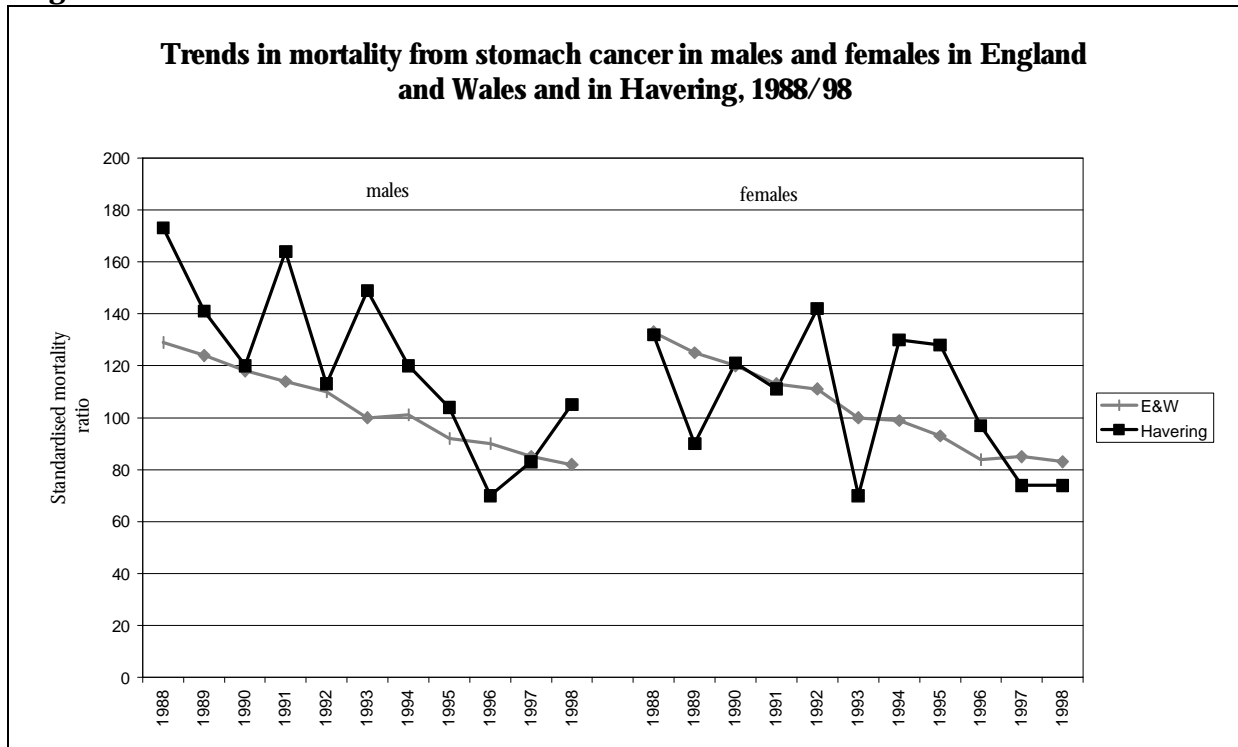


Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Stomach cancer

Death rates from stomach cancer have decreased by a third in the last ten years in LBH: see Figure 4. In 1998 rates were slightly higher than the London average, although lower than national rates.

Figure 4

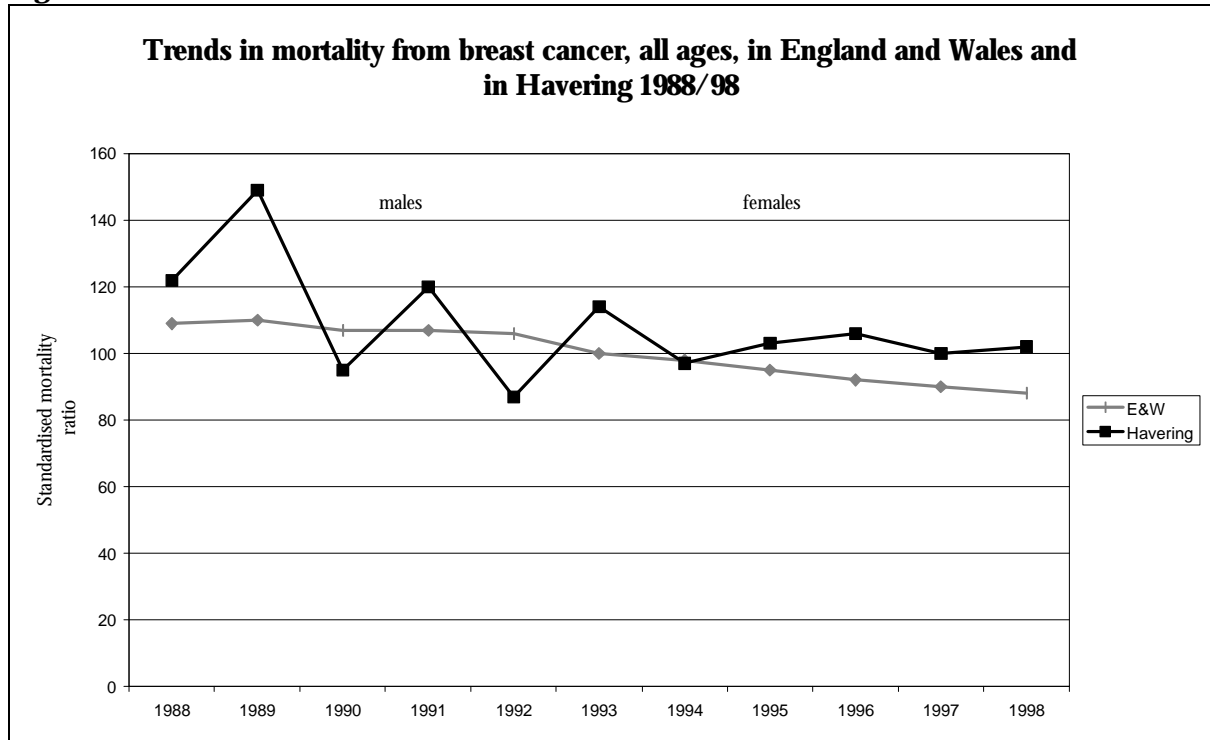


Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Breast cancer

Deaths from breast cancer (all ages) nationally and in London have shown a steady decline of about 20% in the last ten years. Although there has been some decline in LBH, it has not been as great as England and Wales: see Figure 5. Rates have not declined at all in the last five years. They remain higher than national or London ones. In 1998 death rates in LBH were the fourth highest in London. For women aged 50-69 years, decreases in LBH have also been less than in London. Hornchurch had higher death rates from breast cancer than London in 1997/98 but not significantly so.

Figure 5



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.
- Recently, there has been some improvement in terms of CHD deaths.

Key action points

- Hornchurch PCG, 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 patients 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.

Summary of trends in death rates

There were 509 deaths from CHD in the Hornchurch PCG in the three-year period 1997/99. This represents an 11% reduction on the preceding three-year period: see Table 9.

Seventy people under 75 years died from CHD during 1997/99. This represents a 20% 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 Hornchurch, BHHA and the country. 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. After several years, when rates actually increased, deaths from CHD in LBH now appear to be following a similar downward trend: see Figures 6 and 7. Currently rates of death from CHD in Hornchurch are similar to those elsewhere in LBH, London and the country as a whole: see Tables 9, 10 and 11.

Death rates at ward level are prone to considerable fluctuation due to the small number of events involved. However it would appear that rates in Airfield, Rainham and South Hornchurch wards are consistently higher than other wards in the PCG area: see Tables 12 and 13.

Rates of revascularisation in Hornchurch are higher than those observed in other local PCG areas, except Barking, but are lower than the London average. Rates will have to rise considerably to achieve the ultimate target set in the CHD National Service Framework: see Table 14.

Rates of admission for heart failure, seen as an indicator of effective primary care management, are consistently lower than the BHHA average: see Figure 8.

Detail of trends in death rates

Table 9 CHD: deaths of persons of any age, by PCG area, local authority area and BHHA 1994/96 and 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
London Borough of Barking & Dagenham (LBBD)	1312	197.0	105	1221	177.3	108
LBH	1770	177.3	97	1555	151.4	95
BHHA	3082	184.8	100	2776	161.3	100

* Number = number of deaths recorded

Rate = the directly aged standardised mortality rate/100000

SMR = standardised mortality ratio

Source: Public Health Mortality File

Table 10 CHD: deaths of persons aged under 75, by PCG area, local authority area and the BHHA 1994/96 and 1997/99

Area	1994/96			1997/99		
	Number	Rate	SMR	Number	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	33.3	88
BHHA	466	50.6	100	359	39.1	100

* Number = number of deaths recorded

Rate = the directly aged standardised mortality rate/100000

SMR = standardised mortality ratio

Source: Public Health Mortality File

Table 11 Ischaemic heart disease: SMRs, BHHA by PCG area, 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 12 CHD: deaths of persons aged under 75, Hornchurch by ward 1992/95 and 1996/99

Ward	1992/95				1996/99			
	Annual rate per 100,000 population	SMR	Deaths over period	Rank	Annual rate per 100,000 population	SMR	Deaths over period	Rank
Airfield	110	108	49	16	97	113	44	17
Elm Park	74	73	42	39	72	85	40	31
Hacton	98	93	55	29	80	87	44	30
Hylands	91	91	44	31	88	102	40	23
Rainham	110	105	58	22	113	128	51	8
South Hornchurch	99	94	53	28	105	118	48	15
St Andrews	80	77	42	37	58	64	28	42

Source: Public Health Mortality File

Table 13 CHD: deaths of persons of any age, Hornchurch by ward 1992/95 and 1996/99

Ward	1992/95				1996/99			
	Annual rate per 100,000 population	SMR	Deaths over period	Rank	Annual rate per 100,000 population	SMR	Deaths over period	Rank
Airfield	215	115	104	8	168	102	91	19
Elm Park	147	79	89	39	138	87	85	36
Hacton	161	84	110	35	153	91	117	33
Hylands	189	102	111	23	149	86	93	38
Rainham	212	110	116	14	207	117	104	7
South Hornchurch	173	89	87	34	218	125	95	5
St Andrews	178	99	139	27	133	83	121	40

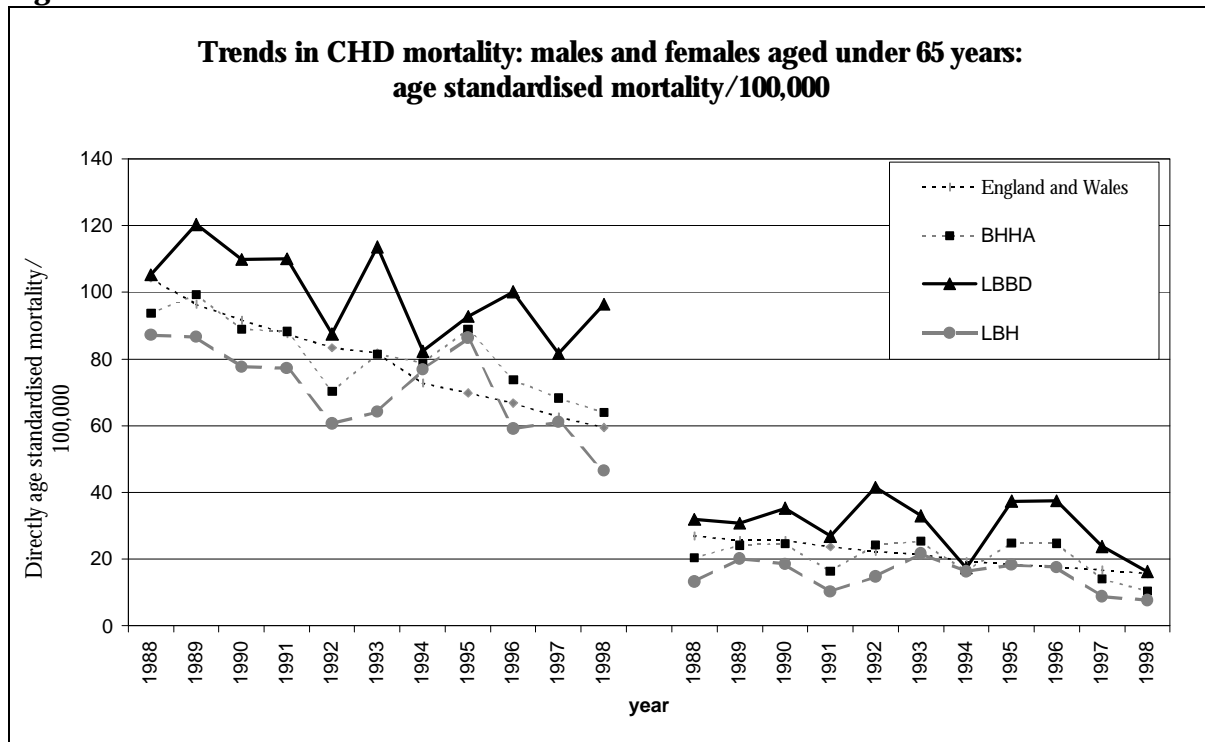
Source: Public Health Mortality File

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

Area	ASR	95% CI
Barking PCG	62.7	45.5 - 86.4
Dagenham PCG	35.4	23.4 - 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

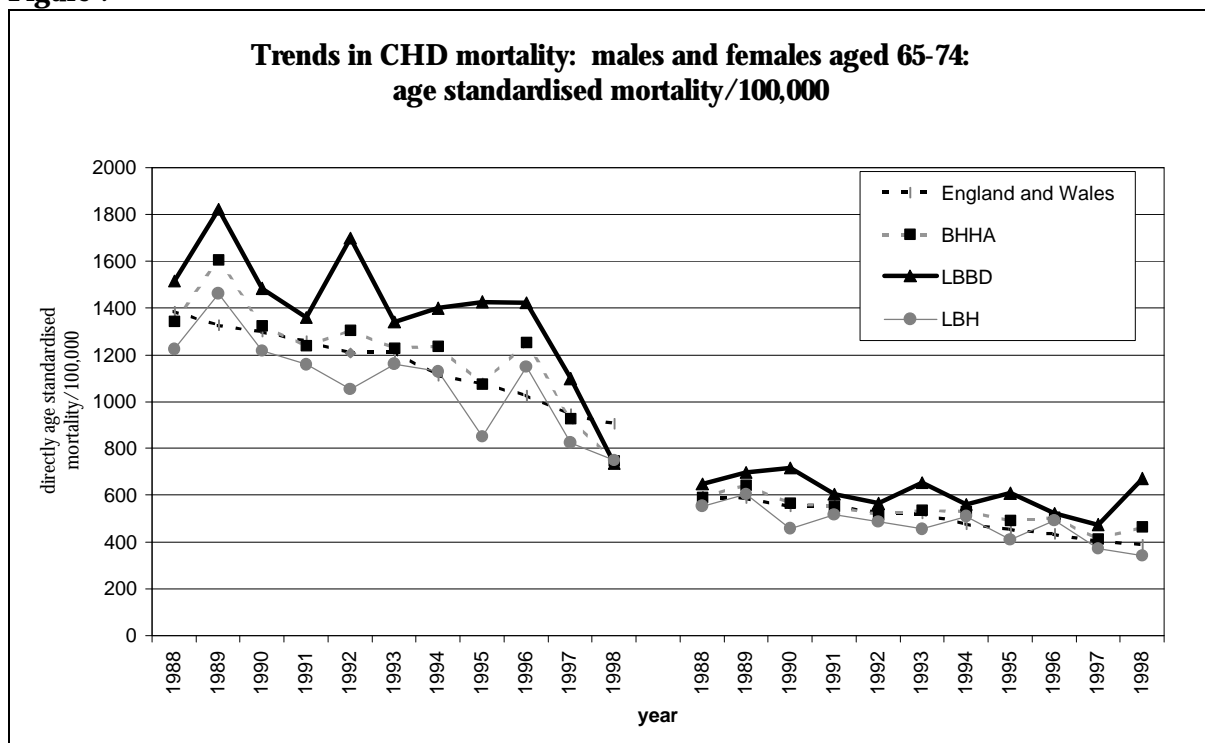
Source: Mapping Health for Primary Care Groups, Health of Londoners Project, 2000

Figure 6



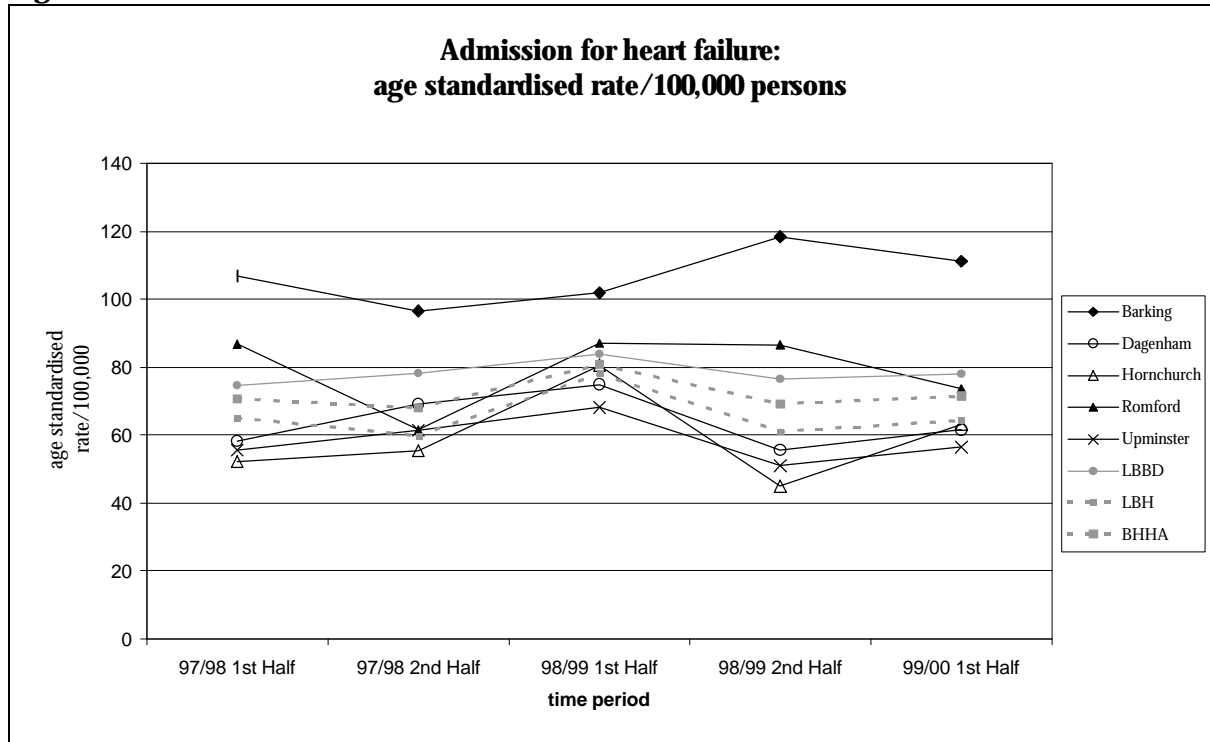
Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Figure 7



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

Figure 8



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 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 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 PCG areas and further improve links with general practice;
- reprovide acute mental health services for the population of the 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;
- 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.

Homchurch (PCIP) response

The PCG will continue to work with BHHA (as purchasers of mental health services on behalf of the PCG) and increasingly the shadow Mental Health Trust. Particular focus will be given during the planning period on reviewing counselling services to determine the merit in their extension to all practices within the PCG area (40% coverage only at present).

Mental health data

Data at PCG area level in Information Pack Number 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 Number 69 Child and Adolescent Mental Health
- Report Number 60 Mental health services for patients who present with severely challenging and offending behaviour
- Report Number 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 Barking and Havering Health Authority (BHHA), BHB Community Health Care NHS Trust (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 deaths due to osteoporosis between the PCGs 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 are 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 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 Two and, for a more comprehensive discussion, Public Health Report Number 96, obtainable on request from the Public Health Department.

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, which 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 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 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 in children are lower in Hornchurch 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 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

Hornchurch had 110 deaths from COPD in the three-year period 1997/00: see Table 15. The death rate and the standardised mortality ratio (SMR) are lower than for BHHA. Wards with higher SMR are Airfield and Rainham.

Table 15 Chronic obstructive pulmonary disease*: deaths, all ages, Hornchurch by ward, LBH, and BHHA 1997/00

Ward	Number of deaths	**Rate per 100,000 population	Standardised Mortality Ratio (SMR)
Airfield	20	78.4	137
Elm Park	13	43.4	76
Hacton	12	30.2	53
Hylands	17	57.0	100
Rainham	18	67.2	118
St Andrews	16	41.2	72
South Hornchurch	14	57.9	101
Hornchurch	110	51.2	90
LBH	332	48.5	85
BHHA	665	57.1	100

* ICD9 code 490-496 (underlying cause of death)

** Indirect age-standardisation using BHHA population

Source: Public Health Mortality file

Hospital admissions for COPD

The admission rate and standardised admission ratio for COPD in Hornchurch are lower than for BHHA: see Table 16.

Table 16 Chronic obstructive pulmonary disease *: hospital admissions, all ages, Hornchurch, LBH and BHHA 1997/00

Area	Number of admissions	**Rate per 100,000 population	Standardised Mortality Ratio (SMR)
Hornchurch	638	235.2	77
LBH	2,054	252.1	81
BHHA	4,302	310.3	100

*ICD10 code J40—J47 as primary diagnosis

** Indirect age-standardisation using BHHA population

Source: Hospital Episode Statistics

Hospital admissions for asthma

The admission rates and standardised admission ratio for asthma in Hornchurch are lower than for BHHA across all age groups: see Table 17.

Table 17 Asthma*: hospital admissions by age group, Hornchurch, LBH, and BHHA 1997/00

Area	Number of admissions (3 years)	Rate per 100,000 per annum	Standardised admission ratio
Age 0-14 years			
Hornchurch	91	219.5	76
LBH	320	275.7	96
BHHA	632	286.6	100
Age 15-44 years			
Hornchurch	65	66.7	78
LBH	202	70.9	84
BHHA	409	83.3	100
Age 45-64 years			
Hornchurch	30	53.5	61
LBH	98	59.9	69
BHHA	220	87.1	100
Age 65+ years			
Hornchurch	27	76.3	96
LBH	81	70.9	90
BHHA	152	79.8	100
All ages			
Hornchurch	213	98.1	76
LBH	701	113.2	87
BHHA	1413	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 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 1,580 persons could be affected with diabetes in Hornchurch.
- Death rates for diabetes are lower in Hornchurch.
- The burden of hospital admission for diabetes (as the primary cause of admission) is lower in Hornchurch 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. The team has also undertaken group education programmes and enhancing self management skills in people with diabetes along with training of practice nurses.
- A 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 from diabetes

There were 16 deaths from diabetes mellitus as the underlying cause of death in Hornchurch in the three-year period 1997/00: see Table 18. 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 for Hornchurch are lower than for BHHA.

Table 18 Diabetes mellitus*: deaths (underlying cause of death) by age group, Hornchurch, LBH 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	
Hornchurch	16	0.0	15.1	5.4	87
LBH	64	0.0	17.9	6.5	104
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 Hornchurch are lower than for BHHA: see Table 19. There were 192 finished consultant episodes (FCEs) with diabetes mellitus as the main reason for admission. We have excluded all FCEs where diabetes mellitus is mentioned in any other diagnosis field. This will exclude, for instance, admissions for CHD and stroke if diabetes mellitus is mentioned in one of the other diagnosis fields.

Table 19 Diabetes mellitus*: finished consultant episodes, all ages, Hornchurch, LBH and BHHA 1997/00

Area	Number of admissions (3 years)	Rate per 100,000 population per year	Standardised admission ratio (SAR)
Hornchurch	192	73.4	95
LBH	564	70.7	93
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 in Hornchurch are generally low compared to other local PCG areas and to London as a whole. They have been decreasing, except in Rainham.
- The proportion of babies that have low birthweight is generally low, but babies of young mothers show much higher rates.
- There is a relatively high and increasing proportion of older mothers.

Key action point

Increasing maternal age may have implications for obstetric services that are required.

Teenage pregnancies

Conception rates among young women aged under 18 in LBH are in the lowest 20% of London boroughs, and teenage pregnancies account for only 4.0% of births in Hornchurch. However, there are differences within the PCG area, with Hacton and South Hornchurch wards having higher numbers of teenage pregnancies than other wards: see Table 20.

Table 20 Conceptions to young women, ages as shown, Hornchurch by ward 1992/97

Area	Under 16	Under 18	Under 18
	1992/97	1992/94	1995/97
Airfield	8	22	11
Elm Park	5	14	11
Hacton	11	20	19
Hylands	5	19	17
Rainham	7	17	25
St.Andrew's	5	16	17
South Hornchurch	13	33	22
Hornchurch total	54	141	122

Source: Office of National Statistics (ONS)

Overall in Hornchurch there was a decrease in teenage conceptions between 1992/94 and 1995/97. Almost all wards showed a decrease although conceptions in Rainham ward increased in that period by nearly 50%.

Marital status

Hornchurch has the highest proportion of births within marriage in BHHA. In line with national trends there has been a slight decrease in the proportion of babies born within marriage from 73.1% in Hornchurch in 1993/95 to 68.1% 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. Lone registration generally indicates a lone parent.

Table 21 Marital status and low birthweight in Hornchurch, 1993/95 and 1996/98

Years	% of births within marriage	% of births in marriage that are under 2,500g	% of births which are lone registrations	% of lone registrations where birthweight under 2,500g
1993/95	73.1	7.0	3.3	10.0
1996/98	68.1	7.4	5.6	9.8

Source: ONS

The proportion of babies that are of low birthweight (less than 2,500g, about 5½lb) has increased in married women but decreased slightly in lone mothers in that period. This is the reverse of what one would expect, as babies of lone parents are more likely to be low birthweight babies.

Birthweight

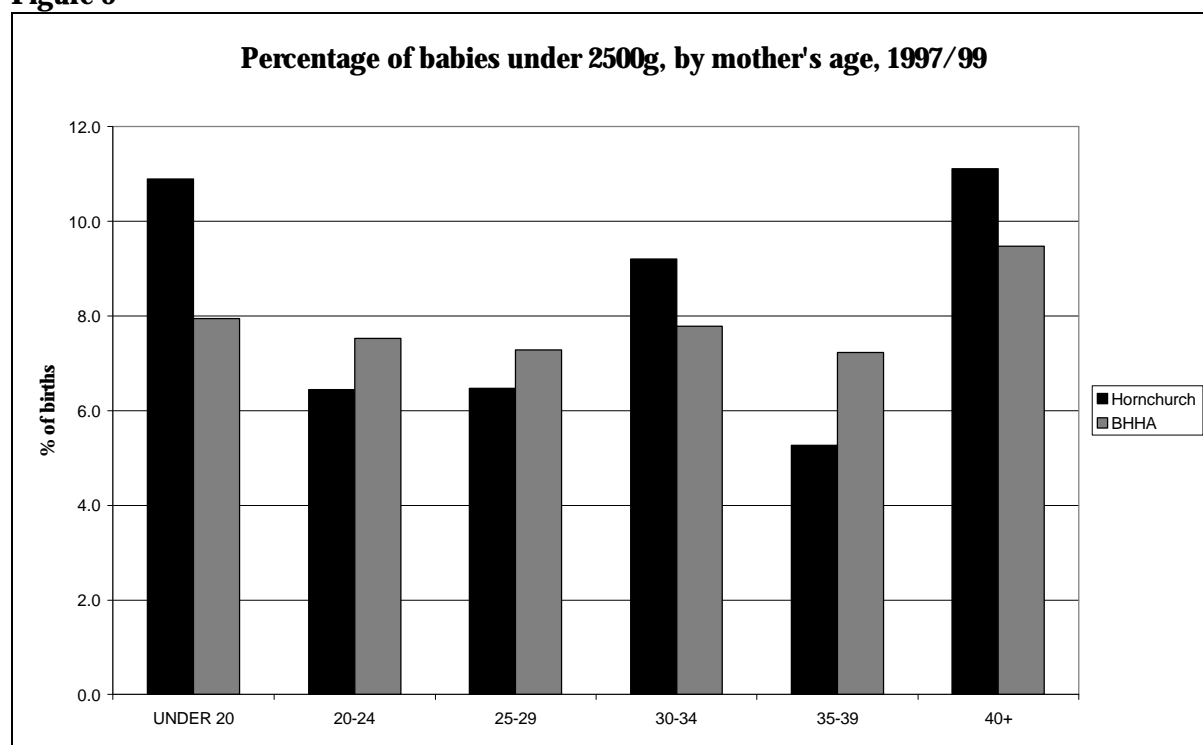
Hornchurch had a lower proportion of babies of low birthweight in 1997/99 than national or London proportions: see Table 22. However, younger (under 20 years) and older (40+ years) women had higher rates of low birthweight: see Figure 9.

Table 22 Rates of low birthweight in Hornchurch, BHHA, London and England and Wales, years as shown

Area	% of babies born under 2,500g
Hornchurch 1997/99	7.6
BHHA 1997/99	7.6
London 1998	8.3
England and Wales 1998	7.8

Source: Regional Integrated Child Health Surveillance (RICHS)

Figure 9



Source: RICHS

Hornchurch has a larger proportion of older mothers than the BHHA average, but lower than London or national rates: see Table 23.

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

Area	% of babies born to women aged under 20	% of babies born to women aged over 35
Hornchurch 1997/99	4.0	13.0
London 1998	5.2	18.6
BHHA 1997/99	6.8	12.4
England and Wales 1998	7.6	14.5

Source: RICHs

The proportion of births to older mothers in Hornchurch has increased from 11.0% in 1995/97 to 13% in 1997/99. Older women (over 35 years) tend to have higher rates of pregnancy complications, particularly those relating to hypertensive conditions.

Health needs identified in community nursing

Author: Hornchurch Community Nursing Team

Recommendations by the Community Nurses

Health visiting

To meet the needs of refugees/homeless families

Investment in a multi agency collaborative initiative such as an advice clinic, with interpreters available to assist the clients in discussing their financial, social and health issues.

To increase uptake of breastfeeding

- Invest in breastfeeding information initiatives in local secondary schools.
- Invest in breastfeeding support groups to encourage breastfeeding mothers to continue for at least 15 weeks to enable their babies to gain the full benefit from breastfeeding.

District nursing

To improve health care for diabetic patients

- Invest in a co-ordinated, multi-disciplinary approach to screening and education in general practice for diabetic patients.
- Increase the provision for screening housebound patients. District nurses provide diabetic foot screening for the patients known to them, but this is ad hoc.
- Establish a multi-disciplinary diabetic foot care centre.

Recommendations to Hornchurch PCG to improve wound management

Set up and evaluate a pilot wound care clinic for non-housebound patients.

Recommendations to Hornchurch PCG to improve care of the elderly

- This client group's needs may well be better met by the health visiting service for the elderly, currently being developed within the PCG.
- There is a need for a co-ordinated service from GPs, practitioners, health visitors and district nurses to ensure that the elderly population is cared for safely in their home environment.

There are three integrated teams of community nurses operating in Hornchurch. Community nurses are aligned to designated GP practices.

Health visiting

Caseload description

Health visitors mostly work with the under fives and their families in the areas of health promotion, health surveillance and family support.

Local features/factors affecting health visitor practice

Deprivation profile

There are seven wards covered by Hornchurch PCG. Hornchurch has overall a social and economic environment similar to the national average: see Table 24. Unemployment is low in the PCG area; however evidence from caseloads suggests that there are pockets of deprivation in Airfield and South Hornchurch wards, with higher unemployment.

Table 24 Jarman underprivileged area scores, Hornchurch by ward

Ward	Jarman score*
Airfield	6.0
Elm Park	-9.7
Hacton	-8.6
Hylands	-3.3
Rainham	-7.3
St Andrews	-6.2
South Hornchurch	-1.0

* National average = 0. Negative values are better than average

Source: DPH Annual Report 1995

Fertility

Rates are particularly low in the 15 to 24 age group where rates are less than half those in BHHA: see Table 25. Fertility in the older age groups is similar to BHHA. The number of teenage mothers is low overall in all wards in Hornchurch except South Hornchurch and Rainham.¹

Table 25 Births with significant factors, current residents, Hornchurch by ward and BHHA 1998/99

Ward	Number of new births	Number under 2,500g	Number under 1,500g	Number of teenage mothers
Airfield	110	13	1	4
Elm Park	114	7	2	4
Hacton	123	8	4	4
Hylands	132	14	4	4
Rainham	150	14	0	11
St Andrews	118	10	0	6
S Hornchurch	137	12	3	10
Hornchurch	884	63 (7.1%)	17 (1.9%)	43 (4.9%)
BHHA	4,832	364 (7.5%)	100 (2.1%)	342 (7.1%)

Source: RICHs

Ethnic minorities

Only 3.7% of Hornchurch residents are members of ethnic minorities (1991 census). Since 1997 there has been a small number of refugees settling in South Hornchurch ward. There is a homeless hostel in Elm Park where many of the residents are members of ethnic minorities.

Vulnerable families with social or special needs

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	data not available	28
Romford	195	16
Hornchurch	data not available	15
Upminster	166	22

Source: BHB Child Protection Register

Health visitor identified needs

Refugees/homeless families

The London Borough of Newham places clients in the Homeless Hostel at Elm Park. A named Health Visitor visits the hostel regularly and, in supporting these clients, spends a considerable amount of time liaising with the education department, social services and the homeless unit in Newham on behalf of the clients.

Small but increasing numbers of refugees from the former Yugoslavia are being located in the area, mostly within the South Hornchurch ward. In supporting these clients holistically the health visitor interventions include assisting clients to apply for social fund loans, accompanying families to voluntary organisations for furnishing and clothing, helping them apply for adult education classes and for school placements for the children.

Recommendation to Hornchurch PCG to meet the needs of refugees/homeless families: Invest in a multi-agency collaborative initiative such as an advice clinic, with interpreters available to assist the clients in discussing their financial, social and health issues.

Breastfeeding

There is a low level of breastfeeding in Hornchurch. Approximately 40% of babies born between January - December 1999 were breast fed at birth, falling to approximately 20% at six weeks. This is considerably lower than the national average of 63%.

As women generally decide how to feed their baby either before or in early pregnancy,² introducing information about the benefits of breastfeeding in secondary school as part of the personal, social and health education programme³ may be of benefit. The South Hornchurch/Rainham team has registered with the UNICEF Baby Friendly initiative to promote breastfeeding and UNICEF is promoting the establishment of support networks for breastfeeding mothers.

Recommendations to Hornchurch PCG to increase uptake of breastfeeding:

- Invest in breastfeeding information initiatives in local secondary schools
- Invest in breastfeeding support groups to encourage breastfeeding mothers to continue for at least 15 weeks to enable their babies to gain the full benefit from breastfeeding

Postnatal depression

Most of the health visitors in the PCG area have on their caseloads between 5 and 10% of mothers who gave birth in the past year who have suffered from postnatal depression. The

mother - infant relationship can be adversely affected by postnatal depression.⁴ The health visitor offers supportive visiting/counselling to these clients to support recovery of the mother and promote the emotional and psychological wellbeing of the child. As social isolation is a factor in postnatal depression, each team runs a series of postnatal support groups. These groups provide an opportunity for health promotion topics on the care of young babies and for new mothers to meet others to develop a support network, and prevent social isolation.

Behaviour problems

Behaviour management visits are time consuming and families experiencing difficulties may need weekly visits for many weeks to support them in carrying out the behaviour management strategies. Since the beginning of January a proactive parenting group has been set up, targeted for first time mothers of children aged approximately 15 months to provide information on child and behaviour management to promote good enough parenting.

Child health surveillance and under 5 immunisations

Table 27 Child health development checks and under 5 immunisations, percentage completed, current residents, Hornchurch 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
Airfield	96%	90%	83%	75%	97%	89%
Elm Park	97%	90%	91%	83%	93%	92%
Hacton	97%	90%	91%	78%	99%	95%
Hylands	96%	94%	90%	82%	96%	86%
Rainham	98%	94%	90%	78%	99%	90%
St Andrews	99%	93%	85%	82%	99%	87%
South Hornchurch	94%	83%	78%	77%	91%	91%

HIB Haemophilus influenzae B MMR Measles, mumps and rubella

Source: RICHs

All wards achieved their target of 90% immunisation (MMR) except for Hylands and St Andrews. Initial take up of child health checks is greater than 90% and uptake remains high up to 3 years.

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 nursing interventions by care category, Hornchurch and BHB average April-June 1999

Intervention	Hornchurch number of interventions	Hornchurch % total duration*	BHB Trust % total duration*
Blood pressure	91	0.5	0.6
Cancer care	840	12.1	10.3
Continence	967	9.9	10.0
Diabetes	1,092	6.7	8.3
Elderly care	116	1.2	2.5
Eye care	179	1.2	3.2
Wound management	5,352	56.2	50.1
Other advice/counselling	174	1.7	2.3
Other assessment	152	2.8	2.3
Other: injection/Hickman/VP	280	1.8	1.8

*The time spent on each activity group expressed as a % of total duration

Source: RICHS

Local features/factors affecting district nurse practice

Hornchurch has a population of 79,839. The population structure is similar to that of BHHA, with a smaller proportion of people aged over 65 years. Health care needs for this age group are comparatively lower in this PCG area.¹

District nurse identified needs

Diabetes mellitus

Statistics obtained from GPs within Hornchurch PCG suggest that 2.3% of the local population are diabetic. Type-2 diabetes usually presents later in life and approximately 70% of these patients are over 55 years old.

The major impact of the condition upon an individual's health arises through its complications.⁵ BHHA has a higher than national average for amputation among patients with diabetes. There is strong evidence from multiple studies that suggests that up to 50% of these amputations could be prevented with effective screening and education.

Recommendations to Hornchurch PCG to improve health care for patients with diabetes:-

- Investment in a co-ordinated, multi-disciplinary approach to screening and education in general practice.
- Increase the provision for screening housebound patients. District nurses provide diabetic foot screening for the patients known to them, but this is ad hoc.
- Establish a multi-disciplinary diabetic foot care centre

Wound management

Some 56.2% of district nurse interventions are in this care category, which is above the Trust average. Many of the referrals to district nurses for wound care are for patients who are not housebound and who could easily access a clinic. Due to the increasing numbers of day case surgery, the number of referrals is increasing.

Recommendation to Hornchurch PCG to improve wound management:-

- Set up and evaluate a pilot wound care clinic for non-housebound patients.

Vulnerable elderly people

A significant number of vulnerable elderly clients, who no longer have specific nursing needs, are being kept on the caseload for supportive visiting.

Recommendations to Hornchurch PCG to improve care of elderly people:

- This client group's needs may well be better met by the health visiting service for the elderly, currently being developed within the PCG area.
- There is a need for a co-ordinated service to ensure that the elderly population is cared for safely in their home environment.

Caring for terminally ill patients at home

Currently patients who wish to spend the last stages of their terminal illness at home are dependent on their relatives to assist in their nursing care. The district nursing day and night services and the Marie Curie sitting services assist in the care, but this is not a 24-hour provision. The Hospice at Home Service is due to start in April and it is hoped this will bridge the gap in the current service. Further evaluation will be required in the near future to ensure effective monitoring of the service provision and recommendation to Hornchurch PCG.

References

1. Barking and Havering Health Authority.. *Public Health Report Information Pack Number 2: Hornchurch* 1999
2. Wylie J, Verber I.. Why women choose not to breast feed. *Maternal and Child Health* 1994; **March**: 76-80.
3. Hall D *Health for all children*. Third edition. Oxford: Oxford University Press 1996.
4. Murray G The impact of postnatal depression on infant development. *J Child Psychol Psychiat* 1992; **33**: 543-61.
5. Cavanagh P Biomedical aspects of diabetic foot disease: aetiology, treatment and prevention. *Diabetic Medicine* 1996; **13**: 17-22.

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 Hornchurch 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 five primary schools signed up to the Healthy Schools Initiative in Hornchurch: see Table 27.

Table 29 Hornchurch 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
Scargill Infants													
Suttons Primary													
Parsonage Farm Infants													
Wykeham Primary													
Towers Infants													

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 is 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.