

**Barking and Havering Health Authority**

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

**Health overview: health in  
Barking, Dagenham and Havering**

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## Glossary

ASR	Age standardised hospital admission rates
BHB	BHB Community Health Care NHS Trust
BHHA	Barking and Havering Health Authority
CABG	Coronary artery bypass graft
CHD	Coronary heart disease
CI	Confidence intervals
COPD	Chronic obstructive pulmonary disease (respiratory disease)
DEXA	Dual X-ray absorptiometry - osteoporosis detection scanning technique
ENT	Ear, Nose and Throat Department
FCEs	Finished consultant episodes
GLA	Greater London Authority
HImP	Health Improvement Programme
HIV	Human immunodeficiency virus
HRT	Hormone replacement therapy
ICD	International classification of diseases
LBBD	London Borough of Barking and Dagenham
LBH	London Borough of Havering
LRC	London Research Centre
MRSA	Methicillin-resistant staphylococcus aureus
ONS	Office for National Statistics
PCG	Primary Care Group
PCIP	Primary Care Investment Plan
PCT	Primary Care Trust
PTCA	Percutaneous transluminal angioplasty
RICHs	Regional Integrated Child Health System
SAR	Standardised admission ratio
SMR	Standardised mortality ratio
TB	Tuberculosis

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## **Foreword**

**Author: Dr C J Watts**

The recent reorganisation of the health service, with a focus on primary care, has called for a radical re-think of the public health report this year. From 1<sup>st</sup> April 2001, subject to satisfactory consultation and approval by The Secretary of State, there will be two Primary Care Trusts in the Health Authority. Within these trusts there will be Locality Directorates, which correspond to the existing Primary Care Groups (PCGs). These Trusts and Directorates will have responsibility for assessing the health needs of their populations and setting health priorities, within the framework of the Health Authority's Health Improvement Programme (HImp).

To support this process, the public health report has been radically redesigned. We have, in effect, produced health reports for each of the PCGs. Trust specific health priorities can easily be derived from these reports. We hope this will provide a good starting point for the new Chief Executives when they look for public health advice on the main health problems in their Trusts.

The benefit of this approach is that the areas of health inequality in the Health Authority can be specifically targeted. The health priorities summary in the report highlights the wide variation in health problems being tackled across the authority. It is not the nature of the high health needs in Barking and Dagenham PCGs that is unusual, but their extent. The resources needed to tackle the extensive HImps that will be needed in these areas should not be underestimated. Preparation is needed for expansion in the population in the Barking reach area. The plight of refugees is emphasised, with estimates in excess of 3000 living in the authority. They live in PCGs that already have high levels of deprivation. The report draws attention to local government wards, which have especially high mortality levels. We will be supporting PCGs in investigating the reasons for this. Upminster has a particular problem in dealing with the large numbers of older people in the PCG and supporting those living in the large number of residential and nursing homes.

The Health Authority overview sets out the authority wide priorities. Emphasis is given to the continuing need for integration of the planning processes in the local health economy. We emphasise improving early life circumstances and a health improving approach to the organisation of work and social organisation.

The approach adopted in looking at epidemiologically defined need has been to concentrate on national priority areas such as the National Service Frameworks for Mental Health and Coronary Heart Disease (CHD). There is also a concerted drive to reduce smoking levels in the community, which requires the support of all. Cancer is a particular problem for us. The London Borough of Barking and Dagenham (LBBD) has one of the highest mortality rates in

London. Breast cancer is especially high. It is anticipated that further National Service Frameworks for older people, diabetes and stroke will be published in 2000/01.

Your comments on the approach we have used in this report are welcome and whether a return to a more thematic report in future years is supported.

Finally, we are continuing to improve internet access to the report and the statistical tables that support it. These will be available in Adobe portable document format (PDF) format this year to improve downloading time.

*Insert signature*

Dr. C. J. Watts  
Director of Public Health

## **Progress since last year**

**Author: Dr C J Watts**

The main progress on the Annual Report of the Director of Public Health from last year is contained in the HImP for the Health Authority,<sup>1</sup> published this year. This itemises the programmes established by the authority to prevent ill health and combat and control diseases. It also itemises programmes to deliver better services to client specific groups. Joint investment plans with the local authorities for older people are included. The detailed implementation plan for the National Service Framework for Mental Health is also included. The tackling of health inequalities in the Health Authority is mainly contained in the Primary Care Investment Plans (PCIP) prepared by each of the five PCCs under locality commissioning. Monitoring of progress with these plans, including health inequality changes, will be done through the accountability agreements with each of the PCCs.

Work done as part of the annual report has informed all these programmes.

Specific mention is needed of progress in three areas:-

1. This year's report is a collaboration with the local public health partnerships and has a strong contribution from community nursing and health promotion.
2. A public health research unit has been established within the Health Authority and a research programme is under development.
3. The strategic realignment of health promotion has been completed and a multi-agency Health Promotion Board established.

### **Reference**

1. *Barking and Havering: Health Improvement Programme 2000/2003*. Barking and Havering Health Authority 2000.

## **Readers' views of the 1998/1999 report**

**Author: Janet White**

A survey of 200 selected readers of the 1998/99 report resulted in a range of responses. These came from GPs and GP organisations (including a PCG); acute and community trusts; other health authorities; schools and colleges; a water company; the local police and libraries.

Over 75% of respondents found the report useful or very useful. Sixty five percent said they would, or would possibly, take action as a result of the report.

Comments were:-

- Contributions were requested on employment, housing and leisure and on more tangible links with social care. Whilst it has not been possible to meet all these requests, the opening section of the report includes a chapter that emphasises wider influences on health.
- The layout, design and features were not quite so well received as previously. It was felt that the colour of paper, design and type-face should be more user friendly and that the layout should be simpler. This year's report is plainer, concentrating on giving more information on PCG areas. It is also hoped that the more basic presentation will be easier to read.
- The presentation of statistical information could be improved. There were problems printing tables from the web page. It was requested that graphs be produced so that figures can be extracted easily. The use of the internet alone for access to the data supporting the report was felt to be inadequate and information on methods used for data collection were requested. Efforts are being made to address these comments.
- Comparative data analysis for PCG areas was requested. This has been addressed in this year's report and the supporting tables are on our web page.
- A glossary of terms was needed. This is addressed in this year's report.
- More involvement was requested from trust staff. There are separate sections in each of the PCG reports provided by BHB Community Health Care NHS Trust Health Promotion Department and by community nurses.
- One request was for more of a flavour of local people and settings and a shorter version of the report for the public. The report has been produced largely for PCG areas and it is hoped it will provide a more focused look at local communities.

Other requests were for material on:-

- use, abuse and misuse of medicines in the community
- comparisons with other health authorities
- finance and outcomes information
- comparative data, improvements and gains

These have been noted for possible inclusion in future reports.

## **Health priorities plan arising from this report**

**Author: Dr C J Watts**

The health priorities arising from this report are intended to inform the corporate health needs assessment of various organisations in the local health economy. They mainly represent mainly evidence based health needs assessment and the epidemiological aspects of health need. There has also been a strong input from community nursing and health promotion in identifying priorities.

Many of the health priorities are currently identified in the Health Authority's HImP and the PCG's Primary Care Investment Plans (PCIPs). Others are implicit in Local Authority plans.

The restatement of health priorities is intended to contribute to local the priority setting.

### **Health in Barking Dagenham and Havering**

#### ***Improve integration of the planning processes in the local health economy***

*Improving early life circumstances by:-*

- reducing parental smoking;
- increasing parents' knowledge of their child's health and emotional needs;
- promoting pre-school programmes and involving parents in them;
- developing strategies for providing social and economic support for mothers.

*Develop a health improving approach to the organisation of work by:-*

- giving employees more control over their work, greater variety and more opportunities for development;
- providing appropriate rewards for employees in terms of money, self-esteem and status;
- providing ergonomically appropriate workplaces;
- reducing job insecurity;
- equipping people for work with training and re-training schemes.

*Develop a health improving approach to social organisation by:-*

- providing social support to high-risk groups e.g. those with serious illnesses;
- extending the scope for supporting and helping people to feel valued in schools, workplaces and community settings;
- removing divisive practices that cast others as socially inferior and less valued.

*Plan for the main demographic shifts locally:-*

- Continued expansion of families in the Goresbrook and Thames wards. By 2006, this may be as many as 30,000 more people than current national estimates.

- Despite the fall in overall numbers of people over aged 65, the numbers of very old people (over 85 years) who need health and social care will continue to rise by 2006 by 1000 people.
- Fertility remains high in Barking and Dagenham PCGs. Gascoigne, Thames and Manor have the highest fertility.
- An average of 321 babies are born each year to women under 18 years old: 63 babies to women under 16 years old. Teenage pregnancy is about one third higher than the London rate and is rising. Sixty-one percent of teenagers in Havering and 41% in Barking and Dagenham choose to terminate the pregnancy.
- Lone mothers are in the largest numbers in Barking and Dagenham PCGs, some 2-3 times greater than Havering PCGs.

### ***Plan for the different health needs in the local community***

Overall health needs are about 18% greater in Barking and Dagenham compared with Havering.

#### *Changes in mortality in BHHA:-*

- Mortality continues to fall in the Health Authority by 2.7% over the three years to 1999.
- Mortality reductions for people under 75 years old are greatest in Upminster PCG, especially in the targeted high need areas of Gooshays, Heaton and Hilldene.
- Mortality in Dagenham PCG is rising, especially in the areas of Heath and River. Mortality in the River area nearly doubled in the three years to 1999.
- In Hornchurch PCG, the South Hornchurch and Rainham areas have rising mortality.
- The Collier Row and Rise Park areas of Romford have rising mortality.

#### *Circulatory diseases*

- CHD continues to fall in all PCGs in the BHHA but remains higher than the national and London rate. The local authority wide rate is moving closer to the national average.
- Barking PCG has the highest rate, but showed encouraging improvement in the three years to 1999.
- The greatest improvement has been in Upminster PCG, with falls in the high risk wards of Gooshays, Heaton and Hilldene.
- Stroke mortality has remained consistently lower than the London and England and Wales rate over the past three years.

#### *Cancers*

- Cancer remains a major problem for the Health Authority. The main problem in Barking PCG is lung cancer, where mortality has risen by more than 15% over the three years to 1999, against a 2.6% fall in England and Wales.
- Breast cancer mortality continues to rise against the background of a decline in national rates. Barking PCG is a major contributor to this rise.
- Prostatic cancer mortality rates continue to improve but remain above the national rate.

#### *Infant mortality*

- Infant mortality is highest in Upminster PCG, especially in the Heaton area. Three other areas have exceptionally high infant mortality: Eastbury, Fanshawe and Chase Cross.

#### *Avoidable admissions*

- The highest admission rates for a defined group of conditions where admission can be avoided (ENT infections, urinary tract infections, heart failure, asthma, diabetes and epilepsy) was in Barking PCG, which was 28% higher than the authority average, followed by Romford PCG which was 14% higher.
- Barking and Romford PCGs had the highest emergency admission rates.

#### *Mental health*

- The prevalence of serious mental illness is highest in Barking and Dagenham PCGs.
- Mental health is a national priority and there is a local implementation plan for the National Service Framework.

### ***Implement health protection measures in the local community***

#### *National programmes*

- The local meningitis C immunisation campaign was on target, involving both primary care for the under fives and community child health services for school age children and college students. The implementation will continue in the current year.
- Antenatal screening for HIV infection was introduced this year. Monitoring of uptakes will continue in the current year, aiming to reach an 80% target.

### **Health priorities in Barking PCG**

- CHD, especially for males under 65 years.
- Cancer - All cancers in men; lung cancer, especially targeting risk factors amongst women; breast cancer. Early detection of cancer, referral for treatment and promoting uptake of the national screening programmes.
- Smoking.
- Chronic obstructive pulmonary disease.
- Diabetes.
- Avoidable admissions including asthma (especially of adults) and heart failure are high
- Infant health, including infant mortality in the Eastbury area.
- Teenage pregnancy, especially in the Gascoigne area, including access to pregnancy termination services.
- Social and economic support for families, including lone mothers and older people.
- Addressing the needs of ethnic minority groups.
- Planning for the expansion of the PCG population in Thames ward to 2006.
- Mental health.

### **Health priorities in Dagenham PCG**

- CHD.
- Chronic obstructive pulmonary disease.
- Avoidable admissions especially for asthma, diabetes and epilepsy are high.
- Cancers: lung cancer and stomach cancer.
- Smoking.
- Investigate high mortality in the areas of Heath ward and especially River ward.
- Infant mortality in the Fanshawe area.
- Teenage pregnancy, especially in the Heath area.
- Plan to expand the PCG population in Goresbrook ward to 2006.
- Social and economic support for vulnerable families.
- Mental health.

### **Health priorities in Hornchurch PCG**

- Investigate high mortality in South Hornchurch and Rainham wards.
- CHD as part of the authority wide National Service Framework.
- All cancer as part of the authority wide plan to reduce local cancer death rates.
- Mental health as part of the local National Service Framework implementation plan.
- Smoking as part of the authority wide introduction of prevention and specialist smoking cessation services.
- Develop support for the refugee population in South Hornchurch.

### **Health priorities in Romford PCG**

- Investigate the rising mortality in the Collier Row and Rise Park wards.
- Investigate high infant mortality in the Chase Cross ward area.
- Avoidable admissions are high, especially for asthma in children.
- Emergency admissions are high in the PCG.
- CHD as part of the authority wide National Service Framework..
- All cancer but especially breast cancer, which is the third highest in London.
- Mental health as part of the local National Service Framework implementation plan..
- Smoking as part of the authority wide introduction of prevention and specialist smoking cessation services.
- Diabetes because of the high mortality in the PCG.

## **Health priorities in Upminster PCG**

- CHD as part of the authority wide National Service Framework.
- Cancer as part of the authority wide plan to reduce local cancer death rates. Cancer deaths in younger people (under 75) are especially high.
- Mental health as part of the local National Service Framework implementation plan.
- Smoking as part of the authority wide introduction of prevention and specialist smoking cessation services.
- Investigate high infant mortality in the Heaton ward area.
- Health and social support for older people because of the high numbers of older people and the numbers of nursing and residential homes in the PCG. The detailed needs include nursing support for chronic illness, the management of dementia and confusion and support for housebound people.
- Investigate the high mortality from stroke in Cranham East ward, which is twice the authority wide rate.
- Diabetes because of the high mortality in the PCG.
- Develop support for the refugee population in the Harold Hill area.

## **Social determinants of health**

**Author: Dr Peter Messent**

### **Introduction**

Whilst there is understandable concern with the appropriate provision and financing of health care, it is increasingly being recognised that health is a matter that goes far beyond health services. Scientific knowledge of the social factors that determine the health of a population (the determinants of health) is accumulating quickly. There is also growing recognition that a variety of other policies pursued by Government and the private sector, both nationally and locally, exert a powerful influence on health.

One of the key aims of the national Government's health strategy for England is to improve the health of the worst off in society and narrow the 'health gap'. In July 1997, the Secretary of State for Health appointed Sir Donald Acheson, a distinguished former Chief Medical Officer, to lead an independent inquiry into inequalities in health. Sir Donald's report,<sup>1</sup> published in November 1998, made 39 recommendations underpinned by a broad analysis of the social, economic and environmental determinants of health. The report made an overwhelming case for tackling health inequalities and concluded that, in general, reductions in inequalities are most likely to be achieved if national and local policies are formulated with that specific aim in mind.

If local work to reduce health inequalities is to be given full support, it will be essential that those working in each organisation keenly appreciate:-

- the evidence for the way health is determined by social factors;
- what are the relevant policies and actions of their organisation; and
- where these may need to be developed.

This part of the annual report offers a very brief summary of the scientific evidence for the way these seven interrelated factors determine the health of the population:-

- the need for policies to prevent people from falling into long-term disadvantage;
- the importance of ensuring a good environment in early childhood;
- the impact of work on health;
- the problems of unemployment and job insecurity;
- the role of friendship and social cohesion;
- the effects of alcohol and other drugs;
- the need to ensure access to supplies of healthy food for everyone.

### **The social gradient**

#### ***Outline of the issue***

Poor social and economic circumstances affect health throughout life. People further down the social ladder usually run twice the risk of serious illness and premature death of those near the top. The course of a person's life presents a series of critical transitions: emotional and physical changes in early childhood; the move from primary to secondary education; starting work; leaving home and starting a family; changing jobs and facing possible redundancy; and eventually

retirement. Each of these changes can affect health by pushing people onto a more or less advantaged path.<sup>2</sup>

Advantage or disadvantage in one phase of a person's life is likely to have been preceded and to be followed by similar advantage or disadvantage in the other phases of life. A child from a disadvantaged home is likely to achieve few educational qualifications; to leave school at the minimum age and to enter the unskilled labour market, where low pay and hazardous work combine with no occupational pension. This in turn ensures reliance on welfare payments in old age. It is not any one major factor that is important, but rather a number of comparatively small differences that become linked into a chain of disadvantage. For example, analysis of data on male members of the 1958 British birth cohort<sup>3</sup> found that low birthweight babies were more likely to spend their childhood in a less affluent family and in poor quality housing.

A child's height at seven years of age also proves a powerful key to predicting their subsequent risk of being unemployed. Height at this age can be interpreted as a measure of delayed growth during childhood, caused by economic, social and psychological hardships that in turn result in poor nutrition and disrupted sleep.<sup>4</sup>

Whether we take recorded rates of death and illness or survey findings of people's views of their own health, and whichever indicator of socio-economic position we employ (income, class, housing tenure, deprivation or education), we find that those who are worse off socially and economically are in worse health. Recent evidence suggests that variations in life expectancy by social class are not only continuing but also widening. The difference in life expectancy at birth between occupational groups social classes I and II (high) and IV and V (low) increased from 3.7 years in the late 1970s to 4.7 years a decade later.<sup>5</sup> Groups I and II include professionals, such as doctors, lawyers and managers. Groups IV and V include semi-skilled manual workers, such as miners and machine operators and unskilled manual workers such as cleaners and labourers.

### ***Summary of evidence***

- Poor social and economic circumstances affect health throughout life.
- People further down the social ladder run at least twice the risk of serious illness and premature death of those nearer the top.
- Between top and bottom, health standards show a continuous social gradient.

### ***Policy implications***

- Welfare policies need to provide not only safety nets but also springboards to offset early disadvantage.
- Attaining good health involves reducing levels of educational failure, the amount of job insecurity and the scale of income differences in society. We need to ensure that fewer people fall and that they fall less far.<sup>2</sup>

### ***Early life***

#### ***Summary of evidence***

The effects of early development last a lifetime. A good start in life means providing support for mothers and young children. A child's slow growth and lack of emotional support during this period raise the lifetime risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood. Poor social and economic circumstances present the greatest threat to

growth and launch the child on a low social and educational path. A number of more specific findings are given below. The key evidence is shown schematically in Figure 1.

- Emotional disruption of family life can reduce the likelihood of good educational attainment.<sup>6</sup>
- Childhood or adolescent experience of parental divorce or separation can also be associated with raised risk of subsequent teenage pregnancy, frequent job-changing and own marital breakdown,<sup>7</sup> as well as with raised risk of premature death.<sup>8</sup>
- Family conflict, with or without divorce, is related to reduced health in adolescence and to lower self esteem and psychological wellbeing.<sup>9</sup>
- Neglected and abused children are at greater risk of falling into antisocial or criminal behaviour and substance abuse in adolescence and adulthood.<sup>10</sup>
- Child abuse is associated with low parental self esteem.<sup>11</sup>
- Low levels of self control are associated with raised risk of accidental injury in adulthood, as well as of criminal behaviour;<sup>12</sup> and may be associated with adverse childhood experiences at home.<sup>13</sup>

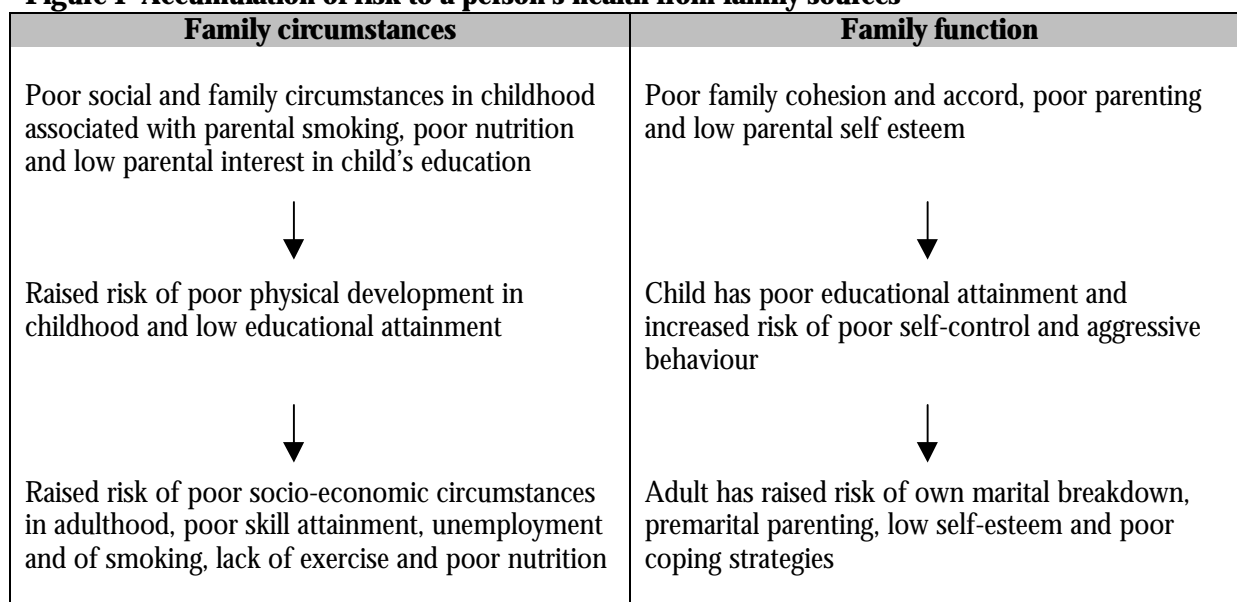
### ***Ways of improving early life circumstances***

On the basis of well-designed experimental research, mostly conducted in the United States and Canada, these methods offer hope of improving early life circumstances:-

- *Frequent home visits* by health professionals to women during pregnancy and their child's infancy, provide advice about prenatal and postnatal care of the child, infant development, proper nutrition and how to avoid smoking, drinking and drug use in pregnancy. Studies suggest that this can lead to a reduction in child abuse by parents, as well as a longer-term reduction in delinquency among the children concerned.
- *Pre-school 'intellectual enrichment' programmes* that are designed to stimulate thinking and reasoning ability in young children increase their school success. The High/Scope Perry Pre-school Programme in Michigan provided high quality nursery education for an experimental group of children in a disadvantaged African American community, including a curriculum that encouraged children to plan, carry out and review their activities. A long term follow-up of former participants at age 27 found that they had significantly higher earnings, a higher percentage of home ownership, higher levels of completed years of schooling, a lower percentage receiving help from social services and significantly fewer arrests than a control group of otherwise similar children.
- *Parenting education programmes* encourage parents to notice what their children are doing; to praise good behaviour; to state house rules clearly; and to make rewards and punishments contingent on children's behaviour. A number of programmes have demonstrated success in reducing children's antisocial behaviour, although reductions in stealing and other delinquent activities have in some instances proved short-lived.
- *A health-visiting programme* supports new parents during the first year of their child's life by giving them a sense of control over their lives. Although not specifically targeted on child abuse, the programme was shown to reduce abuse by up to 50%.<sup>14</sup>

- *Raising IQ.* Other pre-school interventions with infants in low socio-economic circumstances and with mothers with low IQ had a significant impact on raising children's IQ.<sup>15</sup>
- *Cognitive and social skills training* can teach children to stop and think before acting; to consider the consequences of anti-social behaviour; to understand other people's feelings and to solve interpersonal problems by negotiation rather than aggression. Some of these techniques, intended to strengthen children's own inhibitions against anti-social behaviour, have also been used to reduce re-offending among juvenile offenders.
- *Peer influence strategies* offer young people advice on how to resist pressure from friends to engage in anti-social behaviour, ranging from under-age drinking and smoking to drug abuse and other crimes. Research suggests that advice is most likely to be heeded when given by specially trained, high status peers, rather than parents or teachers.
- *Classroom management training* can help teachers communicate clear instructions and expectations, to notice and reward children for socially desirable behaviour and to be consistent in their use of discipline.
- *Anti-bullying initiatives* in school lay down explicit rules that encourage children to report bullying incidents and offer help to the victims. Playground monitoring and supervision may also need to be improved. Programmes in Norway and Britain have demonstrated success in reducing bullying which, if left unchecked, is associated with an increased risk of delinquency.

**Figure 1 Accumulation of risk to a person's health from family sources<sup>16</sup>**



### ***Policy implications***

It is important to:

- reduce smoking by parents;
- increase parents' knowledge of their child's health and emotional needs;
- introduce pre-school programmes, not only to improve reading and stimulate cognitive development, but also to reduce behavioural problems in childhood and promote educational attainment and occupational chances;
- involve parents in pre-school programmes to reinforce their educational effects and reduce child abuse;
- ensure that mothers have adequate social and economic resources;
- increase opportunities for educational attainment at all ages, since this is associated with raised health awareness and improved self care.

### **Work**

#### ***Summary of evidence***

- Stress at work plays an important role in contributing to the large differences in health, sickness absence and premature death that are related to social status.
- Having little control over one's work is particularly strongly related to an increased risk of lower back pain, sickness absence and cardiovascular disease.
- Studies have also examined the role of demands at work. Some show an interaction between demands and control. Jobs combining high demands with low control carry special risk. Some evidence indicates that social support in the workplace may reduce this effect.

#### ***Whitehall studies of British civil servants***

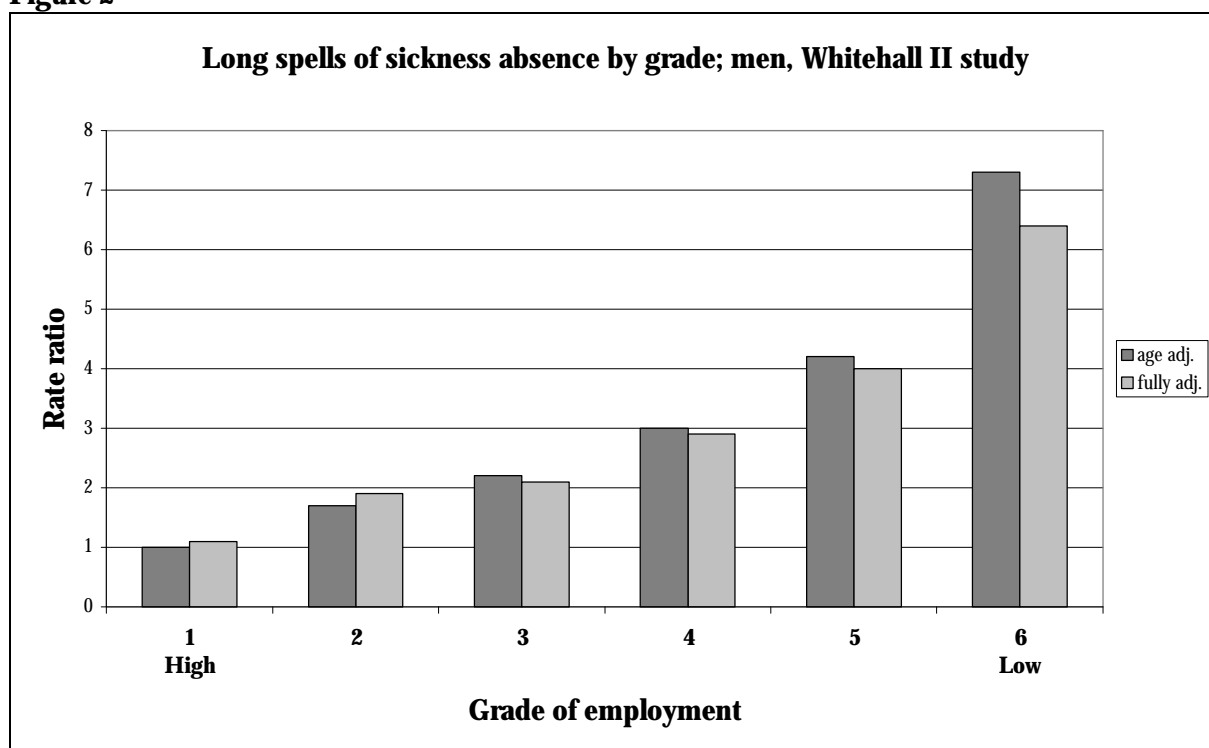
Measures of social and economic status, including occupation, are extremely powerful factors in predicting premature heart disease. In the Whitehall I study, employment grade taken on its own proved to be a more powerful predictive factor than the classic combination of risk factors: smoking, serum cholesterol levels and blood pressure.

Sickness absence was also analysed.<sup>17</sup> It was found to be related to individual characteristics such as smoking, problems outside of work and inadequate support. People who rated their jobs low on control, variety and use of skills, with poor support and a slow pace of work, had higher rates of both short and long spells of sickness absence. See Figure 2.

In the Whitehall II study, both the perceived balance of effort and reward and the perceived level of job control were independently related to CHD outcomes.<sup>18</sup>

Despite the central role of work in these studies, an exclusive focus on working life runs the risk of underestimating the true costs to health of other adverse stressful circumstances arising outside work. Family life and leisure activities are also of crucial importance. If these are satisfying, they can help reduce the stress of working life; if they are not, they can exacerbate it.

**Figure 2**



Source: North et al 1993<sup>17</sup>

### ***Policy implications***

- Improved conditions at work will lead to a healthier work force. This in turn will lead to improved productivity and hence to the opportunity to create a still healthier, more productive workforce.
- Redesigning workplace practices, to give employees more control, greater variety and more opportunities for development, benefits health.
- Work that does not provide appropriate rewards in terms of money, self-esteem and status, damages health.
- Ergonomically appropriate workplaces and practices can reduce the burden of musculoskeletal disorders.

### **Unemployment**

#### ***Summary of evidence***

- Unemployed people and their families are at a substantially increased risk of premature death.
- Job insecurity has been shown to have increased adverse effects on mental health (particularly by way of anxiety and depression), self-reported ill health, heart disease and risk factors for heart disease.
- During the 1990s, changes in the economies and labour markets of the advanced industrialised countries have increased feelings of job insecurity.
- As job insecurity continues, it acts as a chronic stress factor whose effect increases with length of exposure. It is associated with greater sickness absence and health service use.

### ***Policy implications***

It is important to do everything possible to:

- reduce unemployment and job insecurity;
- reduce the hardship suffered by unemployed people;
- restore unemployed people to secure jobs;
- equip people for the work available, with high standards of education and good retraining schemes.

### **Social support**

#### ***Summary of evidence***

- Social isolation and exclusion are associated with increased rates of premature death and poorer chances of survival after a heart attack.
- Lack of social support is associated with reduced wellbeing, depression, a greater risk of pregnancy complications and higher levels of disability from chronic diseases.
- Negative aspects of close relationships can lead to poor mental and physical health.
- A person's ability to develop positive social relations probably depends on satisfactory early relationships with their mother and father.
- Conversely, unhappy or disruptive early relationships may lead to patterns of anxious attachment or dissociation from attachments, which may persist into adulthood.

#### ***Policy implications***

- Interventions with high-risk groups have shown that providing social support improves the outcome after a heart attack, the survival time of people with some types of cancer and pregnancy outcome among vulnerable groups of women.
- Improving the social environment in schools, the workplace and the community in general will help people feel valued and supported in more areas of their lives and will contribute to health, especially mental health.
- In all areas of personal and organisational life, divisive practices that cast others as socially inferior or less valuable should be avoided.

### **Addiction**

#### ***Summary of evidence***

Alcohol dependence, illicit drug use and cigarette smoking are all closely associated with markers of social and economic disadvantage.

Concerning alcohol, in the Russian Federation, for example, the past decade has been a time of great social upheaval. Deaths linked to alcohol use (from accidents, violence, poisoning, injury and suicide) have risen sharply. People turn to alcohol to numb the pain of harsh economic and social conditions; alcohol dependence leads to downward social mobility. The irony is that although offering a temporary release from reality, alcohol intensifies the very problems that led to its use in the first place.

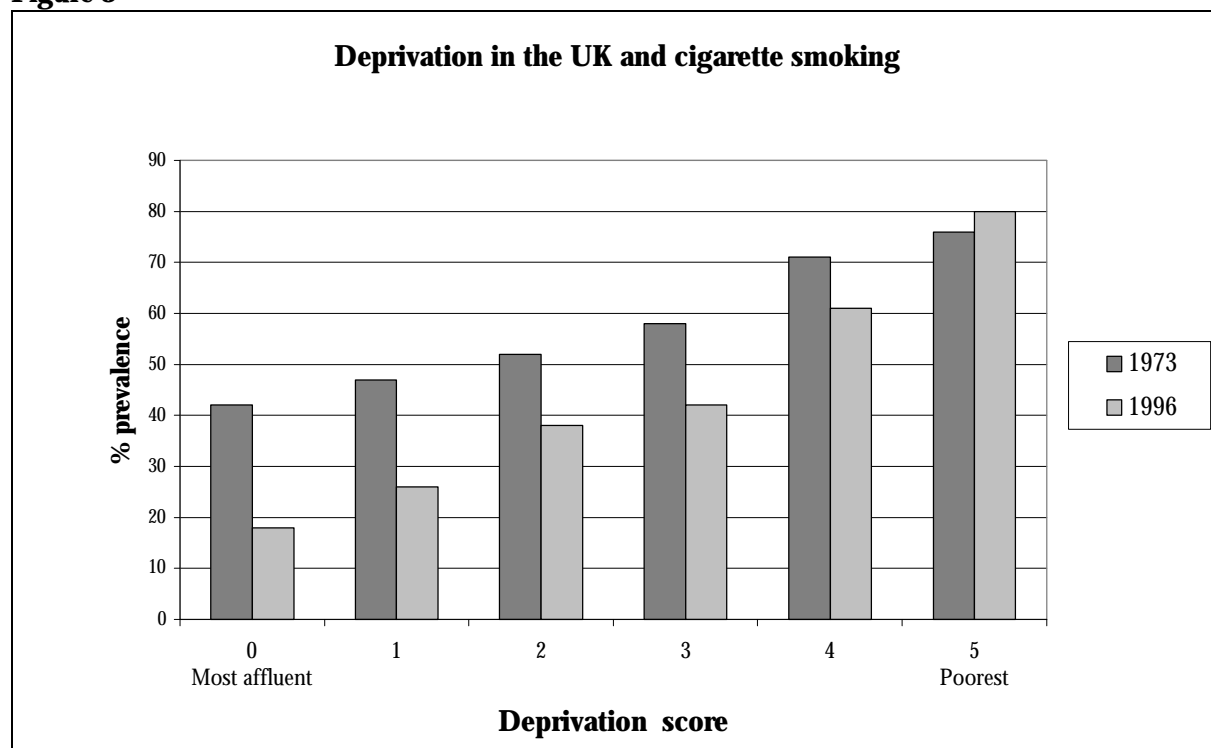
The same is true of tobacco. Social deprivation (as measured by any indicator: poor housing, low income, lone parenthood, unemployment or homelessness) is associated with high rates of smoking and very low rates of quitting. See Figures 3 and 4. Smoking is a major drain on poor

people's incomes and a huge cause of ill health and premature death, but nicotine offers no real relief from stress or improvement in mood.

**Policy implications**

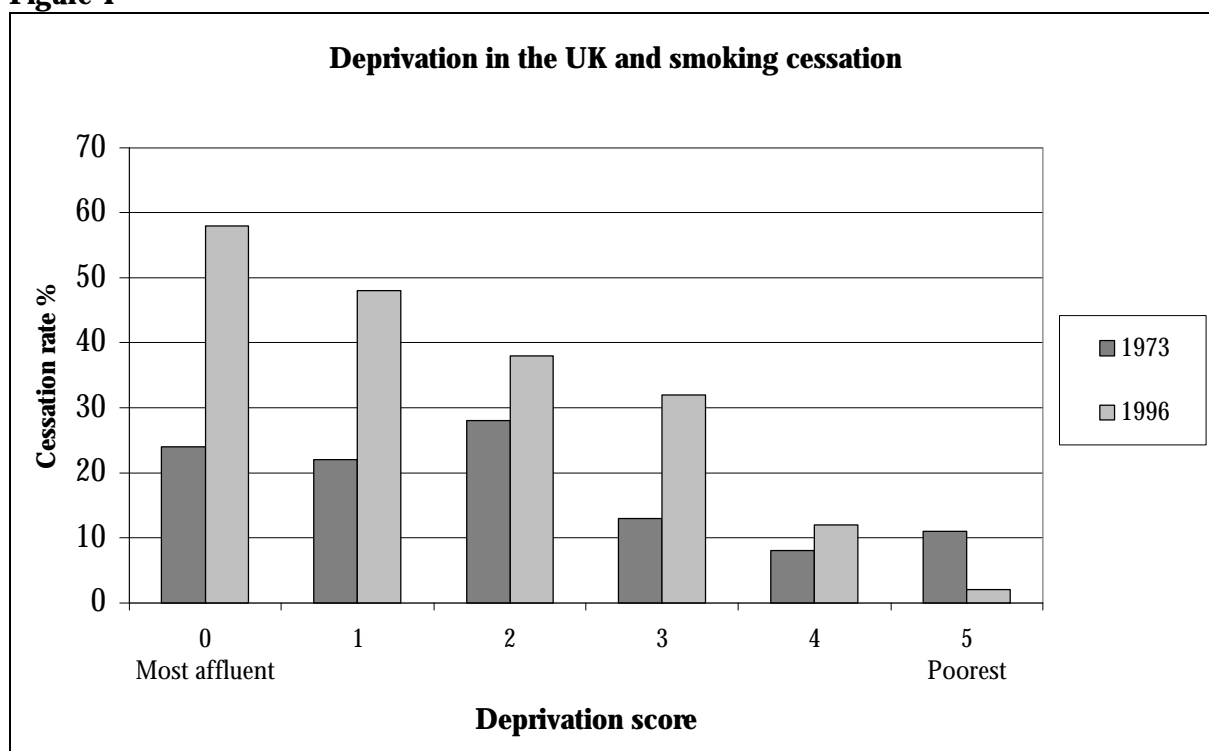
- Work to deal with drug problems needs not only to support and treat people who have developed addictive patterns of use, but also to address patterns of social deprivation in which problems are rooted.
- Trying to shift the whole responsibility onto the user is clearly an inadequate response. This blames the victim, rather than addressing the complexities of the social circumstances that generate drug use. Effective drug policy must therefore be supported by the broad framework of social and economic policy.<sup>2</sup>

**Figure 3**



Source: General Household Survey data 1973 and 1996

**Figure 4**



Source: General Household Survey data 1973 and 1996

## **Food**

### **Summary of evidence**

- Social and economic conditions result in a social gradient in the quality of people's diet that contributes to inequalities in their health.
- The main dietary difference between social classes is in the source of nutrients. The poor tend to substitute cheaper processed foods for fresh foods.
- High fat intake is common in all social groups.
- Advertising and the media are playing an increasingly dominant role, especially in relation to children's eating habits.
- Largely due to advertising, sales of soft drinks have escalated in central and eastern Europe between 1992 and 1996, by 112% on average.
- Children are taking on the role of opinion leaders in relation to family eating habits.
- Most of the food marketing aimed at young children is of sweets, snack items, convenience and fast food. See Table 1.
- Very little is spent on promoting consumption of fruit and vegetables.

Of the fifteen branded food products with the highest sales in the UK in 1996/97, six were soft drinks and three were chocolate brands. These nine brands taken together were promoted with an advertising budget of about £60m, compared to the budget of the then Health Education Authority for promoting better diets of less than £1m. Please see Table 1.

**Table 1 The fifteen top selling food brands, UK 1996/97**

<b>Brand</b>	<b>Sales (£ millions)</b>	<b>Advertising (£ millions)</b>
Coca-Cola	542	26.0
Walkers' crisps	385	7.0
Pepsi	180	8.6
Robinsons' drinks	160	3.3
Kit Kat chocolate	140	4.7
Müller yoghurt	135	5.0
Ribena	130	0.9
Flora	125	5.2
Mars Bar	120	1.4
Heinz soup	115	0.3
Anchor butter	115	5.3
Lucozade	105	7.0
Tango drink	100	6.6
Cadburys' chocolate	100	0.3
Kelloggs' Corn Flakes	95	11.7

Source: Food Magazine, 1998

### ***Policy implications***

Impartial health messages, especially those promoting fresh fruit and vegetable consumption, need to be strongly promoted if they are not to be overwhelmed by commercial marketing messages.

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## **Overview of population health**

**Author: Dr Peter Congdon**

***Tables relating to the discussion below can be viewed on the Public Health website address at [www.bhha.org.uk](http://www.bhha.org.uk).***

### **Introduction**

This overview sketches the demographic and social structure of Barking and Havering Health Authority (BHHA) and its five PCG areas and highlights contrasts within BHHA in the major causes of death and illness.

### **Population trends**

#### ***Trends in BHHA's population and its age***

The mid-year estimates for 1998 of the Office for National Statistics (ONS) show a very stable population of about 384,000 in total (LBB 156,000 and Havering 228,000). Recent Department of Health estimates for BHHA, PCG areas and wards give a very similar 1999 projection of about 380,000. The latter show relatively small changes in the distribution of population within BHHA between 1991 (the last census year) and 1999. The biggest changes are that the population of Dagenham PCG has grown by 2.5%, while Romford PCG has declined by 1%. However, a discrepancy of about 4,000 people is already apparent between the 1998 mid-year estimates and short-term projections for 1999.

### **Population trends and new housing**

ONS projections do not take account of local housing plans and other developments between censuses. Thus there are current and may well be future discrepancies between Greater London Authority (GLA)/London Research Centre (LRC) projections and those of the ONS. These relate partly to the impact of new housing in Barking Reach, but also to other assumptions regarding future birth rates and ethnic population structures. The latest GLA/LRC 1999 population estimate for BHHA is 389,000, as against the LRC 1996 estimate of 385,000. The GLA/LRC work takes into account the effect of about 500 new houses in Barking Reach up to the end of the 1990s. The total planned stock in Barking Reach is about 5,000 dwellings by 2010, or about 15,000 people, assuming a bias towards family housing. This will be concentrated in Goresbrook and, to a lesser degree, Thames wards. For 2001 and 2006 the LRC projections are for 391,000 and 403,000 respectively, compared to the ONS projections of 379,000 and 373,000. The average number of births per woman of childbearing age in the area will also be affected by an increase in the proportion of black and minority ethnic people in the population.

### **Age group and ethnic structures**

Both the age group and ethnic structures of BHHA's population are undergoing change. Both local authority areas in the Health Authority have about 19-20% of their population in the age groups over 65, which have the highest health need. However, the London Borough of Barking

& Dagenham (LBBD) has a higher proportion of under 44s, while the London Borough of Havering (LBH) has relatively more people aged 45-64. Proportions of those over 65 are highest in Upminster PCG and lowest in Barking PCG. The greatest concentration of non-white people is in Barking PCG, and of these the majority are of South Asian descent. In percentage terms, BHHA's black and minority ethnic population was below the London average in 1991 but broadly comparable to the England and Wales average.

ONS and LRC projections show an increase in the population of very old people, in terms both of numbers and of percentage of the total population, amounting to an extra 1,000 persons aged over 85 between 1996 and 2006 in both projections. However, these projections show numbers of all persons aged over 65 falling: from 64,000 to 58,000 according to the LRC and from 64,000 to 60,000 according to the ONS. The LRC forecast shows a major increase in persons aged 15-64; and also in non-white ethnic groups, whose numbers are set to rise from 23,600 to 31,700. Barking PCG currently has the highest estimated proportion of non-white people, at around 16% in 1999 or 10,000 out of a population of 60,000 according to the LRC.

### **Social class, unemployment and income support**

BHHA has a diverse socio-economic structure, ranging from deprived areas in the south-west corner (and in some northern wards in LBH), to affluent suburbia in the extreme east. This also applies within PCGs: for example, the Upminster and Barking areas both feature a mix of affluent and deprived wards. Variations like these imply a range of health needs, since the risk of most adverse health events increases with deprivation. Partly because of this diversity, BHHA ranks lower in terms of under-privilege scores than comparable health authorities in outer east London.

Data from the 1991 Census shows that the percentage of people in social classes I and II varies from 10% to 55% at ward level, and from 17% (Dagenham) to 38% (Upminster) at PCG level. There are corresponding wide variations in household tenure. Owner occupancy exceeded 90% in several wards in LBH, and was also high in some wards in LBBD (Chadwell Heath, Longbridge, River). It is likely that council house sales and new mostly private housing will continue to raise the proportion of owner occupancy, though some wards will retain a large public rented sector.

More recent data on social and economic structure includes 1999 unemployment data showing the wide contrasts at ward level in female unemployment (from 0.8% to 5.3%) and male unemployment (from 1.5% to 11.8%). Barking PCG has the worst unemployment rate at 6% of all persons in the labour force. Youth unemployment exceeds 10% in two Barking wards (with Gascoigne having a rate of 17%), but is also high (around 8%) in two wards in the generally more affluent Upminster PCG. Data on income support claimants in 1996 have been converted to rates for pensioners and children and show the rate for children at ward level varying from 5% (Upminster) to nearly 70% (Gascoigne). At PCG level, the sharpest contrast in children in families claiming support is between 50% in Barking and 22% in Hornchurch.

## **Underprivilege**

Health need is strongly related to deprivation or underprivilege and various definitions of deprivation scores at PCG and ward level are available. The Jarman score is based on the 1991 census and combines measures of economic deprivation and poor housing with those indicative of extra GP workload, such as numbers of pensioners living alone, numbers of children aged under 5 and population turnover. The overall Jarman scores range from over 30 in three Barking wards (exceeding the threshold for deprivation payments) to under minus 20 in three LBH wards (the national average score is zero). The Townsend score is an intrinsic measure of socio-economic deprivation. With BHHA as the benchmark, this score highlights the contrast between Barking (-7.0) and Hornchurch (-2.8). Within PCGs, contrasts in deprivation are greatest in Upminster.

The York acute needs score results from a comprehensive review of the major components of health programme expenditure, undertaken to determine how far such activity reflects measures of need. The needs and age weightings resulting from this work are the basis for the unified allocation scheme for PCG budgets, intended to provide a single cash limited funding stream encompassing the standard categories of hospital and community health services, general medical services cash limited spending and prescribing spending. In particular, the acute needs score results from work on small area usage of acute inpatient services. It combines census variables in respect of prevalence of long term illness, unemployment rate, numbers of lone pensioners and numbers of single carers, with a variable based on recent deaths, namely the standardised mortality ratio for ages under 75. At PCG level there is a basic distinction between higher scoring PCGs of Barking (11.7) and Dagenham (11.5), on the one hand, and the LBH PCGs on the other: Upminster (9.8), Hornchurch (9.8), and Romford (9.7). At ward level, the lowest scores (least acute health need) are for Ardleigh Green, Gidea Park, Upminster, Emerson Park and Cranham West.

## **Overall trends**

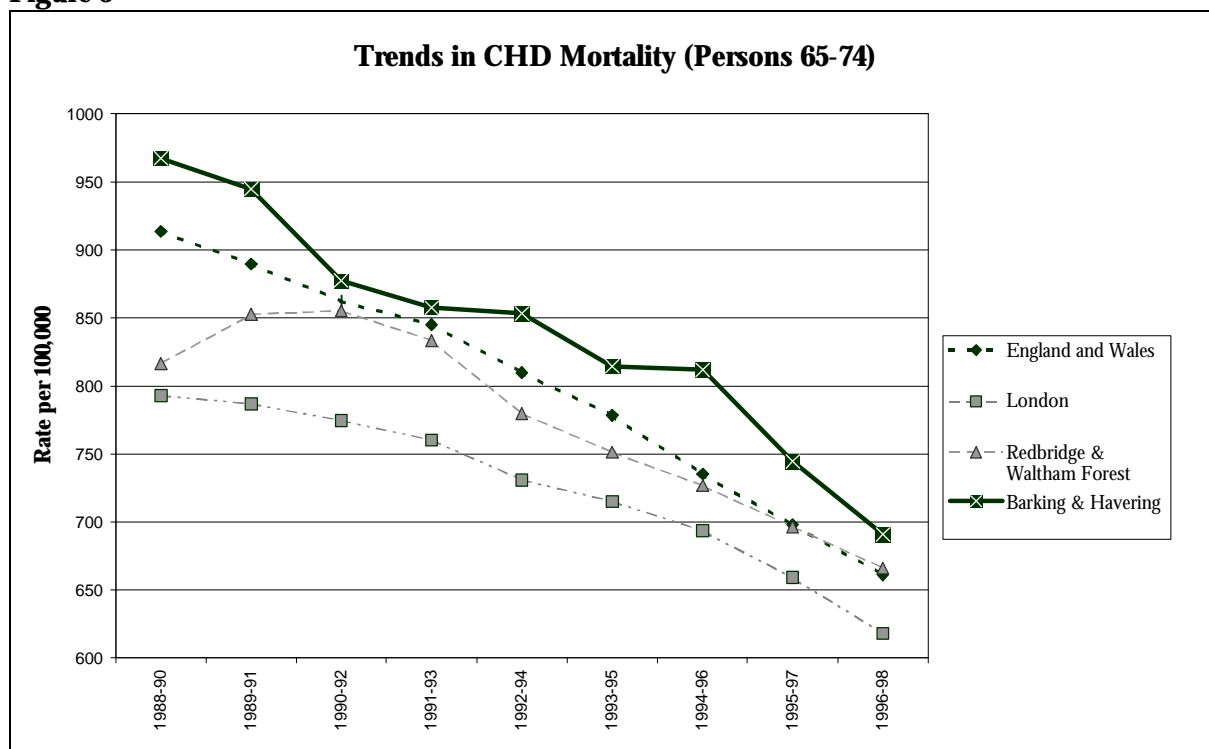
The diverse social structure of BHHA is reflected in its health statistics, for example in patterns of births and deaths. The choice of types of death statistics considered here reflects the focus on inequalities and on certain trends, both in *Saving Lives: Our Healthier Nation* and in the earlier *Health of the Nation* strategy. *Our Healthier Nation* sets a relatively small range of targets in order to offer greater flexibility to focus on particular local health problems and on reducing health inequalities. It also pays greater attention to improving the health-related quality of life and cutting premature deaths.

Analysis has been made of trends in rates of death from all causes, by ward and PCG between 1992/95 and 1996/99, and of trends in 'all cause' deaths in the under 75 age groups, defined as 'premature' deaths in *Our Healthier Nation*. The greatest progress in reducing death rates per 100,000 population (age standardised) between these two periods appears to be in Upminster, especially in the more deprived areas of Gooshays, Hilldene and Heaton. For early deaths the statistical value of small counts becomes an issue and a comparison over a different time frame (e.g. 1997/99 vs 1994/96) may show a slightly different picture. A further analysis using these periods confirmed the better improvement for ages under 65 in Upminster and Hornchurch.

## Circulatory diseases

Concerning the most important cause of early death, circulatory diseases, BHHA has shared in the national decline in death rates. Figure 5 shows a convergence at ages 65-74 to the national and London averages. As for 'all cause' death rates, the greatest improvement has been in the Upminster PCG, though all areas have shared in the reduction in deaths from CHD.

**Figure 5**



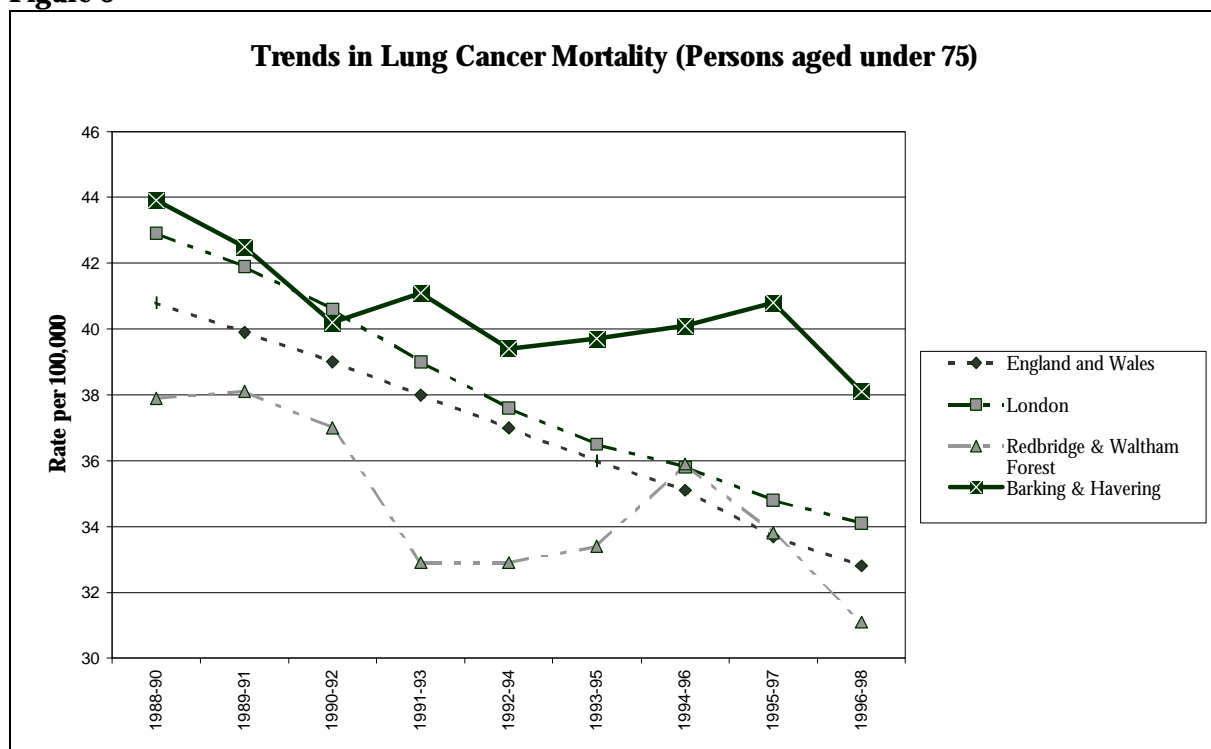
Source: Public Health Common Data Set

Deaths directly from stroke are relatively infrequent and occur at an unstable rate at ages under 65. At ages 65-74 BHHA has fared relatively well since 1994/96, maintaining a low death rate compared to national and London averages. At PCG level, the improvement for all ages is concentrated in Romford and Upminster.

## Cancers

A main cause of early death and health inequalities is lung cancer. Improvements in BHHA have been relatively slow compared to trends elsewhere: see Figure 6 for trends for all ages under 75. At PCG level, an improvement in Upminster has been offset by an apparent deterioration in Barking.

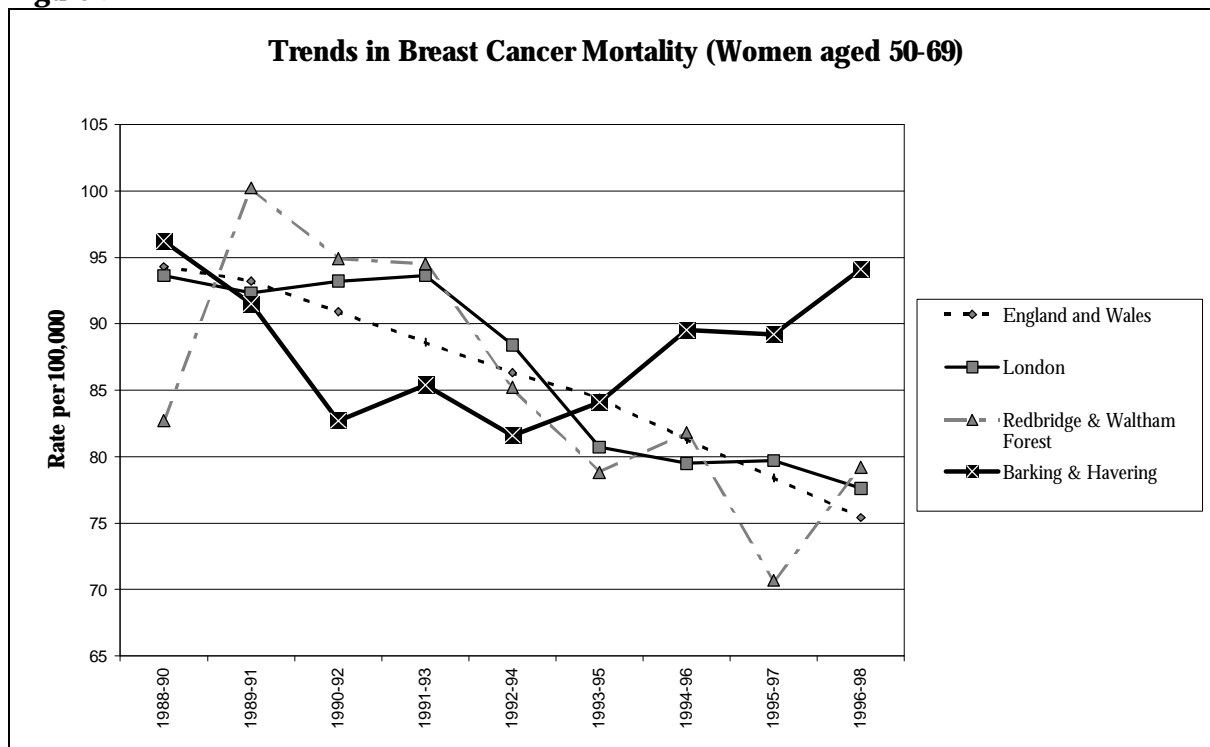
**Figure 6**



Source: Public Health Common Data Set

For breast cancer, deaths at ages 50-69 are relatively uncommon and so comparisons of Health Authority trends with national or London trends should be treated with caution. However, there appears to be an adverse trend in breast cancer death rates in BHHA relative to improvement elsewhere: see Figure 7. At PCG level, gains in Upminster have been offset by a static or worsening position in other areas between 1992/95 and 1996/99. Averages over the last three years include an improvement in breast cancer deaths in 1999. Comparing 1997/99 with 1994/96, the position at PCG level is better.

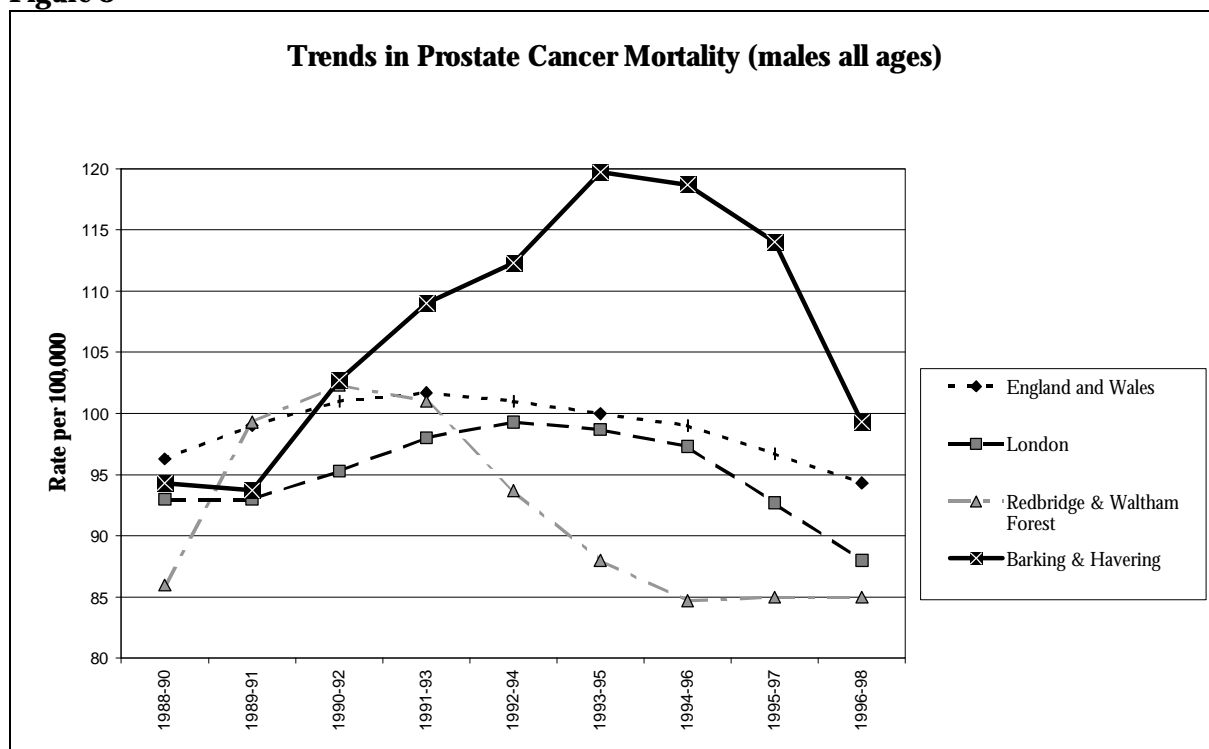
**Figure 7**



Source: Public Health Common Data Set

The trend in prostate cancer deaths shows similarities with that of breast cancer. An adverse trend in the mid-1990s has recently been reversed, with the period 1996/99 improving on 1992/95: see Figure 8. The improvement is greatest in Upminster and Romford PCGs.

**Figure 8**



Source: Public Health Common Data Set

### **Accidents and suicides**

Accidental causes of death and suicides are often considered together since accidents may include some unrecorded suicides. Rates of accidental death are broadly static, though a gradient between high levels in Barking PCG and lower rates in the three LBH PCGs becomes apparent. The 'injury undetermined' component of suicide deaths has increased.

### **Fertility and birth outcomes**

#### **Overall picture**

Fertility rates record the average number of live births per woman of childbearing age, usually taken to be 15-44 years. The total fertility rate is the average number of children a woman would have if current fertility levels were maintained. Fertility rates differ considerably by ward and PCG, with the total rate varying from 3.0 in Thames ward in Barking to about 1.3 in four LBH wards. At PCG level the widest contrast in rates is between Barking with 2.11 and Hornchurch with 1.46. It can be seen that affluent wards (such as Cranham West and Gidea Park) have higher fertility at ages 30-34 and 35-39 than the average; whereas deprived wards (such as Thames and Gascoigne) have higher fertility at ages 15-19 and 20-24.

#### **Ethnic minority women**

There are indications that the proportion of births to black and ethnic minority women is rising in BHHA. Data from the Regional Integrated Child Health System (RICHS) provides evidence on the distribution of births by infant ethnicity and mother's age. The average percentage of non-white infants is 11.5%, with a peak of over 1 in 8 births at maternal ages 35-39. At PCG

level, data for 1998/99 show that about 30% of infants in Barking PCG are non-white, compared to 6% in Upminster. A major share of the total of non-white births in Barking is to be found in the Black African community.

### ***Teenage conceptions***

Teenage conceptions have often been raised as an issue needing to be addressed by any public health strategy. Numbers of conceptions among young women aged under 16 run at about 20-25 a year in LBH and 40-50 a year in LBB. In the under 18 age group, conceptions in London rose from 45 per 1,000 young women aged 15-17 in 1992/94 to 50 per 1,000 in 1995/97. The rate in LBB is above the London average, having risen from 62.5 to 68.5 per 1,000. The rate in LBH is about half of that figure and has, in fact, fallen slightly. However, whereas in LBB the majority of such conceptions are carried to term, in LBH the majority are terminated. At PCG level, the proportion of conceptions by women aged under 18 ranged from 6% in both Barking and Dagenham to 3.7% in Hornchurch over the period 1995/97.

Teenage pregnancy followed by lone parenthood is a particular source of concern. For instance, in 1997/99, 30% of mothers aged under 20 in Barking and 39% of mothers of that age in Dagenham were lone parents. At ages 20-24, one sixth of mothers in Barking were lone parents, compared to 1 in 12 of mothers in this age band in Romford.

### **Infant health**

Problems associated with infant ill health or early death, such as premature birth and low birthweight (weighing under 2,500g, about 5¼lb), tend to be associated with social deprivation, lone parenthood and teenage pregnancy. However, stillbirth rates are also high among women in their 30s.

The proportion of low birthweight infants in BHHA was about 9.8% in 1993/95, falling slightly to 9.3% in 1996/98. By contrast, in both Upminster and Romford the percentage of low birthweight infants rose. The percentage of low birthweight infants with lone mothers rose in most PCGs, and from 8% to 11% across BHHA. Low birthweight is also associated with the birthplace and ethnicity of the mother. In 1997/98, some 11% of births to women born in the New Commonwealth were of low weight, compared to 7.4% of births to women born in the UK. Data from RICHs for 1997/99 show that 7% of births to white women were underweight, compared to 15% of births to Indian mothers. Conversely, non-white infants accounted for 14.8% of all low birthweight infants (and also of those weighing between 2,500g and 3,000g). Also important for assessing maternity health needs is the effect of the mother's age on birthweight. Women aged under 20 and those aged over 40 are more likely than the average to have a low birthweight infant.

Analysis has been made of trends in adverse health outcomes at small area level (ward and PCG), in particular recent trends in stillbirths and infant deaths (number of infants per 1,000 live births who die before reaching the age of one year). The stillbirth rate was clearly higher in the Barking and Dagenham areas in 1996/98, while Dagenham and Upminster had the highest infant death rates. Certain wards were notable for their high infant death rates: namely Eastbury, Fanshawe, Chase Cross and Heaton, all with rates over 25 deaths per 1,000 live births.

### **Avoidable hospital admissions**

A wide variety of targets has been set in relation to populations and healthcare outcomes, in order to improve the effectiveness of health service interventions and so contribute to the broader health gain targets of *Our Healthier Nation*. For example, the proposed National Framework for Assessing Performance emphasised such concerns as the need to reduce emergency hospital admissions of elderly people and avoidable admissions in general. Other outcomes relate to concerns such as demand management and performance.

Recent evidence suggests that about 3,000 admissions per year in BHHA are potentially avoidable. These are cases where the first reason for admission is classed as potentially avoidable according to recent national strategic advice. The figure rises to 6,000-8,000 per year if subsidiary diagnoses are also considered. The most recent half year included in the trend analysis reported in the website tables, namely the first half of 1999-2000, shows a fall in avoidable admissions, especially for asthma and ear, nose and throat infections.

Differences at PCG level by half year should be treated with caution, as numbers are small; yet some clear patterns emerge. Over the entire set of five half years included in the trend analysis, a greater than expected rate of admissions for asthma, heart failure, ear, nose and throat infections and kidney infections is apparent in Barking but not in Dagenham. Since these two areas are comparable in relation to many other outcomes and in deprivation levels, these contrasting patterns raise possible issues about demand management and avoidance of hospital admission by pursuing other options in primary care. Certain other unusual features are apparent, for example high epilepsy admission rates for Romford, but these involve small numbers of cases.

A similar contrast between Barking and other PCGs in emergency admission rates for all age groups is evident. Romford also has a relatively high emergency admission rate for the over 75 age group.

Although hospital psychiatric care is not formally designated as a category of avoidable admission, the need to explore the potential of community-based options is increasingly being emphasised. In particular, Barking PCG has above average psychiatric admissions compared to other PCGs, though the contrast has lessened in the most recent year for which data are available (October 1998 to September 1999). Parasuicide rates do not differ markedly between PCGs, except that Hornchurch has a lower than average rate.

## **Communicable disease**

**Authors: Dr G Double and Helen Sandle**

This section of Barking and Havering Health Authority (BHHA) overview relates to the period since October 1999.

### **Key points of interest**

- A new policy for communicable disease control in schools and nurseries was launched in June 2000.
- There was a serious outbreak of Group A streptococcus in a nursing home and a large outbreak of gastroenteritis in a primary school
- The North East London Sector TB Group was set up and a local Health Authority TB group is co-ordinating with it.
- The local meningitis C immunisation campaign was on target, involving both primary care for the under fives and community child health services for schoolchildren and college students. Routine childhood immunisation will continue indefinitely.
- Antenatal HIV screening was introduced successfully on 1 April 2000. Uptake has reached 74% against a target of 80% by December 2001.

### **Policy developments**

- (1) A policy for communicable disease control in schools and nurseries was launched in June 2000.
- (2) The current infection control policy for nursing homes is being reviewed.
- (3) A BHHA-wide infection control policy for both nursing and residential homes is being planned.
- (4) A leaflet on the correct treatment of head lice was produced in conjunction with BHB Health Promotion and was launched in June.
- (5) The waterborne outbreak policy is being reviewed.
- (6) Antibiotic prescribing guidance for primary care is being reviewed
- (7) A joint agency HIV strategy is being developed.

### **Surveillance**

The main findings of the Alert Organism surveillance are set out below.

#### ***Rotavirus***

Incidence shows an increase during the months of January to March but this is, in part, due to enhanced reporting between the laboratory and BHHA. There was a hospital ward outbreak of *C difficile* between January and March 2000. It was successfully controlled.

#### ***Campylobacter***

Reports decreased from 30-65 per month during the months of April to September 1999 to levels of 6-33 per month during October 1999 to March 2000, with the largest decreases being seen

during the January to March quarter. Similar patterns were also recorded for salmonella with levels of 10-40 per month being reported during April to September 1999 compared with 3-27 per month during the current reporting months.

### ***Meningococcal disease***

Eighteen cases were reported during this six month period, fourteen of which also had septicaemia.

### ***MRSA***

Reports within the community showed a significant decrease during the months of December to March with only 0-5 cases per month being recorded, compared with figures of 22-36 per month during October and November. Efforts are being made to work more closely with nursing and residential homes by reinstating Infection Control Link Nurses within each home.

### ***Group A streptococcus***

The increase of infections in March is due to two separate nursing home outbreaks.

### ***Tuberculosis***

The incidence of TB remains comparable with the previous six months. Levels of 0-5 cases per month were recorded during the current reporting period compared with 0-4 cases per month during April to September 1999. Twenty three cases of TB were reported, 16 of which were respiratory infections.

### ***Viral hepatitis***

Reports have highlighted a number of acute and chronic hepatitis B and C infections. More data will be available on these cases once enhanced hepatitis surveillance is established. It is recognised that without this enhanced scheme current data are inaccurate.

## **Other developments**

### ***Introduction of antenatal screening for HIV infection***

In the UK there is a growing problem of women of childbearing age who have HIV infection and risk spreading infection to their baby before or after birth. HIV is a viral infection that is transmitted by exposure to infected blood or body substances, usually by sexual activity. Currently, there are approximately 5,000 women of childbearing age infected with HIV in the UK. There are 300 at risk infants born each year to infected mothers; they have a 1 in 4 chance of being infected.

Inner London has the highest rate of at risk births; 1 in 170-420 depending on the hospital location. Before voluntary, universal antenatal blood test screening was introduced in 1999, over 75% of the infected mothers were undiagnosed at the time of birth. This meant those babies at risk did not receive the benefits of preventive action to reduce the risk of spread of infection to the baby. Ideally, known infected mothers can be offered antiviral therapy, managed labour and avoidance of breastfeeding. All these reduce the risk of infection spreading to baby to below 1 in 20. In addition, the known positive mother will receive counselling and social support by referral to other agencies. The at-risk baby will be followed up and prophylactic treatment can be offered to maximise the chance of a good outcome.

Locally, we have followed the Department of Health guidance and introduced universal, voluntary HIV blood testing from 1 April 2000 as part of the routine antenatal screen done in early pregnancy. The newly diagnosed pregnant woman receives an information leaflet, 'better for your baby' from the GP which recommends HIV testing. The community midwife obtains informed consent after counselling at the booking visit. If the pregnant woman consents, the midwife completes the blood test request form. If the pregnant woman is unsure, she is referred for further counselling or given the opportunity to change her mind.

The most recent results are encouraging and we can aim to reach the Department of Health's target of 80% uptake by December 2001.

### ***Meningococcal C immunisation campaign***

The Department of Health recommended the introduction nationally of routine childhood immunisation with the meningococcal type C vaccine in November 1999. Last year there were 1,530 cases of meningitis and septicaemia in the UK due to the meningococcus type C bacterium, and 150 of these cases died.

Since the campaign started, the public health benefit of immunisation is evident. There has been a 75% reduction nationally in expected cases in immunised groups. The vaccine was found to be safe and protective. The majority of reported adverse reactions are not serious and children recover quickly. Serious adverse reactions are rare.

BHHA Public Health department has co-ordinated the local immunisation campaign which was implemented by all local agencies. There are approximately 95,000 children under 18 to be targeted for meningococcal C immunisation by the end of 2000. The local campaign was very successful. In future, all new babies will routinely receive the vaccination in primary care.

### ***North East London Sector TB Group***

TB sector groups were set up on the advice of a multi-disciplinary group who reported to the NHSE London Region on improving TB control in London in February 1999. The first idea was to co-ordinate commissioning and service provision across health authority boundaries. Later, a sector workshop in September 1999 considered organisational development, quality of care and data collection. The sector group was formally inaugurated in November 1999. Its aims are that:-

- TB should be included in the Health Improvement Programme;
- the minimum rate of completion of treatment should be 90%; and
- there should be an annual audit of TB control.

## Directorate publications, 1999/00

### Research reports

- No 91 **Guidance for commissioners of neurology and neuro-rehabilitation services**  
Dr C Watts *November 1999*
- No 95 **Review of the effectiveness of optometrists in the monitoring of diabetic retinopathy**  
A Lightstone *November 1999*
- No 107 **An investigation of male circumcision in Barking and Havering Health Authority**  
Dr P Messent *January 1999*
- No 108 **Genetic testing for breast cancer and familial breast cancer clinics: a needs assessment**  
Dr A Kessel *January 1999*
- No 113 **Health and social care needs of people in residential and nursing homes. Phase 2b: postal survey**  
K Janzon and  
Dr S Law *November 1999*
- No 114 **Health and social care needs of people in residential and nursing homes. Phase 2a: survey of admissions**  
K Janzon and  
Dr S Law *November 1999*
- No 118 **Health outcomes 1997/98 incorporating a primary care group perspective**  
Dr P Congdon *November 1999*
- No 119 **Valuing outcomes and health states: a case study of the Barking and Havering Health and Lifestyle Survey**  
Dr P Congdon *February 2000*
- No 120 **Coronary heart disease health improvement programme - final report**  
Dr H Meer *November 1999*
- No 121 **Annual report of the Cervical Screening Programme 1997/98**  
Dr F Haste *March 2000*
- No 122 **Pandemic Influenza Multiphase Contingency Plan**  
Dr K Padki *January 1999*
- No 123 **Chemical Incident Response Plan**  
Dr K Padki *January 1999*
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For copies of the above please contact Janet White on 020 8532 6216
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